The doctor–patient relationship: an analysis of framing in general practice

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THE DOCTOR-PATIENT RELATIONSHIP:

AN ANALYSIS OF FRAMING IN GENERAL PRACTICE

BY

DAVID JOHN JOHNSON

A DOCTORAL THESIS

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE AWARD OF
DOCTOR OF PHILOSOPHY OF LOUGHBOROUGH UNIVERSITY OF TECHNOLOGY
SEPTEMBER 1986

BY DAVID JOHN JOHNSON
I declare that the work contained within this thesis is my own and has not been submitted elsewhere for the award of PhD.
I would like to thank my supervisor Alan Radley, for his support, intellectual advice and perseverance.

Thanks also to Mike Turner for providing audio and video recording equipment.

I am indebted to numerous friends and colleagues who have kept me at it from the Midlands, to Wales, to the North East of England. Of these I would especially like to remember Bempah, Julie, Liam, Sue, Steve and Rosie.

I would also like to thank my family for their continual support.

Finally, I must mention Janette, and apologise for the inability to stop changing things!

Dave
ABSTRACT

Utilizing a research technique involving semi-structured interviews and video-recordings of doctor patient consultations within British general practice, an empirically based 'ideal type' is created. This ideal type is seen to rest upon questionable assumptions, and although actors have expectations for behaviour which are consistent with the ideal type, deeper analysis of patient expectations shows them to be aware of the inapplicability of the ideal type in certain consultations. From this perspective one would expect change to be occurring. However using the concept of frames, a detailed analysis of the interaction between doctor and patient illustrates the social constraints, and power structure of the consultation as playing a significant role in the maintenance of the status quo.
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CHAPTER 1

INTRODUCTION TO THE THESIS
1.1. **INTRODUCTION**

"We are all, at one time or another, patients, sometimes unwillingly in the hands of the doctor, but once in his hands, at his mercy", (Abse 1984).

Abse's comments follow in the wake of quite an extensive research tradition which has investigated a phenomenon, central to western society, and yet one that is so inadequately understood. Although Abse's literary style is somewhat more eloquent than that of the present author, attention must be drawn to the claim that we (yes ... as we are all patients at some occasion in our lives) are at the mercy of doctors. The implication is that he will do with us as he pleases. Let us hope that he is benevolent.

The present research sets out with the aim of enhancing our understanding of the doctor/patient relationship, and indeed one area which it will focus upon is this notion that doctors have influence over us. Although Abse probably did not intend it, he is very close to the truth when he says, "once in his hands we are at his mercy". The present thesis intends to provide empirical support for Abse's observation, and to explore, in depth, notions of power and influence as they exist within the doctor/patient relationship.

1.2. **GENERAL PRACTICE**

There are approximately 55,000 doctors employed in the National Health Service, of which approximately half are General Practitioners. On average each General Practitioner having between 2,500 and 3,000 patients on his list (Tuckett 76), some of which will
be seen at regular intervals, others occasionally and some only once or possibly never. Of the conditions presented in the Surgery, doctors tend to view the majority of these as minor (Beckett 54, Eimerl 60). The number of acute life-threatening illnesses which are presented to the General Practitioner take up between 6 - 17% of his time according to Tucketts review of research in this area. (Tuckett 76), the rest of his time being spent dealing with chronic or minor self limiting complaints. These approximations are understood more clearly when one considers the classic work of Dunnell and Cartwright (72) who showed that many General Practitioners regard at least half of their consultations as involving conditions which people could cope with, or treat themselves, without requiring the attention of a doctor.

If we accept the figures concerning the nature and types of complaints presented in general practice, and there appears to be no reason not to, we can see that the General Practitioner's involvement with acute diseases and the cure of life-threatening illness is a relatively rare occurrence. As Tuckett (76) notes a lot of the work of the General Practitioner is "concerned with the long-term management" of illness, and in dealing with 'minor' or 'trivial' complaints. This would question any view that general practice functions to alleviate serious disease and illness. The present thesis intends to investigate this issue from the perspective of what is the role of the General Practitioner and what is the position of medicine as a whole within society. It is argued that a consideration of issues such as these will enhance our understanding of more typically psychological problems such as the nature of
doctor-patient communication.

For the majority of patients the General Practitioner is the doctor of first contact, and possibly the only doctor they will contact. In face of a symptom, which the individual perceives to be a sign of illness, the potential patient adopts a number of behavioural strategies. He can ignore the symptom, seek the advice of friends or contact another person known to have a similar complaint etc. However the individual may eventually contact the surgery to see the doctor, to discuss the symptoms, this decision being based upon a number of factors e.g. the severity of the pain, the prolonged nature of the symptom, anxiety etc. However the point of emphasis is that the individual will contact a General Practitioner in the first instance.

As will be discussed in Chapter 2 the meeting of the General Practitioner and the patient takes place in the doctor's surgery and lasts on average for six minutes. (Balint 73), a factor which is interesting in its own right as a time restriction of six minutes obviously places limitations upon possible behaviour within, and outcomes of, the consultation. The patient proceeds to present his symptoms; the doctor listens and investigates; the doctor offers his interpretation to the patient, some form of treatment is offered and the consultation finishes. This is a very simple view of the consultation which takes no account of such issues as the extent to which the doctor and patient 'negotiate' over the illness and treatment; the way in which the patient's offering of the symptom can restrict the future flow of the interaction; the way in which the
doctor influences the flow of the interaction, and the effects the
doctor can have upon the patient's behaviour after he/she leaves the
surgery. These are some of the questions crucial to the present
thesis, some of which need exploration. However, it is necessary to
elaborate upon the doctor/patient relationship as an area of study,
and the general place of medicine within the social structure, as
these two themes are crucial to the present thesis.

1.3. THE DOCTOR/PATIENT RELATIONSHIP

A number of titles have been ascribed to research in this area: "The
Doctor/Patient Relationship" (Fitton 79), "Attitudinal and
behavioural aspects of the doctor-patient relationship" (Davis 68),
"The Doctor, the Patient and his Illness" (Balint 64), "Doctor and
Patient" (Engtralgo69). In choosing the title, the 'Doctor/Patient
Relationship', rather than Doctor/Patient Communication, the present
thesis is emphasising that there is more to the encounter between
doctor and patient than what can be gleaned from an analysis of
communication between them.

Research into the doctor/patient relationship and doctor/patient
communication has certainly proliferated over the last decade, as is
clearly indicated by the increased numbers of articles in journals
such as Social Science and Medicine; the advent of conferences and
forums looking at doctor/patient relationships; and the slow
intrusion of psychology into the medical curriculum. However, a
number of general observations have to be made with regard to many of
these studies. Most importantly, is the fact that many originate
from within the institution of medicine or gain funding from within
medicine. Indeed this is not surprising. However, one possible consequence of this may be a narrowing of the critical perspective. Within many of these studies, the basic medical approach to illness is taken for granted and attempts to find sources of dysfunction in the doctor/patient relationship and suggestions for improvement, do not question this. There is implicit acceptance that if we can increase the patient's recall of medical information, improve the doctor's communication skills and generally enhance the ability of the doctor to influence the patient, then we will inevitably improve the medical efficiency of the encounter. A distinction needs to be drawn between medical efficiency and communicational efficiency as an improvement in the latter does not necessarily imply an improvement in the former, although much of the work in the area of the doctor/patient relationship would seem to assume that this was in fact the case. And indeed, the effects upon medical efficiency may be negative, if as will be shown in the following section, there are doubts concerning the suitability of the clinical method within general practice.

A great number of studies have looked at the communication between the doctor and the patient, Byrne and Long (76), Ley (67, 72, 76, 80, 83), Pendleton (83), Korsch & Negrette (72), Buijs, Sluijs & Verhaak (84), and Tucket et al (85). Byrne and Long carried out an excellent analysis of the various styles which doctors use whilst talking to their patients. Ley's substantive research was an attempt to discover which style of doctor behaviour would lead to higher patient compliance, and Pendleton's work was a more comprehensive attempt at improving communication between doctors and patients.
So far the thesis has been implying the weaknesses of narrow communication centred approaches and will propose that some of the difficulties which Ley (67, 72, 76, 80, 83) and Pendleton (83) have discovered can be explained by other factors rather than pure communication, eg. with regard to the efficiency of doctor communication and patient compliance, a more powerful explanation may be derived from an analysis of the power structure of the relationship and the expectations which actors take into the situation. Not only do actors communicate on a verbal and non-verbal level (Argyle 72), but there are also expectations and aims which will influence and arguably determine behaviour in the consultation. Therefore to understand the intricacies of the communicative process we need to assess whether or not the actors expect others in the situation to behave in a particular way. Behaviour may perform a function but if the other does not expect such a behaviour this will certainly influence the effect it has. In Ley's early work he was looking to explain non-compliance in terms of doctor's communicative style. However, what if the patient did not expect treatment, or expect to be labelled as 'ill'? The present thesis intends to investigate the role of expectations within the doctor/patient relationship.

1.4. MEDICINE IN SOCIETY

"The drama of Medical care is carried out in the arena of Society" (Cassell 70), and it is essential to take this into account when carrying out a social psychological analysis of the doctor/patient relationship. Medicine performs a number of functions, among its most important being: the alleviation and cure of illness, the
legitimization of the adoption of the sick role, and the regulation of the behaviour of the population. Medicine is strongly integrated into the Social Structure and the relationship between medicine and Society is the way in which medicine affects society, and society in turn affects medicine, a factor which has been overlooked in much of the research.

That the doctor/patient consultation will not be analyzed within a vacuum, but instead behaviours will be placed within the total context of the doctor/patient relationship, a relationship which is more clearly understood when placed within the context of Britain in 1986.

Kendon (79) provided a succinct description of the type of approach to be used here when he claimed that human communication should be viewed as being carried out by people who are; "participants in complex systems of behavioural relationships instead of as isolated senders and receivers of discreet messages". A move away from analyses of simple communicative acts towards an understanding of behaviour from the perspective of the relationship between those actors behaving, and more broadly the context within which that relationship exists. Consequently, any attempt at understanding the doctor/patient relationship needs to include the status of medicine and need for medication as this is in the context.

Telles and Pollack (81) claim that, "the requirement for legitimating illness, which is experienced as feeling sick, help account for the influence of modern medicine". Society assumes that physicians and
others who use modern medical theory can or should certify illness. Furthermore Telles and Pollack point to the fact that medical knowledge is closely related to that area where individuals feel health problems to be i.e. inaccessible, within their bodies. Therefore, not only is medical knowledge a monopoly of health knowledge, but it is specific to that area in which individuals feel health matters exist.

Telles and Pollack argue that deeper interviewing can show how a great deal of patients' answers are not so much concerned with function, but inner feelings and the doctor's medical knowledge is directed towards the management of these intangible internal feelings and states, which facilitates their social control of the patient and eases the medical control which will be discussed in the following thesis.

The practice of locating illness within the body has its origins in the development of the contemporary medical approach. Foucault (75) notes how "the human body defines, by natural right, the space of origin and distribution of disease". It is therefore, not surprising that Telles and Pollack should make the above conclusion. Furthermore, as Armstrong (83) has pointed out, the development of the 'clinical gaze' allowed medics to look into, "the deepest recesses of the body", and to make our internal states "transparent to the medical eye" ... "the body of the patient has become the unquestioned object of clinical practice". Attempts to improve the human condition and enchance our health involve accepting that the body contains an illness/disease. Once the presence of an illness
has been legitimised, measures can be taken to overcome it.

Why then should the individual need legitimisation of his illness? For Telles and Pollack, "From the perspective of individuals who claim to be ill, legitimisation is a process of proving that they have feelings which represent sickness". Furthermore, they point out that other lay persons cannot say whether a person is ill or not, because they cannot discover how they feel inside (which the doctor can). "When individuals visit the physician, they are examined in the light of reported feelings, behaviour and other symptoms in order to establish whether or not the illness exists. Since physicians locate illness within the body, they complete the process by verifying claims that patients have feelings which reflect something very wrong inside" (Telles and Pollack 81).

Telles and Pollack refer to Medicalization as the way in which we locate illness inside our bodies and that doctors control the knowledge of our inner body states, and they have the technical ability to assess internal states. The resulting control which the doctor has indicates that he has power within the consultation, power which is absent in many of the studies of the doctor-patient relationship, and power which will surely affect the flow of the interaction between doctor and patient. This is exactly what Armstrong is referring to in 'The Political Anatomy of the Body' (83) whereby medicine has proceeded to map out the internal structures of the body, but has maintained monopolistic control over these maps so as to ensure their control over the alleviation of illness.
Zola (75) shows how medicine is an agent of social control, and points to the overriding importance which medicine is gaining in Western Society. For Zola, medicalization occurs, "by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existance".

Firstly, as medicine's commitment to a specific etiological model of disease changes to a multi-casual one, and there is a greater acceptance of the concepts of comprehensive medicine, psychosomatics etc., there is an enormously expanding area to which medicine is relevant. Secondly, medicine increases social control through the retention of absolute control over certain technical procedures, eg. the right to do surgery and prescribe drugs, beyond the scope of ordinary organic disease. Thirdly, medicine increases the social control through the retention of near absolute access to certain taboo areas, ie. the almost exclusive right to examine the most 'personal' areas. And fourthly, it does this through the exposition of what medicine deemed relevant to the good practice of life and the use of medical evidence to advance any cause.

Via these four channels, medicine is achieving an increasingly central role in society. The effects of medicine being such an important institution are sadly missing in many analyses of the consultation. As will be argued in the present thesis, the social context within which the doctor-patient encounter occurs is of central importance to the actual interaction, and much of the behaviour within the consultation will be determined by, and in turn determine, the social context.
Conrad and Schneider (80) describe medicalization as existing on three levels. Conceptual Medicalization, where a medical vocabulary (or model) is used to define the problem at hand. Institutional Medicalization involving looking at the legitimisation of what the organisation looks at as medical. Finally at the doctor-patient level where the physician defines a problem as medical or treats a social problem with a medical label. Both Conrad & Schneider, and Zola are aware of the way in which medicine is encroaching into all aspects of society. However, the crucial question remains as to how the doctor-patient consultation is effective in this process. The present thesis intends to offer observations in that direction.

Davis points to the Social Control aspect of medicine. There is an, "increasing tendency for every social or personal problem now, to have a medical dimension" (Davis 79). He points to two aspects of this medicalization. Firstly that deviancy can be taken out of the sphere of judicial and legal concerns if it is seen as a medical problem and soluble by medicine; and secondly as doctors seek to recruit new patients and to extend medical control into more and more areas of life.

One of the clearest discussions of the relationship between medicine and society is contained within the work of Illich (76). Illich points to the impossibility of understanding medicine if one detaches the individual from society. Illich's major aim was to outline the 'damaging' effects which medicine is having, noting that medicine has over reached its optimum level as provider of health care, and as it develops further it becomes more of a danger to health than an
exponent of it. Illich points to the harm inducing effects of medicine in a number of forms. If the general public are aware of doctor caused illness, which Illich refers to as iatrogenic disease, maybe failures in complying with treatment or remembering medical communications are the result of a rational decision. No one can deny the existence of anecdotal evidence concerning the side effects of medication, or the failure of a doctor to arrive at a correct diagnosis. However, of equal importance for the purposes of the present thesis is Illich's discussion of the all pervading occurrence of medicine within contemporary society. If, as Illich claims, medicine is of overriding importance within modern Western society, is there a social psychological explanation for this. The relationship between medicine and economics, especially with regards to the pharmaceutical industry, has been proposed as a damaging influence. However what part does the interaction within the consultation play in enhancing the prevalence of medicine? As the consultation in general practice is one of the main agencies of medicine, in the form of the doctor of the first (and often only) contact, how do events within the consultation indicate the continuance of medical predominance?

Illich claims that society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might be sick, and what shall be done to such people. The very intensity of the 'engineering endeavour' of medicine has translated human survival from the performance of an organism into the result of technical manipulation. No longer is a healthy homeostasis achieved by the individual, but it is the result or the aim of manipulation by
the medical system. A powerful claim and the present thesis intends to search for evidence of this within the consultation.

Illich claims that the medical system tends to 'mystify' and 'expropriate' the power of the individual to heal himself, and to shape his or her own environment, thereby showing how the populace is reliant upon medicine to maintain its state of health, rather than to bring about health within the individual. If, as Illich claims, the professional and physician based health care system tends to mystify and expropriate the power of the individual to heal himself, then we need to consider these occasions upon which the physician has the opportunity to expropriate power from the individual, and it is here that we turn to the interaction between the individual and the medical system. One of the major agencies of medicine is the consultation where the patient meets the doctor in the first instance and where we should have evidence of the 'imposition' of medicine upon the individual, and in turn the expropriation of the power of the individual to heal himself. If we find this then Illich's claims can be appreciated in a different light.

The most obvious explanation for the high utilization of medical resources, and the status of medicine, could lie in the efficiency of the medical endeavour. There is no greater assistance to the salesman, who wishes to exert power over the customer by getting him to buy, than to be in command of a highly efficient product. Can we then explain the status of medicine, on the grounds that it is highly efficient. The evidence would seem to indicate that we can not. Illich (76) has already provided us with material which suggests that
medicine has over-reached its optimal level as a provider of health care in that hospitals and doctors can be a source of iatrogenic disease. Within Illich's work we begin to see a picture of medicine as not being as efficient as some may believe.

Other authors have looked more specifically at general practice, the focus of the present thesis. Cartwright and Dunnell (72) carried out an analysis of consumption of medical resources, and more recently commentary has been made concerning the prevalence of psychological disorders in general practice (Fitton 79, Williams & Clare 79, Verhaak 86). It would certainly seem that the methods learned during medical training, epitomized by the clinical gaze (Armstrong 83), are not totally, if at all suitable, for many of the complaints presented within general practice. The professional skills of the General Practitioner may lead him away from the crucial aspects of the patient's condition.

There is also a need to include evidence which suggests that even in those areas which doctors are believed to be totally confident i.e. dealing with tangible physical illness, there is cause for doubt. Diagnostic inconsistency was illustrated quite clearly by Koran (80) in a study of bronchial patients. It seems that this would also occur with other illnesses such as Tonsillitis (Bawkin 45).

This section has given an insight into the place of medicine within its social context and has offered a number of observations regarding the medical process. The process of medicalisation, including the high utilisation of medical resources, and the encroachment of
medically defined labels into many areas of society is confronted by
a number of questions concerning medicine and its efficiency and
suitability. It is to be argued that many of the studies of the
doctor/patient relationship, and doctor/patient communication fail to
take this into account. The present thesis accepts the relevance of
comments by Illich (76), Zola (76), Koran (80) etc and subsequently
offers an alternative explanation of events within, and surrounding,
the consultation.

1.5. RESEARCH APPROACH

The present thesis is an attempt to explain a social phenomenon by
bringing it down to the level of the individual, and then to consider
the psychology of the individual within his social context. This
approach is typical of a trend which arose in Social Psychology in
the mid 1970's, to understand the individual within his social
setting, or context, and in so doing to move away from the
restricting methodological techniques which has until then hindered
Social Psychology in its attempts to understand human behaviour,
(Harre 76, Forgas 79, Kendon 79).

Any research in Psychology has an implicit conceptualization of the
philosophy of man. Harre (81), and Goffman (56) have shown a strong
tendency to move away from Skinner's mechanistic model of man and its
minimization of the importance of factors internal to the organism.
Harre and Secord (76) developed what they called the
'Anthropomorphic' model of man as not only an agent of his own
action, but also as a watcher, commentator and critic of his own
action. The human individual is imbued with the ability of
self-determinism: "A person is an active agent in much of his social life. He is, if you like, the efficient cause of his own actions. He monitors his performances and controls the manner in which he presents himself to others. He takes care of the meaning of his acts" (Harre and Secord 76).

With such a conceptualization, Harre and Secord give the individual the ability to determine his own actions, and allow for explanations in terms of the meanings which underlie social behaviour.

Gauld and Shotter (77) support this premise ... "human actions have meaning not just in that they happen to induce persons present to think of some related event or circumstances, but in that agents knowingly carry out these actions to fill a place in some wider scheme of things. Someone might draw the blind as a gesture of respect to the dead; or to protect carpets from the sun; or as a prelude to crime" (Gauld and Shotter 77). With such an approach one can see the limits of not taking account of the meanings of actions, as it is the meaning which differentiates what may be identical behavioural occurrences.

Goffman (56) sees the social actor as able to express himself in such a way as to give others the kind of impression that will lead them to act voluntarily in accordance with his plan. Therefore, here we have the social actor who is able, to a certain extent, to determine the way others perceive him, by managing the impression which he 'gives' and 'gives off' (Goffman 56).
However, this self-determinate man needs to be placed within his social context. Behaviour within any social situation takes place against a backcloth of social meaning, at a particular time, and in a particular place (Mead 34). The emphasis is made again i.e. to understand human behaviour we need to understand the context within which it occurs, and this will be reflected throughout the present thesis.

Berger and Luckmann (66) advocate that society, or in their terms reality, is socially constructed. Although the individual is at the heart of the formation and construction of the institutions of contemporary society, these institutions eventually become 'institutionalized' and develop an 'objectivity' of their own. Although institutions appear massive and self existent, this objectivity is a humanly produced and constructed objectivity. The individual creates the institution, and then reifies it as something which has existence above the individual. One could argue that the 'medical system' has been created by individuals within society, and now has 'objectified' itself and has an existence of its own, beyond the control of single individuals. However, such an 'objectification' process is still compatible with the self-determinate ability of man, in that it allows the individual the right to create his own environment, but eventually the institutions he creates may reach an 'objectivity' above him. This approach, often termed the 'social construction of reality' has implications for the present research in that we can study the individual doctor and patient within the consultation, but must also consider the place of the consultation and medicine, in contemporary society. What
Berger and Luckmann (67) allow us is the possibility of analysing the doctor/patient relationship whilst accepting that there may be some bifurcation between how the relationship has developed historically, and how it exists now.

Forgas (81) draws together current attempts to explain cognition in terms of the influences the individual has upon society and in turn the influences society has upon the individual. The emphasis which Forgas calls for accepts the individual but at the same time highlights the need to note the social influences upon his thought.

Mead (34) argued that there cannot be a bifurcation between individual and social phenomena, as individuals are society and society can only be created and recreated in the course of individuals interacting with one another. Mead accepts that behaviour and interaction are essential to the formation and maintenance of the social structure. An approach which is conceptually similar to that of Berger and Luckmann.

McHugh (68), a follower in Mead's symbolic interactionist tradition, claims that institutions exist at the level of interaction. If we accept this premise then it follows that they will most clearly be understood if we look to the interaction.

Medicine is the doctor-patient consultation, the hospital ward, the surgery etc. The essence of this almost Weberian approach is to bring large scale social cultural phenomena down to the analytical level of actors and meaning and expectations. Phenomena such as Protestantism became socially effective only through their influence
upon individual action and interaction (Weber 30).

The work of all these theorists eg. Weber, Mead, McHugh, Harre point to the necessity to consider the interaction, as this is where the institution of medicine manifests itself, whilst at the same time not discounting the influence of the context within which the interaction occurs, and the representations which the actors have of the situation.

Such an approach points the thesis in a direction markedly removed from the traditional experimental approach to psychology. There is need for an observational study in which data is collected within a naturalistic setting. When investigating an area such as medicine this provokes enormous methodological difficulties in terms of collecting data to analyse. Furthermore, any attempt to impose a rigid quantitative paradigm upon the data is liable to obscure the crucial social psychological processes operating with the relationship (see Brenner 78 for a discussion of the relative merits of quantitative and qualitative studies). Reference here is made to a call by David Silverman, at a recent forum on medical communication (85), for an increase in qualitative studies of medical encounters. Such an approach will be adopted throughout the present thesis.

1.6. SUMMARY
To date a number of approaches have been adopted in an attempt to enhance our understanding of the doctor/patient relationship. As Robinson (73) notes, everyone can expect to fall ill and as the figures show (Annual Abstract of Statistics CSO 1985 and Buxton M.J.,
Klein R.E. 1979), utilisation of medical resources is extremely high. Everyone can expect to be involved in a doctor/patient relationship.

Medicine takes a prominent position in contemporary society. However, there is a great deal of literature which may question the status of medicine. The existence of iatrogenic illness (Illich 76) certainly questions the efficiency of the medical endeavour. The enormous variations in patterns of diagnosis, often referred to as diagnostic inconsistency (Koran 80, etc) would also seem to lay questions at the door of medicine. And questions concerning the applicability of the clinical method to the doctor/patient relationship in general practice, especially with regard to the prevalence of psychosocial complaints, (Williams and Clare 79) also seem to undermine the medical endeavour.

And yet medicine maintains status, and consumption of medical resources remains high. The present thesis does not intend to analyse the efficiency of medicine, but attempts to offer an explanation of the place of medicine in terms of social psychological processes such as giving up responsibility to medicine for our state of health. Attention will be given in Chapter 2 to literature which has investigated the doctor/patient relationship.
CHAPTER 2

REVIEW OF THE RELEVANT MEDICAL LITERATURE
2.1. **INTRODUCTION**

A great deal has been written on the doctor/patient relationship and whether or not it is viable to talk of such a concept. The difficulty of definition is the result of the diversity of subjects which have been studied using this term. Some refer to the immediacy of interaction between the two actors e.g. Byrne and Long (76), whilst others refer to broader aspects of the relationship e.g. Parsons (51a, 51b, 75). Consequently, a problem was posed for the literature review, in that there is not a set and readily defined literature area to consult, criticise, update and develop. However, one point needs to be made here and that is that if we alter the focus of the literature review, we will alter the perspective which the research takes and therefore inevitably alter the nature of the problem. Research on doctor/patient communication makes the assumption that communication problems and non-compliance can be overcome if, for example, we improve the communication skills of doctors (Pendleton 83, Maguire 79). Three basic flaws are seen in this type of approach. Firstly, it is incorrect to assume that the clinical method based upon biomedical knowledge (Tanner 76) is totally suitable to the consultation in general practice. Secondly, such approaches focus primarily upon behaviour to the exclusion of 'external' factors such as knowledge and expectations, and as a result are guilty of narrowing the problem down and avoiding some of the most crucial influences upon the consultation. Thirdly, although the literature claims to be an analysis of the doctor/patient relationship, a great deal of this work is concerned with doctors and patients talking about the consultation, rather than looking at actual consultations. Therefore the present Chapter begins with an
assessment of the traditional approaches to doctor/patient communication and interaction, and then moves on to consider literature which allows a clearer understanding of the problem as we can see the context within which the consultation exists.

2.2. THE DOCTOR/PATIENT CONSULTATION

One of the major criticisms of work on doctor-patient communication is that it attempts to concentrate too heavily on the actual consultation and fails to appreciate the fact that the consultation takes place within a broader social context, (many of these studies do not actually get to grips with actual interaction and focus on actors talking about the interaction), a context which inevitably affects the interaction. There exists an extensive amount of research into communication within the doctor-patient consultation. One of the most precise studies which overcomes the weakness of not analysing actual interaction was conducted by Byrne and Long (76). They conducted a two and a half year survey into doctor's verbal behaviour in surgeries, on the rounds and at the bedside, to discover the general features of the consultation, and any features which were doctor-centred idiosyncracies. They arrived at an eventual list of 55 possible behaviours, ranging from advising, answering patients' questions to refusing patient ideas and then grouped these on the basis of whether their approach was patient centred or doctor centred. The most clear example of patient centred behaviour being 'using patient ideas', and the most clear example of doctor centred behaviour being 'self-answering questions'. Byrne and Long assume that doctors learn a package of behaviours which seem to work in most instances, and this package then becomes ossified, with the doctor
utilizing this style in the majority of his consultations.

A number of interesting observations of Byrne and Long's study can be made. They appreciated that the majority of doctors tended to use doctor-centred styles, which would make the doctor the dominant partner in the interaction, in terms of his ability to direct both the patient and the interaction. The doctor-centred style can be described as the verbal side of the 'clinical gaze' referred to by Armstrong (83) and in so doing contributes to the effect of converting the patient's body into a structure, which is and can only be, understood on the basis of sophisticated medical knowledge. Further to this, Byrne and Long make the observation that, "as long as illnesses can be rationalised into standardised symptoms, then doctor-centred styles are good for doctors to use". Figures relating to the nature of complaints presented in general practice will immediately allow us to draw the conclusion that doctor-centred styles are not (always) good to use, because patients rarely present tangible illness (Fitton 79).

However in terms of its understanding of the doctor-patient relationship, it did provide a very detailed and comprehensive catalogue of the doctor verbal behaviours, but (and the authors accept this) it did not consider the verbal behaviour of the patient, and non verbal-behaviour which would of necessity be an integral part of any comprehensive social psychological analysis. However, their study, and more recently Buijs, Sluijs and Verhaak (84) illustrated some of the problems involved in analysing doctor/patient interaction which is of methodological value.
More recently, Pendleton has carried out a number of studies into communication between doctors and patients, pointing to the importance of, "the social psychology of the particular consultation ie. on the mutual and reciprocal expectations, preceptions, attitudes and communication skills of the participant" (Pendleton 83). Pendleton's studies approach particular aspects of the consultation. One study, which was deliberately one sided, looked at General Practitioners' perceived communication difficulties in general practice (79), finding that the most influential predictor of communication difficulty was the doctor's estimation of tension within his patient and himself. In a further study, Pendleton (83) found that, "General Practice consultations differ in the amount of medical information that is communicated to the patient." There were two extremes; doctors who give very little in the way of explanation and information and doctors who see themselves as health educators and use the consultation as an opportunity to teach. Although Pendleton sets us on the way to understanding social psychological processes within the consultation, there is a dearth of reference to actual interaction.

In a discussion of the implications of his work, Pendleton shows how doctors can improve the amount of influence they can have on a patient's attitudes and behaviour by improving communication and volunteering more information. If this were to occur it could lead to an increase in the control which the doctor can exercise over the patient as the patient's behaviour would be even more influenced by medical ideas. However, Waitzkin and Stoeckle (72, 76, 85) argue that to give such information to the patient reduces his uncertainty
and reduces the power of the physician and it is unlikely that
doctors will give such information as this maintains an imbalance of
power in his, the physician's favour. However, surely it depends
upon the type of information given, as highly technical or medical
knowledge could possibly increase the patient's reliance upon the
doctor. Furthermore, Waitzkin's model of power is based primarily
upon that of Dahl, which as will be shown in Chapter 3, covers
certain aspects of the power structure of the consultation, but is
lacking as a comprehensive analysis. Refering back to Pendleton,
although his work can be interpreted in this manner and therefore
have implications for the theoretical developments to be made within
this thesis - which are concerned with power and influence and the
control of knowledge as a source of power - the particular stance
which he takes is common to much of the doctor/patient work i.e. if
we improve the doctors communication skills we will improve the
efficiency of the consultation. This was taken up by Bochner (83)
who noted that, "Communication effectiveness depends on the doctors
becoming more sensitive to the frames of reference, linguistic usage
and life styles of the patients". This is exactly the point - the
efficiency of the communication may be enhanced, but this does not of
necessity imply any increased medical efficiency. The present thesis
makes the assumption that studies such as Bochner, and Pendleton
overlook the fundamental problem and focus upon minor issues. To
confine problems within the doctor/patient relationship to deficits
in social skills is a gross over-simplification.

Furthermore, an article by Jaspers et al (83) offers the following as
explanations for communication difficulties: because the doctor was
unable to influence the patient or persuade him there was a problem; because the patient did not believe him or had no confidence; because the patient may not offer a symptom; because the patient may offer two symptoms and confuse the doctor and; because the patient may be anxious. Again, and it needs to be emphasised, studies such as these focus largely upon behaviour and how to alter communication styles. As such, the social skills training, and the behavioural theory it is based upon, are always guilty of attempting to paper-over the problem by altering behaviour with no concern for the underlying cause of the difficulty. As far as evaluating the effectiveness of these studies, Pendleton accepts "that a measure of improvement in the patient's health may not be helpful due to the nature of general practice". Implicit in this comment is an acceptance that there is a more fundamental problem.

Indeed, the possibility is raised that compliance with the treatment may not be of invariable value to the patient. (See Chapter 1). However, this is pushed aside as "a matter for medical scientists to discover in evaluation of therapeutic regimes" (Pendleton 83). Two points can be made here. The first is that it is for medical scientists to evaluate their own clinical method, but it is not beyond the scope of social scientists to also offer comment and evaluation. The work of Illich (76), Koran (80), Cartwright 69) does point to weaknesses in the medical approach and for researchers, in the area of the doctor/patient relationship, to avoid such 'evaluations' is largely due to the manner in which medicine and general practice has evolved. Certainly many of the problems which are presented within general practice, and have therefore crept under
the purview of doctors competence, such as the whole array of psychosocial complaints, the doctor has no logical right to deal with, and indeed very little training. Via the process of medicalisation discussed within Chapter 1, the medical perspective is now accepted as being applicable and able to offer legitimate comment upon a number of problems beyond its professional training. Medicine, and particularly general practice, has gained the franchise to comment upon the symptom, whether it is a sign of a tangible illness or not. The second point is that although being aware of such a fundamental hurdle, many researchers go ahead regardless. If as Pendleton and others have shown, studies of compliance show a high degree of variance, one can explain these as being influenced by a powerful intervening variable i.e. the possible inapplicability of the medical model.

Tanner (76) argues that the language in the doctor-patient consultations has to be seen in the context of other non-linguistic acts, and a need to understand both the doctor's and the patient's behaviour within the consultation. Tanner's contention was that if the interviews in General Practice were more accurately oriented as regards language and communication, then General Practitioner's could achieve a better level of primary care; thereby, noting the importance of communication within the consultation upon therapy. Again, although this is accepted, the present thesis places more emphasis upon the pragmatic aspects of communication and how actors influence and direct each other via the communication between them. Deeper consideration of social influence processes may be able to offer an insight in this direction.
Freemon et al (71) were critical of the lack of scientific enquiry or the quantification of the doctor-patient relationship, and conducted research into communication between doctors, mothers and children in a triadic consultation. Freemon used Bales' Interaction Analysis (55) "because it allowed for the quantification of the interaction into distinct units designed to capture the nature of the communication process itself". They, not surprisingly, found that doctors gave most of the instructions in the consultation, and that mothers tended to express agreement with, acknowledgement and understanding of what was being said. This instructional behaviour would appear to put the doctor in a position of control. Furthermore, the "doctor asked for suggestions from the mother in only 6 out of the 285 cases and ... it was primarily the doctor who asked for information". As a result of applying 'Bales' to the consultation Freemon puts the doctor in a powerful position. Although Bales' technique was not developed to be applied to situations such as the doctor/patient consultation, it is of methodological assistance in that it gives an insight into how to break the content of the communication down to facilitate analysis.

However, Freemon also points to another aspect of the doctor-patient relationship which will be developed in the present thesis i.e.

Perhaps the medical consultation itself represents an implicit request for help from mothers and therefore, specific requests are not verbalized. Here Freeman indicates what appears to be fairly obvious i.e. that there is an implicit aspect of the relationship, and certain expectations as to what will occur within the consultation. Moreover, Freemon also points to evidence that patients do not contradict or conflict with the doctor in the
consultation, as it is not within their role prescriptions to do so, which indicates implicit acceptance of the fact that the patient will accept what the doctor says. However, this needs to be taken on the grounds that it is purely in terms of the interaction, and doesn't necessitate that the patient will accept what the doctor says once she has left the consultation, and indeed individual variation may predict that certain patients will question within the consultation.

Ley (76, 83) questions the efficiency of the consultation, and particularly the communication of information from the doctor to the patient. Ley noted how doctors' views differed over the amount of information they felt they should give to the patient. Furthermore, patients often lack the knowledge which doctors think they have given them and often report that they have not been satisfactorily informed about their medicine. Ley substantiated this claiming that patients do not understand, and do not recall what they are told, and are too diffident to ask for information when they do not receive it. This lack of understanding which Ley points to is congruent with the idea that 'medicine' as a whole, seeks to expropriate from the individual the right to assess his own condition, and to keep him in ignorance of it is one way of maintaining this control. However, more recent work by Pendleton (83), shows that patients tend to remember approximately 85% of what they are told, but it needs to be said that such information is housed within a medical context, and may not be a source of control for the patient, but more an acceptance of what the doctor has told him. Ley's work was oriented towards increasing patient compliance with the treatment and he suggested various techniques for facilitating this. However, these persuasive
techniques and technical help will all serve to ensure that the patient is incorporated into the medical system to a greater degree, and it is unlikely that they will lead to a great ability on the part of the patient to look after himself in the true sense of the word. Reference here is made to the locus of control concept (Rotter 71, Lefcourt 76) particularly the health locus of control (Lau 81, Wallston 78). Such studies have shown differences between individuals in their health locus of control - some falling at the internal end of the continuum, others at the external end.

The present thesis argues that such studies tap a somewhat fallacious belief system and although it may be meaningful to the individual to view himself as internal or external, the reality of the situation is that we are all externals when it comes to evaluating our health status and maintaining it.

Garrity (81) claimed that, "studies of clinician-patient interaction ...... are not very numerous in the literature". Although this comment is directed towards compliance studies, it does indicate that it is difficult to analyse doctor/patient interaction. However, one can ask, does the patient receive medical recommendations clearly from the physician, and do doctors communicate effectively? The present thesis is not so much concerned with how effectively they communicate but given this communication is coming from a medical source, whether or not the patient remembers the treatment, or takes the tablets, and does she play the role in the consultation interaction of the person seeking these. In a review of Ley's work, Garrity notes how patients only recalled on average 50% of what they
had been told in the consultation and the reasons offered for this level of recall were that the consultation involved a large number of statements, anxious patients, with little medical knowledge.

This would appear to fit with the idea that the patient remembers aspects of the consultation as put forward by the doctor, but that the doctor maintains the monopoly over medical knowledge, and the patient maybe doesn't remember it because he doesn't understand it.

Furthermore, Garrity notes how much work in the doctor-patient interaction often relies upon the doctor or patients' subjective estimate of some variable, such as doctors' assessment of the state of tension in himself and his patient (Pendleton 79). However, it is felt that research aimed at studying the interaction should focus upon direct analysis of the actual interaction. Social Psychological techniques should be applied to interaction sequences of doctors and patients within the consultation. Tuckett (84) makes this point in his call for the collection of data within consultations.

Svarstad (79) clearly showed how compliance was related to physician clarity and explicitness. 65% of patients in the study asked one or no questions of the doctor. The usual patient response when the doctor used a term the patient did not understand was silence - 44%, and to pretend to know - 33%. If these figures are accepted it would appear that the patient does not question the monopoly of medical knowledge which the doctor has. In fact the patient does not even try to come to grips with a simplified version of it. This leads to the claim that the patient does not need to know the complexities of
medical knowledge. Haynes (76) argued that "The record may well indicate that a physician told a patient to do so and so, but unless the patient understood what the physician said, there was no effective communication". The extent to which effective communication is an essential feature of the consultation is open to debate, and it appears unlikely that the patient will ever be able to totally understand what the doctor tells him, and indeed it may disrupt the functioning of the system of General Practice if the patient ever does attain too 'educated' a role with the consultation, as a result of a too efficient doctor communication. However, it would be interesting to look at the pedagogic nature of doctor communication, certainly in the light of Andersons' findings on correct and incorrect recall (86).

The title of Balint's book "Six Minutes for the Patient" sums up one of the major problems of the General Practice consultation, ie. that General Practitioners have very little time to spare for each patient, and have a busy schedule, with a morning and evening surgery interspaced by house calls and other functions. Appointment sheets are always full, with waiting rooms bulging at the seams with members of the public in need of a doctor. The doctor must exercise a certain amount of control over his patients so that he can at least see everyone who wishes to see him. The constraints of time often enters the doctor-patient relationship, but research appears to give little credence to the effects of time. Balint asked the question; what can be achieved during such short episodes. His solution was to change the emphasis of the interaction to lead to the development of an intimate relationship between patient and doctor, in which there
will occur a 'flash' of understanding. However, for present purposes we will constrain ourselves to accepting his clarification of the problems of time restrictions.

One of the earliest attempts at producing a typology of the consultation and doctor-patient relationship was the pioneering work of Szasz and Hollender (56). They produced a diagramatic representation of three main styles which they felt the doctor-patient interaction could be categorized into. The typology is fairly self-explanatory, and shows how the general behaviours of the doctor and patient could be grouped together. The first model is activity/passivity where the doctor does something to the patient; and the patient is unable to respond, as in the cases for anaesthesia or coma. The second model is one of guidance - co-operation where the doctor tells the patient to do something and he co-operates by doing it, as in the case of acute infections. The third model describes mutual participation whereby the patient helps himself and is a participant in the partnership, as in most chronic cases. This outline can be criticized for classifying consultations as either/or, but it did show the different styles which the consultation could take. Guidance/co-operation and mutual participation would, at first glance, appear to be applicable to general practice, where we see the occurrence of acute infections and the management of chronic cases. However, this gives the wrong impression of the power structure within the consultation and attributes an incorrect style of influence to the patient. The present thesis intends to argue that it is in fact a more complex process with what may appear to be mutual participation, still involving doctor control due to the
medical nature of the interaction. It is argued that the process is orientated so that it appears that the patient is participating, when in actual fact he is largely behaving in the direction desired by the doctor. For example increasing the patient's management of his treatment could be seen as leading to mutual participation. However, the need for treatment as defined by the doctor reduces the patients initiative ability right from the start (for a more extensive discussion of Szasz & Hollander's model, see Stone 79).

In terms of compliance to treatment, it is interesting to note that it is suggested that to incorporate the patient into active involvement with the treatment will increase compliance. However, it is questionable, due to the control which the doctor exercises, that one can incorporate the patient into a strategy at a level where he will feel self determining, and will be self determining. Stoeckle and Swain (77) looked at the extent to which active patient orientation was correlated to blood pressure control and compliance with medical recommendations. Active patient orientation could result from Byrne's (76) patient-centered style, but again the argument within the present thesis is that any active patient participation is housed within a medical frame, which points to the reliance of the public upon medicine, even though they, and their doctor may perceive themselves to be in control. They are controlling, in a way which is medically prescribed.

Garrity reviewed a number of studies which have looked at the affective tone of the interaction (76). Svarstad's work looked at physician's mumbling and cutting off patients in response to their
questions, and how approachable is he in terms of greeting and responding to pain. Svarstad found a variation in levels of approachability to various doctors and Davis and Korsch supported this with claims that the more friendly the doctor was, the more compliance there would be, and vice versa, the less friendly the less compliance.

Brown and Freeling (76), also point to the affective aspect of the consultation, in their three level analysis of the relationship. Firstly, they saw the *informative* nature of the consultation, and the conveying of information within it. Secondly, the *promotive* nature, to initiate certain actions on the part of the doctor. And thirdly, the *evocative* nature to produce feelings within the doctor. Brown and Freeling see the consultation as an environment in which emotive aspects can play a part. However, of more interest to the present work is that they point to the *promotive* nature of the consultation, whereby the doctor can initiate actions on the part of the patient, and thereby control and influence his behaviour. The *informative* aspect of conveyance of information is related to the promotive aspect as many of the doctors actions involve implicit information. The use of a stethoscope directs the patient but also conveys the information that the doctor needs to know the patient's internal state. Moreover, Brown and Freeling note that when a general practitioner is chosen by the patients as the person who possesses the necessary knowledge, understanding and power to help him solve his problems, roles have been allotted and any interaction which takes place will have a particular meaning as a result. Again this indicates how those who look at the doctor/patient situation
from a medical perspective seem to make the assumption that the doctor has the necessary, understanding and power. There are expectations and prescriptions for behaviour within the doctor/patient relationship which need to be assessed (see Chapter 4). However they also need to be analysed in terms of implications for the relationship as a whole. Doctor and patient may share expectations for what will occur in the consultation, but this does not of necessity imply that such expectations are going to be of unquestionable value to the patient. The nature of these expectations needs, at least, to be discussed and evaluated.

Entralgo (69) restricted his work to the doctor-patient consultation as it exists in General Practice. His approach however, goes much deeper than the analysis of communication technique, towards the therapeutic aspects and the attachment between the doctor and the patient. He sees the doctor as needing to find the physical fault in the patient, but also needing to reproduce in his own mind the meaning the patient's illness has for him, as this is essential if diagnosis and treatment are to be perfect. When medical care is what it should be, the link between the patient and the doctor is 'love', thereby indicating that the doctor-patient relationship should go deeper than the interaction between a professional and a client. However, Entralgo was also aware of the communicative behaviours, as the doctor must look at his patient, talk and listen, touch him with his hands and make use of a great number of different exploratory and therapeutic instruments.

Entralgo uses the concept of 'philia' or more specifically 'medical
philia', to describe the relationship between the doctor and patient, "to which the doctor contributes his desire to give technical help, and the patient's confidence in medicine, and the doctor attending him". The patients' friendship for the doctor takes the form of trust, as he expects the doctor will help him regain his health, although this hope always contains a tiny thread of fear, whilst the doctor's friendship should consist above all, in a desire to give effective technical aids. The doctor's benevolence is conceived and realized in technical terms.

Entralgo develops his analysis of the structure of the relationship between the doctor and the patient. The doctor not only needs to look at his patient to objectively perceive him, but to comfort him and discover deeper psychological aspects of his illness. In this sense, Entralgo's work adopts a similar perspective to Balint & Norrell (73), whose aim was to get deeper into the therapeutic aspects of the relationship itself, rather than seeing it as a purely medico-physical encounter. Entralgo's attempts to integrate two aspects of the doctor-patient relationship, the objective physical side and the co-operative assessment of the patient's subjective assessment of his illness, is an early attempt to look at the phenomenological aspects of the consultation.

In looking at doctors and patients talking to each other, Entralgo noted that words perform more functions than just what they say ... by speaking to another we impose ourselves upon one another. Calling on another person's attention makes us begin to live in his company. "By speaking to someone else he is asserting himself". When a sick
person talks to the doctor, merely by speaking to him he is appealing to him, informing him of something, naming that thing more or less exactly and persuading or dissuading him of something. At the same time he is receiving companionship, relieving his feelings, illuminating his own mind and asserting himself. For Entralgo, no consultation can be effective unless the doctor keeps this in mind. This is also the case with expectations. Not only do they exist as behaviours, but they also have deeper meaning and implications which need to be understood.

Entralgo also showed how much the doctor can direct the patient with his verbal behaviours. By interogation, the doctor can question the patient about his life and the symptoms; by stimulation he can get the patient to continue discussion and amplify the problem; by orientation he can help the patient keep on the right track and avoid useless digressions; by suggestion the doctor's remarks can aim at encouraging the patient all the time; with instructions he can direct the patient's behaviour at times of investigation; and by silence he can allow the patient to talk. Furthermore, the doctor must not talk about himself, but about the patient and his illness, and by the tactics referred to above we can see how the doctor can control not only the patient, but also the direction of the interaction. Entralgo is pointing to the ability which the doctor has to influence the patient. As will be discussed in Chapter 3, this influence is to be seen as crucial in understanding the doctor/patient situation.

One of the most important aspects of the doctor-patient consultation is the diagnosis. Blaxter's work 'Diagnosis as Category and Process'
(78) points to this area, which needs to be understood, if we are to produce a critical analysis of the doctor-patient relationship. Blaxter sees diagnosis as central to the practice of medicine, and sees it as a category in that a person's symptoms are designated into some disease or illness category, and as a process in that diagnosis also entails the reaching of a decision as to which category the symptoms are representative of. Poikolaimen (79) sees diagnosis as, "essentially a means of prediction, ... , a hypothesis about a patient's prognosis, based on ideas about his or her diseases and their causes". Both Blaxter and Poikolaimen note how a doctor's diagnosis is based on ideas, and have questioned diagnosis as being a science, which implies that there is a strong subjective aspect to it, although once conferred it takes on the role of an undeniable truth. In this light, we begin to see how some of the criticisms of the clinical method made in Chapter 1 may be over-looked, but what is needed is an analysis which will explain how possible uncertainty may be built into an 'undeniable truth' and further how the General Practitioner can create a situation, with the assistance of the patient where no major questions will be asked.

Balint (72) notes two underlying justifications for diagnosis. It has a reassuring effect on the patient in that if you know what you've got you can hope to get rid of it, and on the general practitioner in that treatment should not be started until a diagnosis is made and the patient's symptoms classified, as a result of which the patient is incorporated into the medical system, and his behaviour affected accordingly. Balint claims that nearly always the chief and most immediate problem is a "request for a name for the
illness, for a diagnosis," indicating the need for a medical verification of the problem. Furthermore, should the doctor find nothing wrong with the patient ie. deny the patients proposition, this is no answer to the patients demand for a name for his illness, and he may therefore feel let down and unable to explain his pains, fears and deprivations. Although Balint possibly overemphasizes this point, it does indicate the public's need for the medicalisation of pathological body states, be they major or minor. However, the present author believes that this notion that all the patient wants is a diagnosis, needs to be questioned. Balint paints a picture of the patient inevitably requiring a diagnosis, and indeed studies of expectations would seem to confirm this. However, such a claim takes away freedom of choice, and although the present author would agree and claim there are pressures towards 'diagnosis', the patient may not be as 'blind' in such a search as is implied in much of the work.

Balint argues that if the doctor arrives at a correct physical diagnosis, even if his therapeutic effort is unsuccessful, or no proper therapy exists at all for that particular illness, he feels reassured because the patient's suffering can be accounted for, can be explained, which in turn means that it can be accepted by the doctor without guilt feelings. He will feel he has done a good job; he has found the cause of the suffering; for the rest he is not responsible, even if there is not much he can do. Any lack of therapeutic success can be ascribed to the present state of knowledge. If one accepts Balint's assertion it appears that diagnosis and the incorporation into the medical system is likely to occur due to the need for justification on the part of both actors.
The principles of self-justification (Aronson 80, Festinger 57), operating with the doctor justifying his own position by diagnosing the symptoms, and the patient justifying going to the surgery with 'at least I'm going to get a name for my illness'. All of which would seem to imply that the forces of self-justification are causal in the medicalization thesis, i.e. if the medical system exists ... use it.

There is considerable literature which has looked at the expectations and knowledge which doctors and patients take into the consultation and the norms and obligations which are contained within the encounter. However, the occurrence of expectations and the influence of expectations and norms upon the actual interaction within the consultation is a neglected area, and the present thesis aims to highlight the influence which these factors can have upon the interaction.

Fitton's (79) assessment of the expectations which patients take into the consultation was of prime interest from the perspective of the present research, although he did not assess doctor expectations of themselves. The following were found to be prime patient expectations: certificates; prescriptions; clinical examinations; investigations; referral. The results of Fitton's work in terms of percentages and detailed discussion of expectations will be reserved until Chapter 4 which assesses the extent to which patients and doctors have shared expectations. However, two points will be made at this juncture. The content of Fitton's expectations is somewhat ambiguous. The distinction between clinical examinations and
investigations is vague and it is 'assumed' that respondents were unsure as to exactly what the difference between an examination and an investigation was supposed to be. Secondly, on the two clearest defined expectations, ie. prescription and certificate, there was a marked similarity between doctors' expectations of their patients and patients' expectations of themselves. This is taken to indicate the possibility of shared expectations and is developed within the present work.

Garrity (81) reviewed studies which looked at the expectations which interactants bring to the encounter. He claims that the symbolic interactionist perspective is one in which people who bring non-complementary expectations to the interpersonal encounter are likely to experience conflict, and how from the doctor-patient perspective such conflicts are liable to lead to non compliance. Overall and Aronson (63) found that patients with unfulfilled expectations were less likely to return for future consultation. Although this research looked at the effects upon compliance, the present research sees expectations and the shared nature of them as contributing to the control the doctor has over the patient. An interesting aspect of this discussion of expectations was put forward by Becker at a conference on Psychology and Medical Practice (82). He argues that "patients express surprise when asked if they concur with the doctor's diagnosis". The surprise is the result of the fact that they don't expect to be asked. It would be interesting to discover at some length whether or not these expectations have a determinate effect upon the interaction.
Furthermore, Davis, Korsch et al (69) noted that as the nature of the physician-patient interaction departs from culturally prescribed norms, compliance grows less. One possible explanation for this is that within any social situation, if events deviate too markedly from what is expected the following interaction will be disrupted. The findings of these studies were replicated by Ley (67) and Kasl (75) whose results substantiated this expectation/compliance hypothesis. In fact further work by Frances, Korsch and Morris (69) has shown how expectations can affect compliance, especially when subjects reported they had expected explanations from the physician about the causation of the problem and investigatory tests, and had not received them.

The discussion of work which has looked at the expectations which are brought to the encounter is building a picture of the consultation as fairly rigidly structured, and any deviation from that traditional structure is disruptive. It will be of value to discover exactly what the traditional expectations are for the doctor/patient situation and to investigate the attempts which both a doctor and patient make to stay within that framework. If, as has previously been inferred, expectations need to be seen in the light of their broader implications, we may be painting a picture of a consultation in which both doctor and patient collude to maintain the traditional structure. A recent paper by Todd and Still (84) points to coping patterns which doctors may resort to when confronted with the problem of not being able to help the patient. In this instance, expectations provided by the traditional roles of doctor and patient did not really fit the dying patient's situation, and yet attempts were made to maintain this structure.
Enralgo (69) notes three obligations of the patient to the doctor ie. loyalty, confidence and detachment. The first one of these obligations certainly allows the doctor to control the patient. For the patient to show that he has confidence in the doctor is a prime concern in Enralgo's eyes. The patient can show this by accepting the doctor's judgement and following the prescribed treatment. Although many studies (Ley 79, Pendleton 83) have shown that patients do not always follow the prescribed pattern of treatment, the existence of this obligation will allow the doctor the potential to control the patient as it will enhance the patient's acceptance of the doctor's direction.

Pratt (57) touched upon the idea of framing to be developed in this work.

"In any social relationship the various participants approach each other with distinctive interests that they seek to assert, and goals that they hope to attain. Each participant holds a partisan viewpoint, based on his distinctive interest and goals, which frames the way he experiences and interprets events in the relationship, shapes his behaviour towards the other participants, and helps him to focus on attaining his goals". Here Pratt has stated that both actors take expectations into the situation which will affect the way they experience the situation. The theory of framing to be developed contains this aspect i.e. that actors have representations of the consultation which determine what they expect and how they behave, and that these representations are based upon experiences in such situations previously.
So far in this review of what the doctor and patient input into the relationship we have considered expectations for the encounter. The most comprehensive review of expectations for the consultation being contained in the work of Fitton (79). However, expectations are not the sole input into the consultation. Both doctor and patient have, what may be called, a stock of knowledge which they take into the consultation, and various attempts have been made to assess the structure of this knowledge and indeed how it may affect the interaction.

Friedson (70) notes how, "practice generically consists in interaction between two different, sometimes conflicting sets of norms" in showing how physicians may share special knowledge, identity and loyalty with their colleagues, rather than the layman. He describes two systems of knowledge, the professional and the lay, and within the doctor-patient situation the two touch and Friedson sets the scene for the bringing together of these two systems: "Obviously the prospective client must perceive some need for help and that it is a physician who can help him". There are two implications of this observation by Friedson. Firstly, that this statement explains a great deal concerning the nature of the doctor-patient relationship. The patient is in need of help and assistance and the doctor will provide a service. Looked at within a vacuum this would appear to place the patient in a subordinate role, as he is open to manipulation by the doctor. However, the nature of this control is confined to the doctor-patient relationship and the patient may return to a superordinate role once away from the confines of the relationship. It is to be argued within the present
thesis that the patient does accept a subordinate role within the consultation, but this is not total subordination as the patient can, and does, exercise power within the consultation and outside of it.

Secondly, conceiving the need for 'outside help' for a physical disorder seems to be initiated by purely personal, tentative self-diagnosis according to Friedson. Initial self-diagnosis is seen to stress the temporary character of the symptoms and to end by prescribing delay to see what happens. If the symptoms persist, simple home remedies such as rest, aspirin, antacids, laxatives and change of diet will be tried. At the point of trying some remedy however, the potential patient attracts the attention of his household, if he has not asked for attention already. Diagnosis is then shared and new remedies may be suggested, or a visit to a physician. If a practitioner is not seen but the symptoms continue - the diagnostic resources of friends, neighbours, relatives and fellow workers maybe explored. Therefore, the whole process of seeking help involves a network of potential consultants, other laymen, someone who has had this symptom, an old nurse and eventually a good doctor. Freidson notes that the 'lay referral system' involves a series of more intimate and more formal consultations until the professional is reached. The individual does not just arrive at the consultation and any analysis of the consultation will be undoubtedly strengthened by at least a brief description of factors surrounding the patient's arrival at the consultation.

"Interviews with urban patients reveal that the first visit to a practitioner is often tentative, a tryout. Whether the physician's
prescription will be followed or not and whether the patient will come back, seems to rest at least partly on his retrospective assessment of the professional consultation”. This retrospective assessment argues gives weight to the possibility that patients do not question overtly within the consultation as they only begin to assess things after the consultation. Furthermore, not only on his/her way to the physician, but also on his/her way back, discussing the doctor's behaviour, diagnosis and prescriptions with his/her fellows, with the possible consequence he/she may never go back. This willingness, or as is more likely unwillingness, to question the doctor needs to be discussed. To what extent will the patient question the doctor's diagnosis or treatment? Studies such as those by Todd and Still (84, 86a, 86b) imply a reticence to disturb the traditional structure of the consultation. To question the doctor would be an example of such a disruption. It would be interesting therefore to investigate, in depth, whether patients do question the doctor's diagnosis or treatment, and if so how far do they go in following up, and how is it dealt with?

Hayes Bautista (78) produced an illuminating analysis of knowledge in the lay-professional interaction: "lay and professional persons have very different perceptions of events which normally fall under the purview of the latter", especially patients in the field of medical care. Bautista also points out that patients and doctors have different knowledge, and looks to the sociology of knowledge to show that the structure of this understanding is primarily determined by the social groups within which it is generated. Furthermore, "specialised knowledge gradually becomes the property of small
categories of specialists who determine who is eligible to partake of that knowledge”. This is the case with medical knowledge which Bautista argues is "unevenly distributed in society". If we combine this monopoly of knowledge with the fact that it is the medical profession who has the right to say who is ill and who is not, this indicates the type of power within the medical system - power which is reflected in the social psychology of the consultation. When combined with the claim that patients see knowledge of internal physical states as being important, and this is where medicine has expertise (Armstrong 83 ), it becomes clear that the medical profession has a great potential to influence the individual. Bautista describes the consultation as a meeting place of two types of knowledge, lay and professional, and uses Schutz's classification of the properties of knowledge of the man in the street, as opposed to the expert, in the case of the patient and the doctor.

A brief consideration of Schutz's work shows how the doctor's knowledge, as applied to the patient, will be exclusive and restricting. The doctor will only call upon exclusive aspects of his knowledge, those primarily derived from his medical training, through structured acquisition. As the doctor interacts with the patient, his interaction will be based upon a fairly rigid 'medical' approach, and this is claimed to be the basis for the doctor's ability to perceive the patient from a medical perspective. It is intended to show this occurring within actual doctor-patient interaction.

Hayes Bautista arrives at a model of five types of interaction in the doctor-patient situation, based upon the sociology of knowledge.
1. **Confirmatory Interaction:**
   Where the patient's assessment is confirmed by the doctor.

2. **Vacuum Filling Interaction:**
   Where the patient knows nothing of the illness and the doctor offers his assessment, which the patient accepts because it does not contradict what is not there.

3. **Additive Interaction:**
   Where the patient accepts knowledge he/she did not previously have, and therefore incorporates it into his/her stock of knowledge.

4. **Exclusory Interaction:**
   Where as a result of the interaction, one party or the other gives up their knowledge and adopts that of the other, which will almost inevitably be the patient giving up in favour of the doctor.

5. **Subtractive Interaction:**
   Where conflict occurs after an initial period of congruity, and the doctor's stock of knowledge may be removed from the patient.

This typology which Bautista arrives at is based upon work largely done within the sociological tradition and *hypothesises* that these are possible types of interaction within the consultation. However, there is very little work which analyses the interaction, where these types are presumed to occur. To perform such a study would comprise a thesis in and of itself and is obviously beyond the scope of the present work. However, it is interesting to note that the patient, as viewed by Bautista, enters the consultation with little knowledge or incorrect knowledge of his condition, and then has this knowledge
reassessed by the doctor. The discussion of medical framing within the present thesis will give some indication as to how and why this can occur.

A number of studies have looked more specifically at the flow of information within the interaction. McIntosh (74) asked the question as to how much, and when, should cancer sufferers be told about their condition. He found that in the hospital setting doctors were of the opinion that patients should not be told. In such a situation, the patient is under the direct control of the medical system, and is deprived of knowledge of his own condition. In this sense, not only does the medical system control the patient, but it also deprives him/her of sufficient knowledge to assess the situation for himself/herself. McIntosh noted how doctors need to convey enough information to the patient to justify medical intervention and yet not too much so as to alarm him/her. The point being made is not whether it is right or wrong to withhold this information, but that it deprives the patient of the ability to control his/her own future, if he does not know where he/she stands regarding his/her own condition! (See Todd & Still 84, 86 on doctors' techniques with cancer sufferers).

Waitzkin and Stoeckle (72) quote Fuchs who noted that, "very few industries could be named where the consumer is so dependent upon the producer for information concerning the quality of the product," as the medical system, "because of ignorance, the consumer can exert little control over the quality of the services she purchases from the physician". The control of the flow of information by the doctor puts the patient in a subordinate position. Waitzkin and Stoeckle
emphasize this control of information as a source of power within the
doctor-patient relationship. Using Dahl's description of power as,
'the power of a person A over a person B is the ability of A to make
B do something that he would not have done otherwise', they point to
the way in which the doctor can behaviourally control the patient –
an issue which will be developed in Chapter 3.

An important aspect of this information control is that it leads to
uncertainty on the part of the patient. In a position of
uncertainty, which results from ignorance, and a lack of information,
the patient's power in the interaction is very limited. A
"physician's ability to preserve his own power over the patient in
the doctor-patient relationship depends largely on his ability to
control the patient's uncertainty. The doctor enhances his power to
the extent that he can maintain the patient's uncertainty about the
course of the illness, efficiency of therapy, specific further
actions of the physician himself". In fact, "the specialists
position may be endangered by the patient becoming his/her own
physician". If the patient were to gain knowledge, which could lead
to autonomous control of his/her own position, this would question the
essence of the doctor-patient relationship. If one accepts that,
"information may be defined as that which removes or reduces
uncertainty", then to maintain control over the patient, the doctor,
to a certain extent, has to maintain the patient's ignorance.

Bautista, in another paper, (78) looked at the way in which a patient
can exercise control in the interaction and calls upon a number of
authors who have explored this area. Friedson looked at the control
implicit in the lay referral system which determines whether the patient shall arrive at the surgery or not: Davis examined the patient's attempts to control uncertainty during treatment and rehabilitation; Roth looked at patients attempts to control the treatment; Glaser and Strauss looked at the way patients attempt to gain awareness of impending death and finally Bautista noted how the patient may exercise control via non-compliance with the treatment or by terminating the relationship. The general opinion concerning power within the doctor-patient relationship is that the doctor is in a dominant position. However, as the above mentioned studies show, the patient can explore a number of avenues in an attempt to exert control. From the perspective of the medical profession, such tactics are probably to the detriment of the patient, such as non-compliance.

Two points can be made here. First of all, as already stated, non-compliance may not be to the detriment of the patient, and secondly if we broaden our conception of power, the patient can exert influence via channels other than non-compliance. To date there is a confusion over the terms power, influence and control as they have been used interchangeably by theorists. These terms will be tightened up in Chapter 3.

Maureen Reynolds (78) in a study of hospital patients, pointed to the patient's lack of information regarding their illness, and how they disliked the doctor withholding medical knowledge. Patients do express a dislike of exclusion from information, and have a number of procedures whereby they can attempt to exercise control, procedures
similar to those noted by Bautista (76).

Boreham and Gibson (78) aimed towards a further analysis of the informative process in consultations. They found that patients attached importance to information concerning their illness, but exhibited a surprising lack of such knowledge. Furthermore, patients gained little additional information during the course of the consultation, largely as a result of their own passivity. Boreham and Gibson claim that it has been the case throughout history that all professions, and medicine in particular, have maintained a knowledge and information gap between practitioners, and patients or clients. In a practice situation, the practitioner believes his knowledge and skills to be so esoteric that the patient is seldom in a position to understand or to raise questions.

Boreham and Gibson explain the activity/passivity model of Szasz and Hollander, as having developed in an era in which the major afflictions were acute and infectious illnesses, and therefore the treatment situation promoted a clearly defined differential in power and status. However today relationships last longer and Boreham and Gibson see it as a means of reducing the gap between the two interactants. "In the course of such longer-term disorders, the status and exclusive control of the medical profession is somewhat diluted and a narrowing of the knowledge communication gap as the lay public's functional ignorance and awe of medical knowledge and techniques is decreased". However, one would beg to ask the question what knowledge the patients had gained, and to answer that it is probably minor treatment timetables and responsiveness to
investigations in the surgery. Although this can be viewed as increased awareness, it performs the function of increasing the patient's dependence upon the medical system. He may have knowledge but this is knowledge of the control which medicine has over him.

Boreham and Gibson claim a 'growing desire' on the part of the public to gain information within the consultation, and Stimpson and Webb (75) show how patient and doctor negotiate on what should pass between them e.g. how much should the doctor tell the patient about the seriousness of the condition. But as mentioned earlier such negotiations over information are concerned with minor details and do not threaten the monopolistic knowledge of the profession. The present thesis is not denying the probable existence of increased demands for knowledge, and a active role in the consultation, but questions the extent to which this threatens the doctor's prerogative right to control. Furthermore, what the patients were told was almost entirely dependent upon what the doctors were prepared to tell them. It would appear that the doctor is clearly the principle determinant of what information the patient receives. Not because the doctor refuses, but because requests are very rarely made, which is concordant with the idea that the doctor is the agent charged with responsibility for the patient's condition. It is to be argued within the present thesis that the patient gives the doctor the responsibility for his condition. In so doing the patient must also allow the doctor to exercise control, and the practice of the patient asking questions is not concordant with this. Indeed Boreham and Gibson note, in agreement with Coe (70), that patients tended to think that questioning doctors implied a lack of confidence in their
judgements. Boreham and Gibson conclude that, it is quite clear that the ideal role for the patient, as perceived by both doctor and patient is one of co-operative acquiescence and deference to the doctor. Pratt (57) noted how patients appeared to wait for the doctor to take the initiative, a good patient was seen as a passive patient.

Danziger (78) looked at the problem of the use of knowledge in doctor-patient encounters with particular reference to pregnancy. "In our society the state of the individual's well being is largely in the hands of experts who assess its status and designate ways to improve it". These experts have privileged access to knowledge, resources and skills that presumably can benefit the lay person. Moreover, Danziger concurs with the idea of 'asymmetry' between the expert and lay person, in that doctors and patients have different power and knowledge, and how they are therefore in a different position within the relationship. Danziger sees the doctor as in the autonomous position of having a monopoly on the applied use of scientific knowledge, and also having the prerogative to define what is therapeutic, and what is outside the bounds of consideration, what aspects of the case shall be deemed relevant and irrelevant. Danziger goes on to ask the question, what is the position of the client, as he is in an inferior position versus the doctor with respect to information? He lacks the professional knowledge, skills and resources, and this is what presumably brings him to the surgery. Danziger points to the service seeking, dependent role of the patient, and he goes on to discuss Haug's description of the consultation as falling into one of three types, on the basis of the
patients interpretation of the role:

1. As passive recipients who do not seek information from the doctor, and who are unresponsive to any attempt by the physician to impute knowledge;

2. The active dependent recipient who seeks assurance that the doctor is reliable and competent. A minimum of information is sought, enough to convince the patient satisfactorily of the physicians ability to handle the therapeutic process;

3. The potentially knowledgeable participant, whose interest in the doctor's expertise exceeds a minimum, and who exhibits a willingness to share in the responsibility of decision making, provide information and asks for feedback from the doctor.

Patient styles (1) and (2) are going to place the patient in a subordinate position within the relationship, whilst (3) appears to offer the patient a certain amount of control within the situation. However, it is argued here that although the patient may seek knowledge and responsibility, whatever he achieves will be medically determined and furthermore an increase in medical knowledge on the part of the patient, will surely increase his reliance upon it, as he sees it become more relevant. However, it again needs to be emphasised that the theoretical notion of power and influence as contained within the work of Danziger, Bautista etc, is such that the patient is inevitably in a position of weakness. Within Chapter 3 it will be shown how an alteration of our conception of what power is... will alter the position of the patient.

As a compliment to these styles of patient behaviour, Danziger
describes three styles of doctor behaviour. The doctor can provide services as a:

1. Expert - a medical expert acting as a technician and exhibiting little willingness to discuss her/his plan of action or to impute knowledge to the patient;

2. Counsellor - who displays more general, rather than merely technical wisdom, is informative in the doctor-patient encounter, authoritatively guiding the client through the therapeutic process;

3. Teaching Co-Participant - who acts with recognition of the client's need for valid information about his or her condition, and encourages the patient in medical decision making.

Again, styles (1) and (2) allow the doctor to control the patient, whereas style (3) appears to impute a certain amount of responsibility to the patient. However, as the theory of framing will show, the doctor can control the patient both by giving information and withholding it.

2.3 ILLNESS WITHIN SOCIETY

Duff and Hollingshead (68) note that, "physicians and patients are inextricably parts of the society to which they belong" and furthermore, "When an individual becomes a patient he is confronted with the necessity of dealing with a physician or physicians" and the physician assumes responsibility and discharges obligations to care for the patient. Duff and Hollingshead refer to this as Sponsorship, whereby the physician accepts the sponsorship of the patient, i.e. responsibility for the patient. The issue is two sided in that the patient accepts the competence of the physician to diagnose and
treats his problem. Therefore, we can state the doctor and patient are bound together and that the essence of this bond is the doctor taking responsibility for the patient's condition and the patient accepting the doctor's competence to do this. In the case of a patient who enters the surgery for the first time with pains in the chest, the process of sponsorship is set in motion whereby the patient will allow the doctor the ability to diagnose him and the doctor will accept this responsibility in his attempts to help the patient. It is to be argued that this is a central aspect of the consultation, and has definite implications for the interaction.

Parsons (51, 75) views illness as a socially legitimated state which exempts the sick individual from the roles and tasks for which he has been socialised. The doctor's role being essentially the opposite of this sick-role as the doctor must apply technical knowledge to the task of healing patients as efficiently as possible. Illness and therapy are seen as aspects of the social equilibrium of society, "the sick person, and those with the responsibility for his welfare, above all the members of his family, have an obligation to seek competent help and to co-operate with competent agencies in their attempt to help him get well, in our society of course, principally medical agencies". It is this obligation to seek medical help and to co-operate with competent agencies, which affects the 'power structure' of the consultation. The patient who enters the consultation obliged to seek medical help and to co-operate with the doctor, allows the doctor the ability to control the interaction between them. And related to Duff and Hollingshead's discussion of sponsorship we see the doctor as willing to accept responsibility to
help the patient. A question which is left unanswered though is how does the doctor assume responsibility for the patients condition? It is to the actual consultation that we can look for an explanation in terms of social interaction.

Furthermore (Parsons' discussion of) the behavioural prescriptions associated with the sick-role shows that it is a permissive role, in so far as the various obligations and expectations of the sick person permit the doctor to apply his technical expertise in healing the sick, with maximum efficiency. Parsons here is pointing to the notion of intersubjectivity (Rommefweit). Shared expectations allow the other person to realise their expectation somewhat easier. The patient who expects the doctor to investigate him is more easily manipulated by the doctor. Parsons sees the sick role as that of the person who lets the doctor heal him with most speed, and the ideal patient is the co-operative patient. In such a situation the patient is very much under the control and manipulation of the doctor and the medical system.

As mentioned earlier, Parsons sees the problem of health as intimately related to the functional pre-requisites of the social system. Too low a general level of health, or too high an incidence of illness is dysfunctional for society. Although Parsons claims that there is an equilibrium level of health and illness is not at issue, what is taken up is that Parsons places the doctor-patient relationship in social context. Health care is a social role relationship between a person needing help and a helping agent, and the social roles of health care are a patterned section of the
culture, and thus a learned sequence of behaviour. Again Parsons points to the learned nature of such roles and the present thesis intends to offer observations concerning the way in which individuals internalize an awareness of such roles.

Parsons' model of the sick role notes the status of dependency in the sense of being temporarily exempted from daily responsibility, and being entitled to care and support on the part of others. Such rights however are conditional in that they only occur when the ill person seeks the help of a physician and submits to that authority. Here we have further evidence of power implicit in the consultation. In this case the power is seen to derive from authority and responsibility. Parnass (75) however, is critical of Parsons over-emphasising the professionalism in the sick-role, and its medico-centric nature, and this points to the importance of other significant lay persons in this process. Furthermore, he is critical that Parsons sees treatment as solely dependent upon the physician's reliance on knowledge of medical categories, diagnostic categories. However, this criticism can be countered in that subsequent behaviour may vary but it varies within the limits of medical restrictions imposed, and the act of returning to a doctor and exposing oneself to further medical control makes the patient reliant or dependent upon the doctor. Furthermore, Gallagher (76) has noted that "the professional as an agent of social control regulates dependency, sometimes inducing it and at other times curbing it, in the interest of cure or return to health", and when the patient enters the relationship, although he can refuse to comply, or not understand, it is always the doctor who takes the lead in decision making.
Herzlich (73) looked at the psychological experience of being ill, and offers comment upon the psychological dimension of the sick-role. She sees health and illness as always thought of in association with two other notions ie. the individual and society. She sees a 'conflict' between the individual and society, "which finds expression in the states of health and illness", and further "these states are defined as health, or illness only by referring to an individual in society". Herzlich is attempting to develop a conceptual framework, which will show how illness is a response on the part of the individual to society - society being opposed to the individual in the same way as illness is opposed to health, and the individual acts in response to the pressure of the way of life. Society thereby governs the genesis of illness, whereas health on the other hand is a very individual thing, produced and used by the individual and never something outside him/her. The important point for Herzlich is that health is entirely within the individual whereas illness is an external and more complex interactive phenomena, and it is the social origin of illness which makes it necessary to look at the social context of the consultation, as the behaviour within the consultation is just one aspect of a person's overall illness behaviour. One important point needs to be made here - although Herzlich conceptualises illness as external, interviews with patients have shown how they see illness as existing within them (Telles & Pollack 81). This has implications for the concept of medical framing to be discussed in Chapter 3.

Herzlich outlined three conceptualizations of illness as destructive, an occupation and as a liberation. The essential aspect of illness
as destructive is the inactivity which has various implications such as the giving up of professional and family role, consequent financial problems, and the exclusion from one's social groups. All of these lead to the desocialisation of the patient. "The individual is wholly located within a social universe, as a personality indentified with his social role which requires health and rejects illness". Illness as destructive involves inactivity, the dependence on others and social exclusion, alone in the midst of others. Herzlich sees this as a kind of social and psychological death in which although he is alive, the individual is annihilated and deprived of any future. With illness as an occupation, the recognized function of the individual is to struggle against his illness, a function which has some of the qualities of an occupation as it is prepared for and learned. As opposed to illness as destructive, man establishes himself in his infirmity, just as he adjusts more or less to any social situation which he finds himself in. Relations with the doctor can be seen as a form of co-operation or exchange, in which the patient must make a moral effort to discipline himself. With illness as a liberation, the beginning is inactivity, although the individual sees it as a lessening of the burdens which weigh upon him. Desocialisation occurs as with destructive illness but this time a beneficial effect is attributed to solitude and privileges which the solitude of being an invalid makes possible.

With this approach Herzlich shows how individuals have varying cognitive interpretations of illness, which need to be understood as part of the individuals social existence. The present review does
not intend to discuss how these varying conceptualizations are effective within the consultation but to highlight how perceptions of the illness may affect the patient's expectations for the consultation.

Robinson (73) sees becoming ill as a biosocial process, whereby we can all expect to fall ill, as illness is a fact of life. Again, as with much research in this field, he is concerned with the way in which given symptoms may be differently perceived, evaluated and acted (or not acted) upon. Some patients may be more concerned about a return to minimal normal functioning, rather than to complete psychological health, and the doctor may be more concerned with the disease and its cure, rather than the more immediate alleviation of pain. This may lead to differences in how each actor expresses himself within the consultation, and it is hoped that the present research will point to differences in actors behaviours, based upon what they bring to the consultation, especially in terms of expectations.

Drossman (75) asks why doctors find it hard to understand the patient's behaviour in relation to illness. There is a belief that medical illness is independent of social and psychological variables. Drossman sees the dilemma which occurs when the doctor applies the 'medical' approach to patients whose physical manifestations of illness are reflections of deeper psychological factors. He suggests the biopsychosocial model of illness which sees illness as the product of mutually interacting biological, psychological and sociological dimensions. To use such a model
depends upon the physician's flexibility, clinical experience, sensitivity and self-awareness. He must avoid the use of the rigid functional/organic dichotomy and look more towards behavioural manifestations of deeper internal states. This is easier said than done and what is needed is a means of breaking down the patient's illness into a format which the doctor can begin to understand.

Continuing this review of illness as it is essential to understanding events within the consultation, we move on to the work of Entralgo (69). Entralgo considers how a patient begins to feel ill. One needs to distinguish the conscious experience from psychological mechanisms, as the generic feeling of being ill is not a simple one. There are at least seven distinct experiences, disability, discomfort, awareness of danger, absorption in bodily sensations, loneliness, aware of being different, and feeling of refuge. These are present in every sick person although some are more apparent than others. Added to these experiences are the symptoms arising from the special disease the individual suffers from, and those depending upon his own personality. Entralgo paints a picture of illness, and the experience of illness as a very complex process. In such a situation it would be almost impossible if a General Practitioner were to adopt a similar behavioural style to two people who both offered the symptoms of tonsillitis. Their experience of the illness and their reactions towards it may well be totally different. The way in which a General Practitioner would handle two such cases could provide the basis for a very idiosyncratic study of illness. The present thesis, however, will move in the opposite direction to show how the doctor will attempt to group patients into diagnostic categories in an
attempt to reduce individual difference.

Cassel (70) asks the question: Does the helplessness of the patient tend to make distress, pain and weakness the only realities? The withdrawal from normal functioning (which Herzlich calls desocietisation) is very frightening, and the impediments to the senses become very worrying. The patient begins to build a world around himself in which to incorporate his role as a sick person. Cassel in fact brings the individual back into what Parsons describes as the sick-role. The individual will build up a picture of what the sick-role involves, an important aspect of which will be what the illness means to him. It is interesting to repeat the observation of Todd and Still (84) that helplessness is as much a problem for the doctor as it is for the patient.

It is argued therefore that to analyze illness behaviour, including behaviour within the consultation, without taking into account the persons life style would lead to an inadequate understanding of the problem. Furthermore, the consultation and its interaction is not solely concerned with the physiological symptomology. Shontz (75) points out that the individual human being is in fact an organized indivisible whole, and yet many professionals still avoid their patient's personal problems. Modern medical practice focusses more clearly upon the illnesses than upon the people who have them. The concept of disease led to the view that the patient is passive in response to a life-threatening outside agency. Medicine devoted itself to discovering the means by which the sequence and causes of a disease could be interrupted. The therapeutic 'duty' of the patient
was to do as he was told. Not until recently have physicians again realized that illness is more than an attack by external destructive agencies; it is an interactive process of stress and organic counteraction in which sometimes the disease represents not the stress per se, but the individual's reactions against it. In most cases of heart disease, the illness may be the result of a complex pattern of physical and psychological factors contributing at levels of intensity varying from patient to patient. In noting this, Shontz directs us to appreciate not only the various meanings which an individual can attribute to his illness, but also that it may be causally related to his life style. It is interesting to note that there is a substantial amount of literature on life style and illness, but a dearth of attempts to actually relate this to the consultation.

A number of authors have attempted to show the relationship between life style and illness. Robinson (73) notes how the social environment needs to be considered as an aetiological factor in disease. According to Robinson everyone can expect to fall ill - illness is a fact of life. A number of tentative theories have been put forward to show how illness can result from life style. These theories tend to fall into one of two groups. Firstly those which argue that stress can cause physical illness, the most obvious example being the work on the Type A behaviour pattern as a precursor of heart attack. And, secondly studies which show a more indirect relationship between physical illness and life style, such as the work of Totman (79) who argues that illness is partly a function of a person's inability to continue to follow the social roles to which he
is accustomed, or to adopt alternative role systems. With regards to such theories it is necessary to keep in mind the cyclic nature of the problem i.e. not only can life style affect illness, but illness affects life style.

2.4. DISCUSSION

It is possible to discern a number of the functions which medicine is seen to perform such as: the cure of illness; the regulation of the population's health; the legitimation of the sick-role; and the regulation of the behaviour of the population. These functions are all closely related, although much of the research in this area is directed towards the first two, especially the regulation of the patient's health. However, the present thesis makes two comments upon these studies. First of all, that there exist fundamental problems which underly the relationship which must be taken into account and not overlooked, or be pushed aside, as Pendleton has suggested. Problems of the nature of iatrogenic disease (Illich 76), diagnostic inconsistency (Koran 80) and psychosocial illness (Cartwright 81) are crucial to an understanding of the doctor/patient relationship. Secondly, discounting this tendency to overlook such fundamental problems, the studies have offered a great insight into the nature of the doctor/patient relationship, however, there are also problems of a theoretical and methodological nature related to the studies themselves. This discussion intends to pull together the threads of a diverse literature to point out the contributions to understanding, what is missed and to offer suggestions for development.
A great deal of the work on doctor/patient communication indicates that the consultation needs to be seen as a teaching situation, a medium for health education, in which the doctor can teach the patient how to live his life to enable an optimum level of health to be maintained. Work on communication skills would be a successful approach if the consultation was a truly pedagogic situation. However, there are a number of factors which need to be introduced here: that doctors do not wish to impart all of their knowledge has been clearly illustrated (Waitzkin and Stoeckle 72); six minutes is barely enough time to impart any knowledge (Balint 73); patients' perceptions of medical knowledge is that it is beyond their comprehension (Telles and Pollock 80), and it is unlikely that the patient views it as a teaching situation. Once again, we are getting a feel that the view of the consultation is wrong, or at least incorrect.

Authors such as Pendleton (83), and Macguire (79) adopt an approach which tends to bring the problems of the consultation down to the level of a problem of social skills. Medical efficiency, patient compliance and patient satisfaction can all be improved if we adopt a social skills training approach and improve doctors' communication skills. The review of the literature within this chapter has clearly illustrated that there is a great deal more to this.

One of the first points to be highlighted is the incredibly high utilisation of medical resources. £315.5 million worth of prescriptions, in England alone, is very high (Annual Abstract of Statistics CSO 1985) and is taken to imply that the public are
dependent upon the medical system. Today drug dependency is seen to be a problem amongst the youth of society. If we accept the above figures, there is an indication that many are dependent upon prescriptions and therefore dependent upon medical agencies as they control the allocation of such prescriptions.

The figures on the utilisation of medical resources relate closely to the process of medicalisation as discussed by Zola (75), and Conrad Schneider. Medical agencies are having an increasing role to play within contemporary society. Parsons (57, 75) argues that much of this is due to the legitimising requirements of the doctor with regard to the sick-role i.e. a person cannot be 'ill' as such without having the existence of an 'illness' sanctioned by a doctor. The present thesis accepts ideas such as these but feels there is a need to look to instances of interaction between the public and the medical agencies (namely the consultation) to discover evidence of medicalisation. Can a study of consultation interaction offer any support for these ideas.

An attempt to relate this to the doctor/patient relationship indirectly can be found in the work of Duff and Hollingshead (68). They see a transfer of responsibility whereby upon entering the relationship the patient gives up responsibility for his own condition to the doctor, who in turn accepts responsibility for his patient's condition. Illich (76) also argues that we have transferred to the medical profession the responsibility for designating, and maintaining, our state of health. If we were to find evidence of this actual transfer of responsibility within the consultation, this
would go a long way towards explaining medicalisation and high consumption figures. **Is it possible to see doctors assuming responsibility within consultations?**

Illich (76) has referred to medicine's expropriation of the power of the individual to heal himself. Armstrong's (83) discussion of the clinical gaze shows how our bodies are transparent, but only to the medical eye. Telles and Pollack (81) have pointed out how people view illness as something within them, to be viewed and analysed only via the clinical gaze. Even the diagnosis of lay symptoms into a medically defined category (Blaxter 78) seems to remove from the patient the ability to be responsible for his own condition. All of these processes are seen as inducing dependence upon medicine which, if it is discovered, needs to be viewed as both an output from the relationship and also an input. To break the consultation down into input-process-output (Pendleton 83) overlooks the possibility that an output at one stage will be an input if reintroduced at a later stage. (This will be discussed further in terms of the need to view the consultation in its temporal context).

As was mentioned through the chapter there have been a number of references to notions such as power, influence, control, and attempts made to analyse such phenomenon within the consultation. The basic conclusion of the present thesis is that, to date, studies of the power structure of the consultation have been lacking in that they attempt to create typologies which are grossly oversimplistic (Szasz and Hollander 56) and use the term power rather loosely. For example, Byrne and Long (76) discussed doctor behaviour in terms of a
power shift model. Patients are able to exert influence via non-compliance (Ley 83) or the lay referall system (Friedson 70). The question which needs to be asked is what is power in the doctor/patient situation, and how does it operate. This question will be dealt with in Chapter 3, but basically, it will be taken to refer to the ability of Person A to bring about a behaviour in Person B which he would not have engaged in without the behaviour of Person A.

The model to be developed in Chapter 3 will incorporate the expectations which actors take into the situation, and it will be argued that the ability to exercise power is to a certain extent based upon the existence of expectations (this will be clarified in Chapter 3). Studies of expectations within the doctor/patient relationship have been carried out by Fitton (79), Stimpson and Webb (79), Pendleton (83). Expectations are largely seen as behaviours which a percentage of those interviewed expect to occur. However, what needs to be discussed is what are the implications of these expectations; do expected behaviours occur; what happens if expectations are not realised; and furthermore, are expectations restricted to behaviours?

Finally, within this discussion of literature, reference is made to the temporal context of the consultation. By talking about medicalisation and dependency we are placing the consultation in its social context, and therefore are not guilty of analysing the consultation in a vacuum. However, many studies have looked at individual consultations without at least being aware that this may
be the third, second etc in a series of consultations dealing with Patient C's Bronchitis. Also each consultation will pass through a number of stages. Although only lasting an average six minutes, they do have a life time. If we break consultations down into their component parts we can study the effects of a behaviour such as the introduction of the diagnosis to subsequent events.
CHAPTER 3

REVIEW OF THE FRAMING LITERATURE,
AND THE ESTABLISHMENT OF A FRAMING PERSPECTIVE
3.1. INTRODUCTION

Following the review of the medical literature, it was felt that many studies of the doctor/patient consultation adopted too narrow a perspective for a number of reasons. Studies of communication and communicational difficulties (Ley 83, Pendleton 83) were seen to ignore the transfer of responsibility (Duff and Hollingshead 68); the possible weakness of the clinical method (Illich 76, Koran 80); and the complexities of the power structure of the relationship. Furthermore, attention had been focussed upon expectations for the doctor/patient relationship (Fitton 79), which although insightful, had failed to fully explore the implications of such expectations. The present thesis intends to devise a theoretical model to be applied to the doctor/patient relationship which will allow expectations to be tied more closely to actual consultation interaction, and overcome the weaknesses referred to above.

A theoretical approach was required which should allow us to consider the complexities of expectations; to consider the occurrence of expectations as interaction; and to assess the basis of, and implications of such expectations. One conceptual approach which allowed the analysis of expectations, and the integration of expectations with actual behaviour, was found in the literature on 'frames' and 'framing,' which although having a diverse usage does contain certain common themes which will be explored.

3.2. ORIGINS AND PREVIOUS USES OF THE TERM 'FRAME'

The notions of 'frames' and 'framing' need to be described in detail prior to the construction of a model of framing, so as to allow the
reader to appreciate its logical development. For Minsky (77), a frame is a data structure for representing a stereotypical situation, such as going to a child's birthday party, or going to the consultation in General Practice. Information is attached to the frame to tell the individual how to use the frame; what will happen next; and what to do if expectations are not confirmed. When one encounters a new situation, one selects from memory a substantial structure called a frame, and in this sense the frame allows an individual to call upon tacit knowledge, and to create anticipations based upon what went before.

If we accept Minsky's conception, individuals will have a frame in which they represent the doctor/patient consultation in general practice. Both doctor and patient will use frames to guide their behaviour within the consultation. Frames are remembered in the individual's cognitive structure, implying that there is a need for some type of internal representation of an external situation, to enable the individual to act within that situation. And furthermore, as the individual acts in further similar situations, his framework for that situation is gradually altered to take account of new information which may be received. Frames are composed of upper and lower levels, the top levels of the frame being fixed and always true, and the lower levels filled by specific circumstances or data. In this sense, this is a somewhat static notion of frames, as a place to put information, rather than a means for obtaining more of it. Overall, Minsky's concept of frame refers to an implicit data structure, which the individual has to enable him to know what to do in a situation; what will happen in a situation; and what to do if
certain expectations are not confirmed. Minsky is also looking at the expectations which actors take into social situations and in this sense is conveying a very cognitive approach similar to studies on internal representations within social psychology (see Forgas 81). The present thesis does not intend to get involved in the theoretical debate concerning the existence, or non-existence of such cognitive structures (Gibson 60, 79). It is to be argued that expectations for the doctor/patient relationship exist, which can be elicited via interviewing, discussion, questionnaires etc, and these will be referred to as comprising the frame for that situation. When we look at expectations for the doctor/patient consultation from a 'framing' perspective, as is intended within the present thesis, rather than simply as behaviours, this facilitates a more comprehensive understanding of the relationship.

Neisser (76) discusses frames under the guise of schemata, and is more concerned with perception. He traces the term schemata back to Piaget, who saw a schemata as an internal organization of external events, and in which schemata were involved in the perceptual cycle. Neisser was critical of Minsky's conception of frame as being too static, a place to store information, rather than to pick it up. "A schema is that portion of the entire perceptual cycle which is internal to the perceiver, modifiable by experience, and somehow specific to what is being perceived. The schema accepts information as it becomes available at sensory surfaces and is changed by that information; it directs movements and exploratory activities that make more information available, by which it is further modified."
As with Minsky, Neisser views a frame as an internal data structure for representing a particular type of situation. However, Neisser takes the concept a step further to show how a frame can be reflected in an individual's behaviour. Not only must the information received be of a particular sort, if it is to be interpreted coherently, but the frame is also a plan for finding out about objects and events. In the doctor-patient consultation, it is the 'frame' of the consultation which will determine the behavioural pattern adopted in an attempt to discover facts relating to the patient's illness. Furthermore, schema develop with experience and schema, which exist at any particular moment are the product of a particular history, as well as the ongoing cycle itself. The extent to which it is possible to discover what Minsky would call the lower levels of a frame is uncertain, however, it is proposed within the present thesis to map out the upper, stable aspects of these frames and to show their effect upon interaction. This will be developed to become a crucial feature of the theory of framing to be developed i.e. that there are established expectations for behaviour, and that such expectations, are the basis for any information which may be transmitted within the encounter e.g. if it is expected that the doctor carries out a physical investigation, then this will inevitably produce a particular type of information. This issue will be referred to at length.

An individual's behaviour, "depends on the existing state of affairs, on what has gone before, and on the plans and expectations of the performer", and Neisser's discussion of the functions of schema allows the conceptual linking of cognition with interaction. Schemata
may be viewed as an information accepting system, like a format in a computer programming language. Formats specify that information must be of a certain sort if it is to be interpreted coherently. A schema is also a plan for finding out about objects and events, for obtaining more information to fill in the format. An important function of schema is to direct the head and eyes in perception, but schema also determine what is perceived when no overt movements occurred. Frames are similar in that they direct the individual's behaviour, which is his source of finding out further information. Neisser is arguing that perception is inherently selective in that only information which results from the accepted pattern can be accepted. If we can look at the accepted patterns of behaviour in the consultation we will gain a clear insight into the type of knowledge which is relevant to the encounter. Frames are a plan of action, the execution of a plan.

"The schemata which exist at any given moment are the product of a particular history, as well as of the ongoing cycle itself". People do not know all about the world, but they have information about it through their actions within it. Schemata enable the individual to perceive present events and also store information about past ones. "By constructing an anticipatory schema, the perceiver engages in an act that involves information from the environment, as well as his own cognitive mechanisms. He is changed by the information he picks up". Neisser's use of the term anticipatory schema, implies a highly cognitive approach to social situations, that we have knowledge which we take into situations. This may be so. However, it is possible to argue from an interactionist perspective that the situation
determines behaviour. Which side of this argument is correct is not at issue here. What is being taken from the work of Minsky and Neisser is that there are expected ways of behaving in situations, which will inevitably influence the form of information which comes to light within such situations. The more interesting focus considers the nature of these expectations and the types of information they will yield.

Bateson's (73) concept of frame is also more dynamic than that of Minsky, although his discussion is somewhat removed from that of Neisser and introduces the idea that frames can implicitly comment upon interaction. Bateson's conceptualization of frames has both psychological and communicational aspects. 'Psychological frames are exclusive', and 'psychological frames are inclusive'. By including certain messages within a frame certain other messages are excluded, and vice versa, by excluding certain messages, others are included, and furthermore messages within the frame are regarded as relevant whilst those outside the frame may be ignored. This can be taken to imply that only information which results from the expected patterns of behaviour is to be considered. Information which is derived from means other than those contained within the expectations will be excluded and seen as irrelevant. Bateson's discussion of the inclusive and exclusive qualities of frames allows us to place possible restrictions upon behaviours within the doctor/patient consultation. If we can discover the expectations for the doctor/patient situation, it is possible to argue that behaviour is restricted to these expectations. An interesting analysis would look at the effects of out of frame behaviours, behaviours not expected.
By introducing certain verbal and non-verbal behaviours to the consultation interaction, the doctors and patients are providing evidence of the representation which forms the basis of their frame. Furthermore, Bateson notes that by introducing these behaviours, the actors will in fact be directing the interaction, and limiting possible future behaviour. Both the doctor and the patient have the ability to direct the interaction to the extent that certain behaviours cannot follow, e.g. if a patient introduces the symptoms of a sore throat to the interaction it is unlikely that the doctor will wish to inspect the patient's feet. In this sense, behaviour restricts future possible behaviours and the patient can be seen to exercise control over the direction of the interaction.

As this chapter is concerned with building the theoretical model to be applied to the doctor/patient relationship, the main points so far will be summarised. On the basis of the literature in Chapter 2, it was seen that one important aspect of the situation is the expectations structure. However, the literature discussed so far within Chapter 3 allows a deeper analysis of expectations. It is taken for granted that expectations exist, but these must not be looked at simply from the perspective of percentages. Utilising the literature on framing it is possible to hypothesise that expectations impose a controlling influence upon the interaction. If expectations need to be adhered to they will have a powerful influence upon the type of information which is elicited, and the decision which is reached. If we can pick out and discuss the nature of these expectations and argue that this framework of expectations needs to be adhered to we have a powerful tool for explaining certain problems
within the doctor/patient relationship highlighted in Chapter 2.

One theme which was seen to be lacking within the literature was a true grasp of the power structure of the relationship. It will be argued that there is an element of power contained within the expectations in that expectations restrict behaviour.

However, expectations need to be realised in the interaction if any power contained within them is to be effective. To look at this issue of the manifestation of power within behaviour we need to move away from the framing literature.

Kelvin (70) utilised Dahl's (57) conception of power as the ability of Person A to bring about in Person B behaviour which he would not have engaged in apart from the occurrence of the behaviour of Person A.

"In all relations between two or more people ... one can detect an element of power in all instances of interaction" (Kelvin 70). As was discussed in Chapter 2, analysis of the power structure of the doctor/patient relationship ignore the complexities of the situation. By integrating framing and power it is possible to clarify much of this over simplification. For Kelvin there are 3 dimensions in power: a) power is an attribute of the relationship between two or more people. Consequently, we cannot understand power in the doctor/patient consultation by looking at the actors in isolation, we need to consider them in relation to each other; b) The power relationship is causal ... i.e. the more powerful A is in some
sense, the cause of the actions of the less powerful B; c) The causality is not total, as other factors can intervene to affect behaviour. "Power is adequately exercised when it modifies the behaviour of the subordinate" (subordinate does not imply inferiority), "even if this modification is no more than public compliance without personal acceptance. In effect power affects the behavioural component of the attitude system". As a model of framing is outlined in Section 3.3, the link between frames and power will be clarified.

Bateson also discusses the communicative nature of frames. A frame is metacommunicative, "Any message which either explicitly or implicitly defines a frame ipso facto gives the receiver instructions or aids in his attempt to understand the messages included in the frame, and the converse is also true, every metacommunicative or metalinguistic message defines either explicitly or implicitly the set of messages about which it communicates" (73). Bateson is primarily concerned with the fact that verbal behaviour may be contradicted by non-verbal behaviour and thereby create a 'double-bind' situation. However, for present purposes it is interesting to note this implicit aspect to communication. Argyle (81) claimed that language functions to communicate information, whilst non-verbal channels communicate interpersonal attitudes. However, Bateson indicates that such aspects of the doctor/patient relationship, as the power structure, may also be implicit within verbal communication. The work of Watzlawick provides an excellent development of this idea.
Watzlawick (67) claimed that one cannot not behave. Activity, inactivity, words, silence, all have message value and other actors cannot not respond to them. The person who ignores everyone else is communicating as clearly as anyone, although this communication appears 'negative' e.g. to be the only person sat on train when another person gets on, whether that person sat right next to you, or 'ignored' you by sitting at the far end of the compartment, he would still be communicating.

Watzlawick elaborates on the two functions of communication. Not only does it involve the flow of information, but at the same time stresses a relationship and mediates the relationship. Their concern was not so much with what is said, but how it is said, and what it means in terms of the nature of the relationship. Watzlawick describes these two aspects of communication as the 'report' aspect which involves the transmission of information, and the 'command' aspect which denotes what sort of message it is to be taken as, and therefore 'frames' the relationship between the two actors. Watzlawick was interested in the extent to which this command aspect of communication was clearly visible. In a 'healthy' relationship this would not be so, whereas a 'sick' relationship would give evidence of a constant struggle about the nature of the relationship with the report aspect becoming less and less important. One can quite easily imagine how ineffective a relationship would be if the communication of information became of secondary importance and the actors were continually arguing over who has the right and authority to say and do what to the other. It is hypothesised that within the doctor/patient situation, the relationship is 'healthy' and both
doctor and patient agree as to who has the authority to carry out particular behaviours and therefore they do not 'waste' time arguing over or deciding how they should behave. This is closely tied to the frames they hold of the situation as it is also argued that their expectations for behaviour are shared. The doctor/patient situation can be contrasted to a hypothetical dyadic situation where, for example, husband and wife disagree as to their own and others roles, their expectations for behaviour are discordant, and consequently they spend more time discussing who has the authority to do and say what to the other, rather than passing of information.

Goffman (74) takes, as his central concern, the problem that any event may support a number of interpretations and possible realities. Historically, Goffman's 'Frame Analysis' can be seen as a development of his previous work into the presentation problems of the self in social situations. His aim within 'Frame Analysis' was to isolate some of the basic frameworks of understanding available in our society for making sense out of events and to assess the special vulnerabilities to which these frames of reference are subject. Goffman's concept of frames is closely linked to his previous, rather loose use of the term "definition of the situation". For Goffman a definition of the situation is only consequential if ratified by other participants in the encounter. In essence, Goffman is arguing that two individuals in a dyadic situation need, to a certain extent, to have shared perceptions of that situation. Within the doctor/patient situation this implies that there needs to be a certain amount of congruity between doctor and patient's frame for the situation. It is hypothesised that this will be reflected within
the expectations they hold for each others behaviour.

When an individual in our western society recognises a particular event, he tends whatever else he does, to imply in his response (and in effect to employ) one or more frameworks or schemata of interpretation of a kind that can be called primary. A primary framework is seen as rendering what would otherwise be a meaningless aspect of scene into something that is meaningful. Implicit within Goffman's use of the term frame is the idea that we have some kind of representation of a situation, which not only contains what will happen within that situation, but which also helps in our understanding of the situation. Primary frameworks vary in their degree of organisation as some are neatly presentable as a system of entities, postulates and rules whilst others, indeed most others, are apparently of no particular shape, providing only a way of understanding, an approach, a perspective. Each primary framework allows its user to locate, receive, identify and label a seemingly infinite number of concrete occurrences defined in its terms. In this sense we see how Goffman uses the concept of framework as a means of cataloguing a large number of events within the world. Structurally it does not appear to be too dissimilar to Minsky's concept of a frame as a data store, a place to put information.

Although Goffman's frames tend to be seen as a means of understanding and interpretation, this is compatible with certain aspects of his earlier writing. In the 'Presentation of Self' (59) Goffman's social actor chooses by impression management which behaviours to engage in in a particular situation. To be able to successfully participate in
social interaction, an individual has to acquire appropriate strategies for performing the roles he seeks to assume. Within the doctor/patient situation the individual's frame for that situation will provide the basis for his choice of a particular strategy. These frames will be built up in earlier encounters of a similar kind, from previous doctor/patient encounters, from what other people say does and should happen etc.

Young (78) comments upon an unpublished paper by Shields. Shields uses the concept of frame in her analysis of nursery dialogue, suggesting that each speaker's potential for participation is structured by some conception, however elementary, that the perceptual and interactional field is shared, that previous experience can be remembered and brought into play, and that there is some agreement on what here is called the 'latent context' which frames a situation, from which rules for coherent behaviour in a given context are derived, and within which options for action are chosen. This latent context is a series of embedded frames and includes the more diffuse socially derived rules of what behaviour goes with what, and how certain roles are played, and also very specific rules pertaining to the framework of the immediate setting - in this case the nursery - and the rules and customs concerning the activities of its members. Shields has a dynamic notion of frame as a frame of reference that can be applied to any situation, and more importantly modified in interactions with other people with different experiences and conceptions. Shields defines her use of frame to include what the participants bring with them into the encounter from knowledge of the world, including the social world and its rule
systems. Again this conceptualisation is compatible with the present thesis where a frame is to be seen as expectations actors use on entering situations.

Young was primarily interested in the strategies which mothers used in their attempts to develop their childrens' ability to understand and impose structure upon the world. Indeed there have recently been a number of attempts to utilise the literature on framing to explore the area of mother-child interactions. One of the most succinct discussions in this area is contained within the work of Kaye (82) who defines a frame as a "recurring unit of organised activity ... provided by adults but fitted to the intrinsic features of infant behaviour". Many of the studies in child development are moving away from the 'tabula rasa' picture of the child to a more interactionist approach whereby the intrinsic features of the child behaviour, can at least impose certain restrictions upon the mothers ability to structure the child's development. However, of relevance to the present thesis is the conceptualisation of 'frames' as units of organised activity. Initially, this would seem to be totally discrepant with the cognitive approach of Minsky and Neisser, however, this is not the case. Within the present thesis the expectations which actors hold for the situation are to be held as the basis for what Kaye would refer to as units of behaviour. It is possible to step back from a social situation and to look at the gross expectations for behaviour; to locate the influence of expectations upon behaviour; and to explore the ways in which Kayes' interactionist concept of frames operates.
From a developmental perspective, Kaye notes the three functions of frames: they facilitate interaction between parent and infant; they facilitate the infants' own exploration of the world and sensori-motor developments; and they provide a means of educating the infant about universals, and culture specific conventions of language. Although Kaye aims to provide an interactionist perspective, his concern is primarily with the infant and as such maintains the imbalance which permeates studies of mother-child interaction. However, the question which needs to be asked at this stage is to what extent do such frames operate in adult-adult interaction, within the doctor/patient situation. The present thesis will explore the manner in which frames facilitate interaction between doctor and patient. It is unlikely that frames pertinent to that situation will facilitate sensori-motor development of the patient, but one will need to build a model to incorporate the functions of doctor/patient frames.

Bernstein (75) developed his notion of frame in the context of the transmission of educational knowledge. Frame refers to the strength of the boundary between what may be transmitted and what may not be transmitted. Where framing is strong there is a sharp boundary, where framing is weak there is a weak boundary. Frame can be seen to refer to the degree of control teacher and pupil possess over the selection, organisation, pacing and timing of the knowledge transmitted and received within the pedagogic relationship. Bernstein questioned the relationship between the strength of boundary and the degree of insulation between the everyday community of teacher and taught, and their educational knowledge.
For Bernstein, framing is closely tied to the process of socialisation. Through socialisation the pupil soon learns what of the outside world may be brought into the pedagogical frame. Such frames also make educational knowledge something not ordinary or mundane, but something esoteric which gives special significance to those who possess it. Furthermore, the stronger the classification and framing the more the socialisation relationship tends to be hierarchical and ritualised, with the socialised person seen as ignorant, with little or few rights. Within the doctor/patient situation it would be interesting to discover who decides what knowledge should be transmitted, and how it should be transmitted and, at the same time, discover who has control over what behaviours are allowed within the consultation. Inevitably it would appear that the doctor is very much in control of what is deemed as relevant and not relevant to the encounter. However, the present thesis intends to highlight the role the patient plays in this context, and thereby destroy the illusion that the patient is a powerless pawn.

Young's work (78) was an attempt at an analytic description of the process of mother-infant interactions as they develop over time, using the concept of framing, by analysing in detail how the mother could be said to be framing interactions for the child. Young's work allowed the description of the patterning of communications between the mother and infant as they develop over time, and also allows an analysis of the power relationship between the mother and the infant. Evidence of the power relationship may be explicit or remain implicit within the communication.
The meaning of the encounter is not contained within isolated utterances, but can be considered to arise from the tacit knowledge of participants in an exchange, which they use to attribute meaning to what is said. Different participants in an interchange have different bodies of knowledge and at different moments treat one or another sub-system of knowledge as relevant to the understanding of what is being communicated. The sub-systems are theoretical constructs which provide for each participant the frame of reference within which their own, and other persons communication is assigned relevance and meaning. "Calling upon a sub-system of knowledge and applying it to the present situation, with implications for future behaviour, can be considered, it is suggested, adult competence in framing" (Young 76).

In the mother-child interchange the mother, as the adult charged with the care of the child, has a fully developed frame system and in the course of her negotiations with the child she must intersubjectively frame interactions with the child i.e. the mother supplies the dynamic intersubjective context for the child's meanings, in which the child can learn meanings for his, or her activities. In the same manner, it is arguably the doctor as the professional charged with the care of the patient, who has a fully developed frame system, and in the course of negotiations with the patient he must intersubjectively frame interactions with the patient. The extent to which the doctor is in such a position of control or influence is uncertain, and will be commented upon by the present thesis.

In framing interactions for the child, the mother selects a frame
from her own tacit knowledge, and uses it to supply the context in which the child and her own actions can be interpreted as meaningful, and therefore the mother is the primary introducer of the preconceived aspects of framing. However, the child does have some capacity for framing, and therefore it is better to see the situation as negotiated as both mother and child construct a framing of their joint activity. The mother seeks to establish her framing as intersubjectively shared (i.e. the infant has to operate spontaneously in terms of it, as well as the mother). Young sees this as the end point in a developmental process whereby the mother's frame becomes shared. The child is in the early stages of the process of building up frames of understanding. However, it is assumed that both doctor and patient will have frames of understanding, as the doctor/patient encounter is not new to them. On the basis of this assumption, it is not expected to witness overt negotiation over the upper levels of the frame (Minsky '77) and furthermore it is unlikely that the strong framing which Young noted in his studies of mother-child interchanges will occur.

However, the question remains as to what exactly are these 'frames'. Young's discussion of 'tacit knowledge' remained implicit within his work, and the present thesis intends to elucidate this. One possible reason for this will have been the age of the children Young was working with, and their limited verbal capacity. However, if a situation involves two linguistically able actors it is possible to assess and map out more clearly the nature of these frames, and show further how they are related to behaviour. It is intended to use an adaptation of the original model as put forward by Young and to apply
it to the doctor/patient situation.

For Young, 'frames' exist on two different levels, and can be located separately within the interaction. Frames have a 'content' and 'metacommunicative' dimension which can be discussed separately, but which are part of the same conceptual tool and work together within the interaction.

1. The 'content' level. This can be assessed in terms of intersubjective boundary maintenance, behavioural constraints and sequential constraints.

2. The 'metacommunicative' level - which in the mother-child sequences arises from the mother's use of her power.

It is possible to summarise Young's work in the following manner. The mother has a frame for the situation (in this case a ball and shapes game), composed of knowledge and expectations, which she attempts to get the child to act in accordance with, so that the child accepts her rules for the game. If the child does not accept these rules, the mother can resort to overt 'metacommunication' to assert her authority over the child. "The analysis of the content level of framing serves to build up a picture of the interchange as either strongly or weakly framed by the mother, implicit in which is the metacommunicated relationships" (Young).

Intersubjective boundary maintenance refers to the manner in which definite restraints are exercised by the mother upon possible interpretations of the situation, possible roles within it and the potential to express meanings. Which, of the entire range of
potential aspects of the situation, is to be focussed upon and then intersubjectively taken for granted as the framing develops, is chosen by the mother and tacitly accepted by the child the moment the child engages in reciprocal communication, either verbally or non-verbally. Therefore the mother has control of the 'here and now' and the taken for granted assumptions of what the child comes to know about the 'here and now'. Young argues that expectations are created for the child's behaviour, and once the child behaves in accordance with these expectations, she has tacitly accepted the premises upon which they are based. Young continues noting that we can explore intersubjectivity by paying attention to expectations and taken for granted assumptions (as does the present thesis). However, it is also necessary to look at expectations created for the self, as well as the other, to allow a deeper grasp of the intersubjective context.

Accepting that the mother had expectations for the child's behaviour, the question for Young was "how are these expectations for frame related behaviour, actually conveyed to the child?". Intersubjectivity restricts the actors, but there is a need for a behavioural manifestation if these behaviours are to be made explicit. "The mothers expectations for the child's behaviour must be generally backed up with more concrete cues for the child's behaviour" e.g. eye contact, gestures, deictic hand movements, non-verbal markers of significance, physical constraints.

The first observation to note is the absence of language from Young's analysis. As previously mentioned, this is probably due to limited linguistic capacity of the child, but it will be argued within the
present thesis that behavioural restraint can also take the form of linguistic restraint, as this is the behavioural expression of the intersubjectivity shared expectations. (The present thesis intends to deviate slightly from Young's concept of behavioural restraint and to incorporate the Dahl, Kelvin concept of power in describing influence within the consultation).

Furthermore, "in any discussion of framing, framing through time is implied" and Young accepts time as an important aspect of any theory of framing. In fact, it would be unwise to do any analysis of a social situation within a temporal vacuum. Within the mother-child pairs, Young noted how there may occur a "progression from 'less powerful' to 'more powerful' behavioural constraint on the child's activity" (78). The mother-child interaction sequences had a history, and intersubjectivity between them builds up over time, and because certain things were done in a certain way in the past it has become intersubjectively understood that this is how it has to be done. It is necessary to notice how the mother-child relationship developed over time, and the same principle can be applied to the doctor/patient relationship. It is hypothesised that there will be noticeable differences between consultations in which the doctor has previous knowledge of the patient's illness, and consultations in which the patient is presenting 'novel' symptoms. Furthermore, as the consultation progresses, it is hypothesised that the nature of the interaction will vary.

However, Young's work highlighted that the child may not wish to accept the mothers' frame for the situation. To explain how the
mother would deal with this, Young called upon the notion of metacommunication. Metacommunication is a part of the total communication and refers to the power dimension i.e. who has the authority to say and do what to the other. To take Young's example, if the child accepts the frame as offered by the mother then this authority to dictate the rules of the game will remain implicit. However, if the child does not accept the frame as offered by the mother and attempts to throw the shapes around, then the mother may make her authority to frame the situation overt by more or less forcing the child to play the game her way.

This notion of metacommunication running parallel to the communication is derived from a number of sources, but much of the significant developments have occurred in the area of psychotherapy, particularly family therapy (Bateson 56 73, Watzlawick Beavin Jackson 67, Laing 61). Implicit within much of this work is the differentiation between the content and relationship levels of communication, which Young (78) used in his analysis of mother-child interaction. However, theorists in the tradition of those mentioned above, were interested in the contradictions inherent in the communications between family members. It is possible for a mother to express love towards a child, and to request a loving response, whilst in the same sequence of behaviour it is possible to withdraw from the child and deny love and affection. The contradiction is not particularly important here. What is, is the need to appreciate the dual level of communication. Messages do not only convey information, they make an implicit statement concerning the nature of
the relationship. There is a need to explore this duality within the doctor/patient relationship.

3.3. A MODEL OF FRAMING

It is possible to discern a number of themes which run through the literature on frames and framing, which can be integrated to form a model of framing to be applied to a social situation, within this thesis, the doctor/patient situation. However, before elaborating upon those aspects of frames which are to be incorporated into the model, two general points must be made. The use of the term 'frame' is somewhat misleading as it does orient the reader towards the content of the frame rather than the 'process' of 'framing', of which the content of the frame is a crucial aspect. This is really what Neisser (76) was implying in his attempt to highlight the dynamic qualities of schema; as opposed to Minsky's (77) somewhat static information storage analogy of a computer file. The point of departure of the present thesis is that framing needs to be viewed as a dynamic concept, with both content and process dimensions, which in reality operate in an inseparable manner, but for the purposes of analysis are often referred to as distinct units.

The second point, which needs to be made at this juncture, is that not only is there a diverse and often inconsistent use of term frame, the term frame is often introduced without any acceptance of previous usages. As such there was a felt need to explore previous usages so as to provide a 'framework' (yes, again the term is being used loosely, but as a means of illustration) whereby the reader can appreciate the model to be outlined in the present chapter.
As a result of reviewing the literature on framing the following model was devised, to be applied to the doctor-patient situation, although with minor modifications it could readily be applied to any social situation.

1. Expectations for behaviour within the doctor-patient situation exist and are shared.

2. Expectations must be seen to occur, and what is not included within the expectations is excluded from interaction.

3. Such a restriction of possible behaviours inevitably restricts the decision making process.

4. Behaviour constrains the future flow of the interaction.

5. Implicit within every behavioural act is a metacomment on the nature of the relationship.

1. Young (78) referred to the intersubjectivity which builds up between mother and child whereby they both begin to operate in terms of shared meanings and understandings. This notion of intersubjectivity has proved difficult to explore in mother-child interactions (see Kaye 82), however, the literature accepts that some kind of latent context provides a framework, against which individual behaviours are attributed meaning.

A central aspect of Young's model was 'intersubjective boundary maintenance' whereby the mother expressed her taken for granted assumptions for the child's activity. It is taken for granted that there is an established way of doing things. In Young's work the mother-child pairs were engaged in a ball and shapes game whereby the mother had to guide the child to place the
correct shape in a ball full of holes. Intersubjectivity builds up between mother and child as they both begin to operate in terms of how the mother thinks the game should be played.

Within the present thesis this notion of intersubjectivity is felt to be expressed more clearly as expectations for behaviour. It is assumed that if actors have shared expectations for a social situation then this is based upon shared meaning that this is the way to do things. Furthermore, by looking at expectations from a framing perspective, we can clarify exactly what level expectations are operating at. Minsky (77) offers an interesting distinction between upper and lower levels of frame. The upper levels of frame are those behaviours which are stable, and will occur repeatedly in a said situation. This is consistent with Kaye's (62') definition of a frame as a 'recurring unit of organised activity'; and it is this which the notion of intersubjectivity is seen as applying to. What can be described as gross patterns of behaviour which will occur in consultation A, Consultation B, Consultation C etc....

However, Minsky also pointed to lower levels of frame which refer to more specific features of one particular occasion, and will be influenced by factors peculiar to that situation. Within Young's mother-child pairs, presumably individual mothers had different approaches to the game, and presumably each child was either willing to conform to, or escape from, the game in its own individual style. Within the doctor-patient situation, there are three factors which can immediately be seen as leading to
variation at lower levels of frame i.e. individual doctors, patients and illnesses. However, the important point which needs to be accepted at this stage, is that there are higher levels of frame, which are intersubjectively shared patterns of behaviour pertinent to the doctor-patient consultation. Minsky allows us the possibility to appreciate how individual consultations will vary within this general theme.

Finally, in this section, it must be emphasised that much of the work on expectations focuses upon expectations for the other. Intersubjective restraint must be supported by subjective restraint, and if we wish to explore expectations for others, we need to explore expectations for self, as from an interactionist perspective the two are inseparable.

2. At this stage in the thesis we are restricting the development of the model to these 'higher order' expectations, which comprise the upper level of frame. Accepting Bateson's (73) proviso that frames are both inclusive and exclusive this implies that behaviour within the consultation will be restricted to what is referred to within the expectations. This led to the second aspect of the model of framing i.e. expectations must be seen to occur, i.e. they must be realised, and vice versa, behaviours excluded from expectations will be excluded from the consultation. To make a claim such as this places quite a constraining influence upon the possibilities for behaviour within the consultation, and is making a very powerful claim regards the consultation. However, it must be emphasised that
this is restricted to upper levels of frame, and as will be seen later in the thesis, there are lower levels of frame to which such a corollary would not, in fact, does not, apply.

This need for expectations to be realised is derived from Bateson's (73) discussion of framing. However, there are implications for the domain of cognitive psychology, in that we could look at expectations as comprising a cognitive representation of the situation. A true test of the validity of such expectations is whether or not such expectations occur as actual behaviour. Serious questions could be raised against a theoretical conceptualisation of expectations if such expectations were not closely related to behaviour. Any incongruity between expectations and behaviour would need to be explained. There are two further corollaries to this postulate. Initially, actors could possibly engage in 'out of frame' behaviour by not living up to expectations. In Young's mother-child pairs the child could engage in out of frame behaviour by throwing the ball away, or by kicking it. Two behaviours which may seem viable to the child, but are incongruous with the frame the mother is offering. As such it would be extremely interesting to analyse consultations where upper level expectations were not realised. Secondly, it is possible for actors within a social situation to exceed expectations, to engage in 'out of frame' behaviour by going beyond these expected behaviour patterns. The implication here is that once we are able to discern these gross patterns of recurring behaviour, this can be built into a yardstick, against
which we can compare situations where 'out of frame' behaviour occurs. The notion of metacommunication to be discussed as the fifth aspect of the model provides a means of exploring out of frame behaviour.

3. The third aspect of the model of framing is that by restricting possible behaviours, this inevitably restricts the decision making process within the consultation. Although this is not intended as a crucial aspect of the model it will be argued that by restricting behaviours to those which are medically sanctioned ensures that a medical decision will be reached. The decision making processes in medical consultations has been explored elsewhere, although it is necessary to integrate this into the present model. (See Cohen & Clarke 79).

4. Implicit within much of the framing literature is a theme relating to control and power. There are constraints upon possible behaviours, as a result of expectation structure and Young (78) referred to the mothers' use of her power and authority in the ball and shapes game. Young's primary concern was with the power and authority as it exists at the relationship level of communication, and this will be returned to in outlining the fifth aspect of the present model.

However, by incorporating the work of Kelvin (70) and Dahl (57) it is possible to look at power as it exists on the content level. As discussed earlier, Kelvin and Dahl define power as the ability of A to bring about behaviour in B which he would not
otherwise have engaged in. A number of authors have pointed to this process within the doctor-patient relationship e.g. Entralgo (69) noted that as soon as we enter the presence of another person, we begin to live in his company, and impose ourselves upon that person, and this leads us to the fourth aspect of the model of framing i.e. the behaviours which actors engage in constrains the future flow of the interaction. Young noted how the mother could use various non-verbal strategies to ensure that the child stayed within the frame she was offering. Within the doctor-patient situation we need to look at verbal and non-verbal strategies when looking at the influence doctor and patient can have upon another. There is a blatant display of power by both doctor and patient throughout the consultation. Every behaviour imposes constraint, although it is not always possible to specify the direction of such constraint. The clearest illustration of this is where the doctor asks/directs patient to remove his shirt. The doctor is bringing about a behaviour in the patient which he would not otherwise have engaged in.

This fourth aspect of the model must not be looked at in isolation, as it only becomes meaningful when looked at within the context of the theory as a whole i.e. that any such behaviour is accounted for within upper level frames, and is commented upon metacommunicatively.

5. The fifth aspect of the model is that all behaviours contain an implicit metacomment that A has the power and authority within the relationship to engage in that particular behaviour.
Watzlawick (67) provides the most elaborate exploration of this notion of metacommunication. Metacommunication runs parallel to the interaction and is a metacommentary upon it. To return to the example referred to above, implicit within the request/direction by the doctor for the patient to remove his shirt, is the metacomment that the doctor has the right and authority, within the confines of the relationship to do this. As will be discussed in greater detail in section 3, there is clearly an element of power inherent in such behaviours as sticking needles into people or in asking them to undress. Watzlawick makes the theoretical statement that within a healthy relationship and the mutual roles of each partner, this metacommunication will remain implicit within the interaction. However should one of the actors not accept the roles, or the frame as offered, it is possible that metacommentary would become explicit.

For example, Young's mother-child sequences - if the child did not accept the frame as offered i.e. to play the game correctly, the mother could resort to overt metacommunication and call upon her power of authority, as the parent charged with responsibility for the child, often non-verbal, to put the correct shape in the correct hole. To continue with the present illustration a female patient may question the nature of the relationship by refusing to unbutton her shirt in front of the doctor. To do so would question overtly the objective and impartial nature of the doctor's investigation, and could lead to conflict. There is a definite need to include these distinctions between content and
relationship levels of communication, and overt and implicit metacommunication, because it provides a theoretical framework whereby we can investigate possible conflict within the relationship. The studies by Illich (76), Koran (80), Cartwright (67), Bloor and Horobin (74), Friedson (74) all point to the potentiality of conflict in the doctor-patient situation which must be analysed.

Taking a frame to be a recurring unit of organised activity, which is an expected part of the relationship, a typology was developed whereby three major frames were seen to occur within the doctor-patient situation:

1. The Specific Frame - which involves the presentation of the patients specific symptomology.
2. The Medical Frame - which involves the investigation of the symptoms.
3. The Diagnostic Frame - which involves the naming of the illness and treatment.

As becomes immediately clear, these are gross, higher level frames, which should occur in Consultation A, Consultation B, Consultation C. However, the concept of framing allows us to explore lower levels of frame which may be pertinent to individual doctors, patients or illnesses.

One of the difficulties of looking at lower level frames is that the present author looks at framing as having both content and process dimension, whereas many of the studies of the doctor-patient
relationship tend to focus upon either content or process. Indeed Pendleton's (83) review breaks doctor-patient communication into input, process, outcome and although accepting the links between the three areas, such a model inevitably leads to fragmentation. The present thesis argues for the inseparability of input, process and outcome and that to understand a problem, such as non-compliance, we need a concept which will allow this linkage. The concept of framing is inherently dynamic and allows for the exploration of these issues.

Having outlined the gross upper level frames it is necessary to outline lower level frames which may or may not operate within individual consultations, and to suggest how a framing perspective has greater explanatory value than exists at present, and more fundamentally to assess whether or not they exist within the actual consultation interaction.

The notion of lower level of frame posed a conceptual problem for the theory of framing. In the previous section, five aspects of framing were described, in which aspects one and two focussed upon expectations and the need for them to be realised. However, by lower levels of frame we are referring to behaviours which may or may not occur, as determined by factors pertinent to the individual doctor, patient or illness. Consequently, such behaviours may not be readily referred to as expectations by all subjects. This problem is confounded by a methodological difficulty in eliciting taken-for-granted aspects of the situation e.g. a doctor may expect the patient to comply with the treatment. However, he may not actually articulate this within the interview as, for him, it is such
a taken-for-granted expectation. These methodological problems provoke a qualitative, and often interpretative, analysis as opposed to a quantitative approach, so as to enable the researcher to elicit as comprehensive a picture of framing within the consultation as possible.

The previous literature on the doctor-patient relationship was used to suggest a typology of possible lower frames, which will be supported by data from the interviews within Chapter 4 and explored within Chapter 5.

The following frames were seen as possibly running through consultations, often subsumed under higher order frames.

1. **The Compliance Frame:** There is a wealth of material which has looked at the problem of non-compliance with the regimen of treatment, and many suggestions have been offered to account for such non-compliance (see Ley 83 for a comprehensive review of this literature). However, within the consultation interaction there will be occasions for the doctor to emphasise/refer to the need to comply with the treatment, and the present thesis will offer observations in that direction.

2. **The Social Frame:** A great deal of the communication within the consultation will relate to the patient's life style. Many authors e.g. Herzlich (73), Radley and Green (85), have pointed to the close relationship between patients' life style and the illness. The present thesis will explore situations within consultations when such behaviours arise.

3. **The Pedagogic Frame:** One can argue whether nor not the
doctor–patient consultation is, or should be, a teaching situation. It is hypothesised that certain consultations will manifest a higher level of teaching behaviours.

4. The Affective Frame: Browne and Freeling (67), in their relatively early analysis of the doctor–patient relationship, pointed to the affective dimension. Again this thesis will look for occasions within the interaction where the affective dimension is manifest.

5. The Informative Frame: This is differentiated from the pedagogic frame in that we are looking for the transfer of information, which could be described as the esoteric knowledge over which the medical profession has monopolistic control.

At this stage, the outline will restrict itself to these five frames, although this is not meant to be viewed as an exhaustive typology. The occurrence of such frames is as yet purely hypothetical, and we may discover little evidence to support the existence of one or all, within the consultations. However, the implications of whether we do, or do not, are wide reaching.

3.4. A TYPOLOGY OF UPPER LEVELS OF FRAME

3.4.1. SPECIFIC FRAMING OUTLINED

For Kelvin (70) "the term power is simply used to describe situations in which the behaviour of one individual is at least partly
determined by the actions of another"...and " in all relations between two or more people one can detect an element of power in all instances of interaction". Behaviour in any dyadic situation will have an influence upon the future course of that interaction, the extent of influence depending upon the behaviour. The thesis will now take examples from consultations to illustrate what is defined as specific framing.

P: Doctor, I've got a sore throat.

Behaviours such as this often occur early on in the consultation and place inevitable restrictions upon possibilities for future behaviour within that consultation. Here the interaction is restricted in the specific direction of what is considered to be relevant to a sore throat, from both the patient and the doctor perspective. The doctor's future behaviour will be restricted to what he considers to be relevant to a sore throat ie. his choice of behaviours will not be free or totally of his volition, even if individual doctors have their own idiosyncratic approaches to statements such as this by the patient eg. Doctor A may allow the patient to divulge more verbal information and allow P to introduce what he/she feels is relevant, or alternatively Doctor B may immediately move towards the patient to carry out a physical investigation. However, in both examples the behaviour chosen is not totally free. Such a choice will be constrained by the patient's utterance. As Kelvin notes, all instances of interaction contain an element of power, although in the initial analysis, the influence may not be that obvious. However, the influence cannot be denied.
Specific framing can be discussed further. The patient may continue to divulge information which he feels is relevant and will be of assistance to the doctor. The patient may support the utterance with non-verbal deitic behaviour by pointing to the throat or holding the throat. Alternatively, the patient may say nothing, believing that the doctor is the person qualified to diagnose the condition.

It is accepted that it is impossible to state the exact direction of specific framing except to emphasize the constraining effect of such behaviour. There are so many possibilities for future behaviour that the chance of delimiting the exact direction of specific framing is impossible. However, in as much as previous analyses of the doctor-patient relationship largely left the patient little opportunity to exercise power (Szasz 57, Brown and Freeling 67) we can see how clearly this is not the case.

The next question involved a discussion of metacommunication contained within the utterance; "Doctor, I've got a sore throat", and what does this have to say about the nature of the doctor-patient relationship. Within the context of the doctor-patient relationship, it is making an implicit statement that the patient has the prerogative to introduce the symptoms into the interaction, (as contained within the behavioural expectations). Moreover, the patient has the right to determine the area of symptomology to be discussed within the consultation, thereby placing constraints upon the interaction. As discussed in Chapter 3, metacommunication refers to the ability to initiate activities and control content. In this example the patient has implicitly indicated that aspect of the
doctor-patient relationship which allows the patient to determine the specific symptoms to be discussed.

In terms of the overall conceptual approach it can be seen that the utterance, "Doctor, I've got a sore throat", behaviourally constrains future interaction to a discussion and investigation of what actors feel is relevant to a sore throat, and secondly it makes the implicit metacomment that the patient has the authority to determine the specific symptoms to be discussed.

Let us now examine a further example.

P: I've got this pain in my eye. Gestures to right eye with forefinger of left hand and circles eye gently with third finger.

As in the previous example, the patient has framed the interaction in the specific direction of what is deemed as relevant to a painful eye. However, this example will be used to illustrate how non-verbal behaviour can support the utterance. P has both pointed to the right eye with the left hand, and also circled the eye gently with the 3rd finger of the left hand which enhances the patient's specific framing of the interaction. In this example, it is clear to see how the patient has offered specific framing in a similar style to the previous example with a verbal utterance to restrict the interaction. However, this is supported by significant non-verbal behaviour which enhances the specific framing.
In terms of metacommunication, again the patient has displayed the authority to determine the content of the interaction and has enhanced this with non-verbal behaviour. However, in this second example, we can point to a difference in the previous example. In this consultation, P did not begin to speak immediately upon entering the consultation, in fact the description of symptoms was in response to the doctor's question "What can I do for you?", which on the content level of communication is 'phatic' or even wasteful conversation as the verbal content of the utterance is not particularly important as it is contained within the expectations for behaviour, that the patient will present symptoms.

3.4.2. MEDICAL FRAMING OUTLINED

As mentioned in Chapter 2, a number of authors pointed to the increasing application and 'relevance' of medicine to an array of different areas of society (Illich 76, Zola 74). However, reference has been made by others to the irrelevance of the traditional biomedical approach (Robinson 76).

This apparent contradiction of the increasing application of an arguably 'unsuitable' paradigm to a social situation required explanation. The basic question asked was could the model of framing derived from the literature offer some explanation concerning the way in which traditional approaches to medicine encroach upon society and exhibit social influence. The process of medical framing as outlined in this section is seen to provide a social psychological explanation for this.
However, before we can illustrate this medical framing it is necessary to outline the traditional approach to medicine. As a result of a highly intensive training schedule, General Practitioner's inevitably approach their patients in an attempt to categorise (Blaxter 78), thereby justifying their involvement and having established strategies to use to overcome the symptoms. Medical science uses a biomedical approach (Robinson 76), and it is assumed that this is the predominant pattern within General Practice, even though certain General Practitioner's express an intention to move away from this approach and to adopt a more holistic and patient-centred approach.

Possibly the clearest outline of the traditional approach to medicine is contained within Kennedy's serialisation of the Reith lectures (Kennedy 83). He outlines eight practices typical to this approach:

1. Medicine is avowedly scientific and produces doctors who view themselves as scientists.
2. Medicine is "curative discipline in which the model of the doctor is that of the engineer/mechanic applying the techniques of medical science to cure a sick engine".
3. Medical practice fosters an attitude that all problems can be solved.
4. 'Medicine is thus committed to a process of reductionism' in which symptoms need to be conceptualised in terms of specific diseases, which inevitably leads to a form of tunnel vision.
5. Medicine also adopts the practice that in the face of a symptom something must be done. This is an interesting extension of Balint's idea of 'don't just sit there, do something' and Kennedy
notes how this might satisfy the expectations of the patient.

6. Medicine is thought of in terms of hospitals.
7. Medicine is and should be an enterprise calling for the use of ever more advanced and complex technology.
8. Symptoms will be labelled as an illness, and medicine is primarily oriented towards illness rather than health, a paradox if ever.

Medical framing is taken as the beginning of the process of removing from the patient the responsibility for his own condition and moreover the ability to comment competently upon it. By utilising the dual level analysis of communication, it is now possible to illustrate the occurrence of medical framing within doctor-patient consultations, e.g.

D: OK, how can I help you?

Comments such as this are typical of the early stages of many symptomatic consultations. "OK how can I help you?" places restrictions upon the future flow of interaction in that it is the cue for the patient to start divulging his symptoms and implies that the doctor is in a position to be able to help the patient. By accepting this cue from the doctor the patient begins the process of transferring to the doctor the responsibility for his state of health, and to use Young's (76) terminology the patient is accepting the frame as offered by the doctor. In terms of placing constraints upon future behaviour utterances, such as this, the process begins whereby medicine adopts the practice that something can be done.
However, comments such as this are more interesting in terms of their metacommunication and give an early indication that metacommunication within the doctor-patient relationship is liable to remain implicit. "OK how can I help you?" provides metacommentary that it is the doctor who is charged with the responsibility for helping the patient. Although in a symptomatic consultation the patient is usually presenting symptoms of her own volition, questions such as this provide metacommentary that it is the doctor who is in a position to be able to help and furthermore has the authority to initiate those behaviours which will lead to a further expropriation of responsibility from the patient.

The thesis looks at the utterance from the perspective of Watzlawick's (67) confirmation and rejection of image in terms of two possible hypothetical patient responses.

D : OK, how can I help you?
P(1): It's my chest doctor.
P(2): I don't think you can.

Response number (1) shows the patient making tacit acceptance of the doctor's impression that he is in a position to help. In this example the patient confirms the doctor's role as a person who can possibly help. However, response number (2) shows the possible onset of the breakdown of the doctor-patient relationship and the possible occurrence of overt metacommunication. "I don't think you can" places a question mark upon the nature of the relationship in that P is showing an initial rejection of the doctor as a person who can help. There are two possible reasons for this. On the one hand the
patient may feel he is seriously ill and that he is beyond the state of D helping, or D may feel he has a psychological problem which he does not believe the doctor can cope with. Response (2) could lead to a breakdown in the doctor-patient relationship as eventually D may react against P's reticence/pessimism and this could possibly lead to an overt conflict on the metacommunicative level concerning the doctor's authority to assess the problem, and the patient questioning whether or not anything can be done for him.

A further example.

P: It's my chest doctor. D moves towards P and picks stethoscope off desk.

D: OK lets have a look.

The term "OK lets have a look" is a continuation of the process whereby the doctor begins to investigate the patient's problem, with the eventual aim of incorporating the patient's symptoms into some type of manageable category. However, it is the proposed use of the stethoscope which adds greater strength to medical framing within this example. As Telles and Pollack (81) noted much medical instrumentation is oriented towards the discovery of what (to the patient) are intangible internal states, and furthermore that these internal states and feelings are believed by the patient to be crucial to the illness. Therefore the patient's belief that the doctor can, via the use of medical instrumentation, assess these internal states, allows the doctor a degree of power over the patient in the area of competence to comment upon the patient's symptoms. In the above case, the doctor's use of the stethoscope is one such example of his investigating these internal states and collecting
information which is of a type the patient is not aware of and would be unable to understand anyway. Illich (76) termed this process the mystification and expropriation of the power of the individual to heal himself, whereby the symptoms are converted into medical concepts about which the lay patient is unable to comment competently. Furthermore, there is a certain amount of literature which points to the use of knowledge as a source of power, and the ignorance of knowledge as a source of weakness. In this instance it is the doctor who is building up a store of information deemed as relevant to the patient's problem and as such is placing himself in a definite position of power over the patient. As Hayes Bautista (78) point out, specialist knowledge is the property of small categories of specialists, who are necessary to reach a competent decision regards the patient.

Furthermore, the doctor's medical training will ensure that he only calls upon that knowledge deemed as relevant and those techniques deemed as useful. Bernstein (75) indicated that within the pedagogic relationship, only certain knowledge in a certain form is regarded by the teacher as relevant in the classroom, and that the teacher will ensure that only such information will enter classroom discussion. The present thesis is arguing that as a result of the previously outlined traditional approach to medicine, that only certain knowledge will be relevant to a competent assessment of the patient's condition, and that as a result of the process of medical framing it is the doctor who will have this information, and the object of this knowledge, (the patient) will be largely ignorant of relevant knowledge. Furthermore, as Schutz (64) points out in his
discussion of the differences between lay and professional knowledge, the latter has a tendency towards increasing exclusiveness and therefore any knowledge not within the professional limits will be increasingly alienated from the interaction. Two further features of Schutz typology of professional knowledge are also particularly relevant to the doctor-patient encounter. There is a quest for certainty and clarity and secondly the elimination of possible contradiction. Although this may be a feature of the structure of professional knowledge it is clearly not the case that this is the most efficient approach as a number of studies have shown the inconsistencies in medical diagnosis (Garland 59, May 74) and questioned the applicability of the typical medical approach (Robinson 76).

Looking at the metacommunicative aspects of D: "OK lets have a look", D picks up stethoscope ... There are a number of interesting aspects here. Initially it is possible to discern the metacomment that it is the doctor who is able to direct the patient within the consultation and is able to initiate the activity of carrying out an investigation of the patient. However, the metacommunicative aspect of this behaviour becomes clearer if we take the hypothetical example of the female patient attending surgery with a male doctor. For the patient to invite the doctor to investigate her chest, and for the doctor to be able to suggest this provides powerful evidence for the metacommunicative power of the doctor to initiate such activities, which in other situations would be highly taboo.

The two previously discussed examples illustrate the types of behaviours contained within the concept of medical framing, and go a
long way towards explaining the patient's loss of responsibility for, and competence to comment upon, his own condition. However, within the next section we will discuss behaviours which impose greater behavioural constraint.

3.4.3. DIAGNOSTIC FRAMING OUTLINED

Diagnostic framing is the third type of framing behaviour seen within the doctor-patient consultation in general practice, and is most clearly understood when viewed within the temporal development of the consultation. To date we have seen the patient introduce the specific symptoms which the doctor investigates from a biomedical perspective. Diagnostic framing is the culmination of the process of removing from the patient responsibility for his own condition.

Illich (76) sums up the basis for diagnostic framing by noting how society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might be ill, and what shall be done to such people. The present thesis argues that such control arises quite clearly within the interaction between doctor and patient. Indeed using Watzlawick's (67) concept of metacommunication it is clear that the doctor is in a position of power with the ability to decide whether an individual is ill or not; to specify what that illness is and to prescribe a course of treatment. All of these are an implicit commentary upon the power structure of the doctor-patient relationship. However, at the same time such behaviours also place restrictions upon the future flow of behaviour. "You're ill", "You've got this", "Do this" all place restrictions upon behaviours within the relationship. The thesis
will now move on to give examples of diagnostic framing, to explain behavioural constraint and metacommendary. For example,

D: You've got tonsillitis. D and P mutual gaze.

The essential aspect of diagnostic framing is the doctor arriving at a diagnosis, i.e. naming the symptoms as a particular illness. The above is a clear example of diagnostic framing as the patient's symptoms of a sore throat have been investigated from a medical perspective and are now reintroduced to the consultation as a defined medical category. Conrad and Schneider (80) discuss this as the medicalisation of society. Conceptual medicalisation whereby a medical vocabulary, or model, is applied to possibly ambiguous and unstructured symptoms. By encompassing P symptoms within a medical vocabulary and model the doctor is exercising power over the patient, as the patient is placed in a position of being unable to freely reassess his own condition. Waitzkin and Stoeckle (72, 76, 85) point to this and explain it in terms of the patient lacking an understanding of the specialist knowledge which is required to competently comment upon P condition. The patient's lack of such knowledge is highlighted by Svarstad (76) who claims that when patients do not understand terms which the doctor uses they either tend to say nothing or pretend they know.

The implications of a diagnosis such as "You've got tonsillitis" for future behaviour within the relationship are marked. For the doctor placing the patient within a particular diagnostic category will place restrictions upon his own behaviour in that he will be constrained to imposing one of a limited number of possible regimens
of treatment, which will be derived from his medical training. Inclusion within such a category also has implications for future behaviour. He will be placed under a particular regimen of treatment which will place restrictions upon his behaviour outside of the consultation.

In terms of metacommunicative commentary upon the nature of the relationship, it is an accepted part of the relationship that the doctor will offer a diagnosis of the condition. However, as Balint (64) notes the diagnosis need not be directly related to medication. Diagnosis is reassuring, and it performs other interactional functions. To confirm to the patient that his symptoms fall into some type of medically manageable diagnostic category will reassure the patient that his symptoms are under the doctor's control. The doctor is able to take responsibility for the patient's condition and is to provide a regimen of treatment which will lead to its successful palliation. As Balint says 'don't just sit there, do something' (73).

The naming of the patient's illness is the first stage in the process of diagnostic framing. However, the designation of a regimen of treatment places further behavioural constraints upon the interaction. For example,

D: Take these four times a day.

Here the doctor has behaviourally constrained the patient by affecting his lifestyle outside of the consultation. However, the doctor can exercise power over the patient to a greater extent in
that D can remove P from his work situation by providing a sick note, and can remove P from what are usually obligatory roles within the home. This ability to remove P from his work situation should not be underemphasised. Work as 'central life interest' has been documented by a number of authors (eg. Lockwood and more recent work by Jahoda (79) has shown how one of the major functions of work is to organise and structure an individual's time. The act of the doctor removing P from this situation has strong implications for the patient's life style. In Kelvin's terms the doctor is clearly getting P to behave in a manner which he would not have otherwise behaved. On a more extreme level, the act of placing the patient on a kidney dialysis machine at home, or hospitalising a patient are examples of powerful diagnostic framing.

Behaviours such as 'take these four times a day' also offer metacommunicative commentary upon the nature of the relationship. It is an accepted part of the doctor-patient relationship that the doctor will impose treatment upon the patient, and the patient will accept the treatment. In simple metacommunicative terms the doctor has the right to direct the patient's life style outside of the consultation, and should the patient adhere to the treatment he is showing tacit acceptance of this aspect of the relationship. However, the power aspect of the relationship is shown more clearly when we consider occasions when the doctor provides a sick note. The ability to impose such behaviour, or the lack of it, upon the patient is a great source of metacommunicative power and also behavioural constraint on the content level.
To clarify this example of the metacommunicative dimension of the prescription of a regimen of treatment we can take a hypothetical situation whereby P could question the nature of the relationship and question the doctor's authority. The doctor could prescribe a course of treatment including a sick note for a period off work. This could pose a threat to the doctor-patient relationship if the patient was unwilling to go absent from work. The patient could mention his unwillingness to lose a few weeks off work and attempt to settle the disagreement on the content level by questioning the behavioural framing which the doctor is imposing. However, this may not prove sufficient to deal with the problem and D may reassert the need for a period of sick leave. At this stage it is possible that the patient could begin to question the nature of the relationship and metacommunication could become explicit. The patient could resort to the basic dimensions of metacommunication, i.e. who has the right to do and say what to the other. The patient may question the doctor's right to keep him off work and argue that he would rather do without the doctor's advice and continue to work. Here the patient is not so much questioning the doctor's decision to keep him off work but his right to make such a decision. Possible dialogue in such a situation could be,

D: I think I'd better give you a sick note as well.
P: No it's OK, I'll still go to work.

D: I still think it's essential that you have a few weeks off work.
P: But you don't have any right to threaten my position at work.

Here we have a clear example of an occasion when the patient has
questioned the underlying nature of the doctor-patient relationship and metacommunication (who has the right to say and do what to who) becomes explicit, the sign of an 'unhealthy' relationship.

Moving on to a further example of diagnostic framing, for example,

D: Come back if there's no improvement.

This is a very interesting and significant illustration of diagnostic framing. As far as the progression of the consultation goes, such a clause will usually follow the naming of the illness and prescription of treatment. In terms of behavioural constraint, the doctor is clearly imposing constraints upon the patient's behaviour in that if there is no improvement which can be attributed to the treatment, the doctor still holds the patient within the medical system. If there is no improvement, the patient is under obligation to return to the surgery.

It is possible to make two points concerning situations such as this. Firstly, derived from the literature which provides the background to the present thesis, is the claim that on many occasions the diagnosis on consequent treatment the doctor provides is often incorrect (Koran 80, Bawkin 45) and so there will be many occasions when this will occur. Secondly, in terms of the present thesis, should the treatment have some functional effect upon the condition, then the doctor-patient relationship will be confirmed as being effective and the expectation and power structure reaffirmed.
3.5. SUMMARY OF THE MODEL OF FRAMING

The literature on framing was called upon because it was seen to provide a means of linking expectations to actual interaction, and allowed the exploration of issues related to the power dimension of the relationship. Figure 3.5. presents an outline of the five aspects of a model of framing which could be applied to a number of dyadic social situations, although in its present form there needs to be a commonality of expectations between actors.

Very briefly, the model of framing states:

Figure 3.5.1.

1. Expectations exist for the doctor/patient relationship, and are shared at the upper levels of frame.
2. Expectations need to be realised as behaviour.
3. Such behaviour elicits particular type of information.
4. Behaviour constrains the actors and the interaction.
5. A metacommentary runs parallel to the communication.

These are the five crucial aspects of the model of framing, which enable the integration of the three distinct notions of expectations, behaviour and power. Three notions which the present author argues are inextricably linked and although they are considered separately, this is probably due more to the influence of previous research, rather than any separatedness in the process as such.

However, the model needed to be orientated towards the doctor/patient relationship, and as a result of extensive reviews of the literature it was possible to establish a typology containing three directions which the process of framing was seen to follow. It is correct to
place the emphasis upon framing as a process, rather than a frame as a structure, as this highlights the link between expectations and the process of behaviours throughout the consultation. The consultation must not be seen as a static event, as it has a history which includes its progression from start to finish and its possible continuation into subsequent consultations. The model allows for the exploration of this history. The three directions of framing process are specific, medical and diagnostic, based upon the link between an expectation and its occurrence as behaviour within the interaction. Section 3.3 outlined how such a process could manifest within the relationship, and Chapter 5 is concerned with a detailed analysis of consultations on the basis of these three directions of framing. However, it must be emphasised that these three patterns of framing refer to upper levels of frame, and within these upper levels of frame there is the potential for behaviours to occur which are peculiar to individual doctors, patients etc. On the basis of the literature review it is predicted that the specific, medical and diagnostic frames will occur throughout all consultations. However Chapter 6 will contain a section whereby consultation behaviour is assessed for the occurrence of lower level frames.

The model of framing and the consequent typology allow the exploration of a whole array of issues which to date the literature has not handled adequately. The first question to ask is how medicine is able to bring about the benefits for society which it inevitably does. It is not sufficient to say that people just go to the doctor and are 'acted upon' by a medical agency. Why should people even contemplate going to the doctor; what do they go to the
doctor for; what do they take into the consultation; what happens in the consultation; what do they come out of the consultation with; what are the implications of an investigation and a diagnosis; and more closely related to the general question of how does medicine bring about the benefits it does .... how and why do patients adhere to treatment (if they do)?

Is medicine and the medical endeavour so overwhelmingly efficient that is is a redundant question to look at the process of social influence in the relationship? There are a number of confusions and contradictions which Illich (76), Koran (60), Cartwright (67) etc have pointed to which make us question whether medicine functions at a 100% level of efficiency. Obviously this is not the case, and this must not be excluded from an analysis of the doctor/patient relationship, even though Pendleton argues that, "this is a matter for medical scientists to discover in the evaluation of their therapeutic regimes" (Pendleton 83).

To study social influence processes we inevitably move in the direction of looking at power within the relationship. Szasz and Hollender (56) were the first to offer a typological description of the power structure of the doctor/patient relationship, but there is a dearth of literature which has attempted to show directly where power comes from and more particularly its operation within the relationship. To concur with McHugh, "institutions exist at the level of interaction" (68) and we need to look at the interaction between the doctor and the patient, as it proceeds throughout the consultation if we are to arrive at any meaningful understanding of
the process of power within the relationship.

Many studies have attempted to look at 'applied' issues such as how to improve patient compliance (Ley 83), patient satisfaction (Pendleton 83) and how to improve doctors' communication skills (Macguire 78). The present author firmly believes that such improvements will be enhanced by a clearer understanding of the processes of framing to be explored in the present thesis. Improvements in level of health, which must be the ultimate aim of all research in the area, will only occur when such programmes are based upon a firm theoretical foundation. Attempts to improve doctor's communication skills may flounder for reasons other than an individual doctor's inability to communicate effectively. There are many intervening variables.

At a more fundamental level there is an absence of studies which have looked at consultations and traced the development of the interaction from start to finish. It is accepted that medicine is one of the most difficult fields in which to carry out research, as was noted by Tuckett (84). However, the number of studies in the doctor/patient area which use as their data reports of what happened, rather than a direct record of what did happen, needs to be reduced. The present thesis presents a detailed record of interaction as basic data.

Having outlined the model of framing, the following three chapters will include:

1. An analysis of the expectations which actors have for the consultation. Such expectations will be used as the basis of the
patterns of framing to be explored in Chapter 5.

2. An attempt will be made to look at the extent to which such behaviours actually occur.

3. A detailed descriptive analysis of the three upper level framing processes, and an exploration of lower level framing.

4. An analysis of consultations. where, for various reasons, the traditional patterns of behaviour are disrupted.
CHAPTER 4

EXPECTATIONS FOR THE CONSULTATION
4.1. **INTRODUCTION**

The issue of expectations and the doctor/patient relationship has been investigated by a number of authors. However, Chapters 2 & 3 showed quite clearly that there is more to this issue than will be gleaned from studies which purport to discover the probabilities of expectations. For example, Fitton claims that 16% of patients expect investigations and yet does not 'investigate' the nature of such expectations. As was argued within Chapter 3 a study of expectations must be approached from the perspective of a particular body of theory.

The purpose of this chapter is to begin to look at the expectations which doctors and patients hold for the consultation from the framing perspective presented in Chapter 3.

Kelvin (69) notes how a norm has been defined, "a set of expectations shared by a greater or lesser number of people", and, "as a shared rule or guide to behaviour that is appropriate or inappropriate". There is an enormous overlap within the social sciences when it comes to the use of terms such as norms, rules, guides and expectations, and such a confusion promoted the present thesis to restrict its concept of expectations to the features taken from another diverse theoretical field i.e. the framing literature. One feature of the definitions of norms referred to by Kelvin is that they imply shared expectations. Individual subjects can be interviewed regarding the expectations which they have for particular situations and norms for that situation will be found when the expectations are shared.
Biddle (79) in his discussion of role theory noted how a great deal of role theory was concerned with looking at the expectations which constitute roles and confirmed that to date there was a dangerous inconsistency in the use of terms such as expectations and roles. The present author is in agreement that usage of a term such as expectations needs to be conceptualised and have its boundaries defined. However, one theme which he does point to is related to the shared nature of expectations, as contained in what Kelvin terms norms. Biddle is interested in the extent to which expectations are not only shared between actors in a dyadic situation but are shared across the culture. There exists amongst the members of a culture a consensus that there is a set way of doing things which is adhered to. Although the present thesis is not overtly concerned with the question, Biddle also makes suggestions regarding the learning and internalisation of expectations, in that "shared expectations are part of our common heritage as members of a given society, community or organisation".

A most interesting observation by Kelvin, relates to the conscious or unconscious awareness of expectations, and has implications for the present study, and some of the theoretical arguments which may surround the thesis. The debate over whether they are part of an actor's cognitive representation of a situation could be drawn into the present thesis. However, as was mentioned previously the thesis does not intend to discuss this issue in great depth, but a number of observations can be made.

1. If expectations for situations are contained within some unconscious store, any attempt to elicit such expectations will
be hindered by difficulties which hinder the elicitation of any unconscious material.

2. Furthermore, as Young noted in his study of mother/child pairs, expectations for behaviour are often taken for granted, and as such verbalisation will be extremely difficult.

These two reflections need to be kept in mind when looking at the responses which individuals make to requests for their expectations for the doctor/patient relationship. Biddle also notes how the "term expectations connotes awareness". However, awareness does not necessitate that expectations will be verbalised. For one thing, expectations which have no formal structure, and are not written down, as is the case with expectations for the doctor/patient consultation, cannot be gleaned from a guidebook, and although members of a culture may be willing and able to act in accordance with expectations, they may find it difficult to verbalise them. It is possible that Biddle pointed to the need to look at the strength of the expectation to deal with this issue. For a number of reasons already touched upon, it will be difficult to get all subjects to elicit all of their expectations. However, the frequency with which subjects refer to expectations will offer a powerful commentary upon the strength of such expectations.

Furthermore, it is essential that some attempt is made to relate expectations to the doctor/patient interaction. The most obvious and crucial question being, do expectations actually became manifest as behaviour? Are expectations realised? Is it necessary to ask the question, to what extent are expectations conformed to? Are they in
fact realised? It is possible that conformity may just be public compliance, an issue much discussed within social psychology (Milgram 74, Aronson 80, Moscovici 76). A most interesting area of social psychological research could investigate situations in which there was a discrepancy between expectations for situations, and actual behaviour within those situations. It is predicted that there will be congruity between expectations and behaviour within the doctor/patient situation.

To place this argument in perspective, it is only necessary to look to situations in which expectations for behaviour are discrepant with the reality of the situation. A most clear illustration here involves the 1st year undergraduate who enters a university seminar expecting to be spoon fed with knowledge, only to realise that her expectations (if any) were misplaced. However, it is interesting to note that even within a situation such as this, communicational influences play such a powerful role that the tutor may acquiesce and confirm these misguided expectations. To offer another illustration, a defendant who is confronted with the courtroom situation, it is hypothesised, will not have such a detailed expectation structure, due to lack of knowledge of, or experience within the situation. The prediction that there will be congruity between expectations and behaviour is based upon the fact that the consultation is a situation which the public have relatively frequent contact with. Figures on the utilisation of medical resources were presented in Chapter 1, and as Robinson says, "everyone can expect to fall ill", not everyone can expect to encounter a university seminar, or a courtroom.
In discussing expectations, Kelvin (69) notes how "the social behaviours of an individual or group can be understood only on the assumption that people hold expectations of one another." If, for instance, an individual asks a question, it is normally because he expects a reply - asking a question is behaviour in the expectation of a response to it. Here, Kelvin is pointing to the possible shared nature of expectations. Within his example, two individuals are involved, the behaviour of A is based upon some expectation that B will perceive and acknowledge this behaviour, and that B will see such behaviour as an acceptable part of the situation. However, this will not always be the case. The university seminar and the courtroom are two situations in which participants are unlikely to have a high degree of confidence that their behaviour is correct.

Kelvin refers to the notion of subjective probabilities which helps to explain this confusion. An individual is seen to have a pool of information which will allow an estimate of the subjective probability of a particular event occurring within a situation. If the probability is high he has the sense that the event is normal, if it is low it is seen as unusual. Kelvin's argument contains an almost implicit statement regarding the maintenance of the status quo. "Behaviour is normal because it is highly probable, and it is highly probable because it is normal". If we have expectations for a situation, we regard this as being the normal and acceptable state of affairs, purely and simply because there is agreement that this is the normal situation. "Its observed or believed frequency is taken as the reflection of a consensus that it is the proper behaviour for the situation concerned".
Here we have Kelvin creating a picture that expectations will be viewed as proper for a situation because so many other people hold identical expectations. This is a powerful argument for social situations maintaining a standard format. However, it becomes all the more convincing if we integrate such ideas with analysis of the relationship within which they exist.

Furthermore, Fitton (79) argues that "hope is synonymous with expectations and adds the implication that the awaited event is wanted and/or desirable". Although this is not always the case e.g. prisoner expecting execution, Fitton does allow us to explore the possibility of affective value being attached to expectations, and within the doctor/patient consultation, it is possible to argue that expectations for treatment etc are perceived as wanted or desireable and if this is the case participants will be more intent upon giving realisation to such expectations. Balint (73) certainly noted that one of the expectations relating to the doctor's behaviour is that he will offer some form of treatment and behave in a manner synonymous with the 'picture' of an efficient doctor.

Parsons (51) looked at expectations from the perspective of role theory as applied to the sick-role. The sick person is not expected to fulfill all of his normal social obligations; he is expected to seek competent help to alleviate the symptoms etc. Although Parsons' initial formulation has undergone great development since its inception (see Parsons 64, 75, Todd & Still 84, 86), these comprise attempts to look implicitly at expectations. Bochner (83) also
looked at expectations under the guise of role theory, although the following quotation also indicates a powerful influence of symbolic interactionism. "When two or more persons interact with each other, their behaviour is greatly influenced by how they define their own and one another's roles. These definitions include the mutual expectations that they bring to the encounter".

Bochner highlights the possibility of role uncertainty occurring when the parties are unclear about their own and the other persons' legitimate expectations and obligations. However, the present author argues that there is a need to differentiate between different levels of expectations, in similar vein to Minsky's (75) differentiation between upper and lower levels of frame. It is predicted that there will be a certain amount of complementarity at upper levels, and that role uncertainty, and disparity is more liable to occur at lower levels of the frame.

Freeling and Harris (84) point to the importance of expectations within the doctor-patient relationship and utilise a technique of calling upon interviews with individuals to illustrate the functions of expectations, but once again there exists a lack of theoretical clarity to explore individual variation in expectations, and as such an overview of the consultation is provided. This lack of appreciation of individual variation in expectations is illustrated most clearly in an article by Holden in the Journal of the Royal College of General Practitioners, 1977.

"Persons who consider that they have medical problems declare
themselves as patients and seek the help of a doctor, usually a general practitioner. They expect. It is the use of the pronoun they which contributes to occluding individual variation. Are all patients the same? Maybe they are, in certain respects, but not all. Such individual variation needs to be explored.

Again criticism must be made of the expectations literature which has to date been derived in the area of the doctor/patient relationship. It is clear that expectations refer to behaviour but that further aspects to this need to be investigated. Expectations may be in the mode of:

1. a description, i.e. that a particular behaviour will or will not occur, e.g. the doctor will give me medicine;
2. a prescription, i.e. that a particular behaviour should or should not occur e.g. the doctor should give me medicine;
3. a cathexis, i.e. that a person expresses personal feelings regarding the expectation i.e. I like the doctor to give me medication.

To approach the issue of expectations noting the complexity of the concept, and to investigate the prescriptive and cathectic nature of expectations, will provide a much deeper understanding of expectations within the doctor/patient situation. An interesting question which is immediately raised concerns the extent to which patients and doctors will attempt to offer any evaluation of the expectations they describe.

The present thesis makes the hypothesis that expectations for
behaviour in the consultation will be shared in that doctor and patient expectations for their own and each others behaviour will be similar. Young (79) described the process whereby the mother attempted to impose her frame for the situation upon the child, and at times the child did not readily accept the frame as offered by the mother, did not fulfil the mother's taken for granted assumptions/expectations for behaviour and the mother then had to use more powerful techniques to impose her frame upon the child. However, if expectations are shared in the doctor/patient situation, there will be no need for either partner to use overt control to impose their frame as there will be mutual expectations that behaviour and events will flow in a particular fashion.

Further evidence of the shared nature of expectations will be found if there is a lack of overt metacommunication in the interaction between doctor and patient, indicating that there is no need for A to persuade B that this is the proper way to do things.

One of the aims of Fitton's work was "to discover patients specific expectations of their General Practitioner in relation to a particular consultation" and their study used Stimpson & Webbs (75) three types of expectations: Background expectations referring to the basic requirements of the doctor/patient script; Interaction expectations which refer to what P expects in this particular interaction relating to the symptoms; Action expectations which are "the specific actions which the doctor is expected to take in the management of his condition". Two comments are made with regards to Fitton's work: Initially that it ignored the role of the patient in
the consultation and secondly that some of the findings seem very strange, e.g., doctors estimated that only 24% of patients expected to be examined (a very small number) and only 2% of patients expected an investigation (a ridiculously low number).

To return to the literature on framing, Minsky (75) differentiated between the upper levels of frames, which are stable and always occur, and the lower levels of frame, which vary and tend to be more specific. The present study is an attempt to investigate the upper levels of frames for the doctor-patient consultation, and to show how at this level frames will be shared. As Balint (73) noted, one of the main expectations for the doctors' behaviour is that he will offer a diagnosis, a name for the symptoms. This is the level at which the present thesis is concerned. However, at the lower levels of frame it may be that the patient expects the symptoms to be named as Tonsilitis and expects the doctor to take time in discussing the condition. In this example, the doctor may confirm expectations at the upper level of frame and offer a name for the illness but may name the illness as Glandular Fever and be very brief in his assessment, thereby disconfirming the lower levels of frame. The lower levels of frame will not be rigorously investigated in the present study although references to lower levels in the interviews will be commented upon.

Further, one important aspect of the theory of framing is that expectations will be adhered to. Accepting Bateson's proviso that frames are 'inclusive' and 'exclusive' in that certain behaviours will be included in the interaction and certain behaviours will be
excluded from the interaction. Kelvin accepts the prescriptive nature of such expectations, in that they prescribe what should be the case and almost prescribe what should not be the case. A central aspect of expectations is that they build a value system around themselves whereby they become the correct, proper and only possible behaviours within the situations. An enormous value judgement. As authors such as Biddle (79) and Parsons (75) have noted, expectations may eventually be seen as a legitimate way of behaving. If the observations of the present thesis are accepted they may be the only legitimate way of behaving. Indeed the process described by Berger and Luckman (67) in the social construction of reality, whereby institutions begin to take on an existence almost independent of the individuals who constitute them, is operating. Accepting the symbolic interactionist position that institutions exist at the level of interaction (McHugh 68), and the present framing perspective that interaction is constrained by expectations, we are creating a picture that events within the consultation are limited by many constraints.

4.2. SUBJECTS

To explore expectations and individual variation in expectations, a semi-structured interview technique was devised to be applied to doctors and patients.

1. 26 general practitioners were approached to take part in the interview. 13 (50%) agreed and comprised the general practitioner group. All were located in the Leicestershire area. 9 were male, 4 were female.

2. (Two groups comprise the patients group). 31 adults were approached at one of the local health centres, whilst in the waiting room, and asked if they were willing to
take part in a study looking at what patients and doctors expect of each other. If they gave their consent a time was agreed when the interviewer could call at the subjects' house to conduct the interview. Of the 31 approached, 6 refused to participate, 4 of whom were very elderly, and it is presumed that they did not appreciate the nature of the exercise, primarily due to hearing difficulties. The other 2 refused by choice. This left a total of 25 subjects (13 male, 12 female) to comprise Group A.

3. Group B comprised individuals who had not been in contact with the doctor in the previous 6 months, either to consult, or collect a repeat prescription. A pool of university students, and local residents comprised this group. A total of 29 individuals were approached, all of whom agreed. However, 8 had to subsequently be discarded as they had been to the doctor recently, or were on some form of medication. This left a total of 21 subjects (9 male, 12 female), who were interviewed in the same manner as Group A.

The next section is concerned with eliciting expectations for the doctor-patient consultation, and assessing consultations for their occurrence/non-occurrence.

4.3. THE INTERVIEWS

A technique was required which would allow subjects to elicit expectations for the doctor/patient consultation, in such a form that they could be explored in greater depth than has been the case in previous studies. One technique of analysis recently developed within social psychology is that of 'accounting' which has its
origins in the work of Harre and Secord (76). According to Harre and Secord the experiment has failed to produce the goods as a tool for social psychological investigation, and they observe a general dissatisfaction with the traditional methodologies of social psychology. A number of theorists, particularly Marsh (78) have attempted to explore Harre and Secord's claim that in order to understand what is going on in social interaction, and what social life is all about, and why people do things, all you really need to do is ask them. The 'accounts' which 'folk' offer for behaviour are as rich a source of data as any experimental paradigm is liable to offer.

Harre and Secord don't just leave their criticisms at that level, and do not expect social psychological researchers to accept subjects' 'accounts' at a surface level. It is necessary to explore the inconsistencies within such accounts, and furthermore, following Biddle (79), to explore the elaborations which subjects make following their initial answers and observations. Such a technique provides the approach to be adopted within this chapter. However, before going on to explore this technique in depth a general criticism needs to be levelled at the doctor/patient situation as a focus of research. The literature is full of studies of subjects talking about what goes on in the consultation, and what happened, but there is a dearth of actual analysis of interaction, an absence of Doctor A talking to Patient B in the consultation.

The present thesis argues that listening to people talk about what happens within the consultation is a valuable source of data, but
this data need to be supported with analysis of the actual event. (This will be provided in Chapter 5 and Chapter 6)

Before outlining the interviews it is necessary to provide a short review of the literature which has looked at the interview as a research technique. Pother and Mulkay (85) note that, "interviews are used as a technique for obtaining information that will enable the analyst to describe, explain and/or predict social actions that occur outside the interview". In this sense the interview is directed towards providing information regarding the doctor-patient situation, and when incorporated into the model of framing is directly relevant to that situation.

Furthermore, Brenner (85) has pointed out the similar vein to Harre (79) that interviews, and more specifically the data contained within them, are not just linguistic pictures of past experience ... "they are pictures that are 'blurred' by the 'gatekeeping' and distorting influences of informants' cognitions of their experiences, which are further modified by the effects of the interviewer-respondent interaction within the totality of the interview situation". Two points can be raised here. Initially, Brenner is re-emphasising an observation made by Silverman (73) that the interview itself is an interaction which has rules and expectations applied to it, as does the doctor-patient consultation. Silverman highlighted that the interview is in many respects an encounter with a stranger, and as such one can immediately envisage problems relating to the elicitation of intimate information. Whether or not such an issue will be problematic within the present research will be discussed.
later. However, the point of emphasis is the recognised need to go beyond 'talk', and beyond initial responses, to explore the elaborations which subjects offer. Silverman points to the manner in which 'social structures' are reflected in talk. The present author would emphasise the power relationships reflected within communication.

The second point which needs to be made is that 'gatekeeping' is to an extent referring to, or will be determined by, frames for the situation. The dominant frames for the consultation will influence the responses subjects provide, and as such we need to look at the data the interviews provide from this perspective. (For a more extensive review of interviews as a research technique, the reader is referred to Danzin 70, Cannell and Kahn 68, and Brenner, Brown and Conter 85).

Two interview schedules were designed which would allow subjects to elicit their expectations for behaviour, and further to elaborate upon such expectations. The suggestions put forward by Harre and Secord (72) and taken up by Marsh (78) provide the basis for these interviews. However, it is possible to criticise the use of Harre's approach as lacking direction if used incorrectly, and there is a need to offer to subjects tentative guidelines to orient them in the direction of discussion of issues related to the research. The focus of the present research is upon expectations for the doctor/patient consultation, and in the initial stages of the interviews, the subjects were oriented in the direction of discussing, and elaborating upon, expectations for behaviour within the interaction,
and it is often when the subjects elaborate upon their expectations that a clearer and more meaningful understanding of events arise.

The interviews comprised a series of open-ended questions, the answers to which were recorded on the data sheets (see Appendix 1). However, the interviews were also audio taped to allow exploration and analysis of occasions which Biddle (79) and Harre (79) would point to i.e. where there are inconsistencies in subjects responses, which may be explained by reference to the literature and where subjects elaborate upon an initial response, and place it within a meaningful context.

According to Marsh, individuals engage in a process of 'transformations' when they produce their accounts of what is happening in social situations. They describe the situation, and offer explanations of the situation which are consistent and comprehensible from their own sub-cultural perspective. They may not be offering a 'true' interpretation of events (that is surely the task of the social psychologist!) but one which they can come to terms with. For example, in Marsh' analysis of soccer hooliganism, "A mundane piece of conflict becomes a 'good kicking' or a 'punch up'. Daily existence (for the hooligan) is rendered remarkable, and in this way sub-cultural life can be built up as an exciting and gratifying alternative to regular and unproductive life in school, work or family" (78).

Although Marsh' interpretations of what lies under the initial account is open to question, his work does highlight the way in which
individuals will 'transform' the accounts they offer of events, and introduces the researcher to the need to be at least sceptical about the initial responses of subjects and to place such initial response in the context of what is said later.

(An adjoiner needs to be applied to the thesis at this stage. The interview technique based upon the above ideas proved successful when exploring what the patient expected to happen in the consultation. However, the general practitioners found the interview difficult to come to terms with and regretfully did not elaborate upon their initial descriptions of behavioural expectations. As such reference is made only to the expectations for behaviour and there is no discussion of the general practitioners attempts to put their initial comments in perspective).

The interviews took the form presented in Appendix 1.

Questions 1 - 3 (see Appendix 1) were a direct attempt at ascertaining the expectations for the consultation. The questions are grouped together as the subjects often offered answers referring to a previous question, and the researcher allocated the response to the relevant question. Questions 1, 2 and 3 were asked of the subjects, who were allowed to elaborate details in support of their answers. As suggested by Harre (79) and Biddle (79), it was felt that this would be a productive technique as it would allow us to move away from straightforward lists and percentages of
expectations. Indeed at a recent forum of medical communication, Silverman (85) made a call for more qualitative approaches to the area of health sociology and the doctor/patient relationship. The initial question e.g. what do you expect to happen in the consultation?, was probed further with prompts such as, what next?, what else?, which was intended to exhaust the upper levels of frame and to dig beneath the 'transformations'. In providing outlines of the major types of behaviour expected within the consultation, the subjects provided a number of highly interesting comments which provide support for the present work. Upon completion of the first three questions, they were repeated to the subjects who were finally asked if there was anything else. This technique of eliciting data provided a wealth of material relating to expectations and the nature of expectations.

The following questions were not administered to the general practitioners.

Question 4 - Within Section 4.1. it was argued that patients were familiar with the doctor/patient consultation as opposed to situations such as a university seminar. This basic confidence regarding their own behaviour was tapped in this question and patients' elaborations upon their initial answers were noted.

Question 5 - This question supports the rest of the interview as it provides data regarding the patient's knowledge of the facilities at the doctor's disposal.

Questions 6-9 - contain an attempt to disrupt the rule of structure of the consultation in an attempt to clarify the extent to
which subjects attached importance to their expectations. One of the themes of the present thesis is that expectations need to be adhered to. It was felt that questions 6-9 would provide an indication of the strength of expectation. A technique for analysing the rules underlying social situations has been termed 'Garfinkel's' after its original exponent (Garfinkel 64). Garfinkel's techniques involved disrupting social situations, by breaking the traditional rule structure and observing the manner in which actors attempted to restructure the situations and deal with the disruption. It would have been a highly interesting venture to do within consultations, to observe the actors attempts to deal with the disruption. (Patients could have been paid to consult the doctor and then not to present symptoms!) From the perspective of the present thesis the ideal outcome of such a situation would be the doctor's emphasis: that the patient should be ill, as the doctor is there to investigate illness, diagnose it and treat it ...why else should you consult a doctor? However, although such a technique could have provided conclusive proof for the arguments within this work, it was deemed as being grossly unethical and an attempt was therefore made to stimulate a Garfinkel's situation by asking subjects to describe how they would react should expectations not be confirmed. It was assumed that subjects would find such questions difficult to deal with, in the same way they would find it difficult to deal with disruption in an actual consultation. These questions were based upon the responses of subjects to Questions 1-3.

4.4. RESULTS

Responses to questions 1-3 were pooled together to provide an outline
of the expectations for behaviour for both the patient and the doctor. As was mentioned in Section 4.1., to date expectation studies have either focussed upon the doctors or the patient, a technique which overlooks the mutuality of expectations which the present work argues is crucial to the relationship. The result of these questions provide two types of data. Initially, the answers were grouped to provide frequencies of each type of response, which gives an insight into the relative importance of different types of response. However, these figures must be accepted in light of the claim that much of the expectations for behaviour within the consultation will be seen as taken for granted, and therefore difficult to elucidate. The second type of data which provides powerful evidence of a qualitative nature looks at the comments and elaborations which patients made. This will focus particularly upon attempts by subjects to place expectations in perspective and comment upon the expectation. Tables 4.4.1 to 4.4.6 contain the frequencies with which each subject referred to a particular behavioural expectation.

The most striking result of this study is that behavioural expectations relating to the patient are extremely restricting, even after exhaustive questioning and prompting. The basic expectation relating to patient behaviour in the consultation is 'to present symptoms', and would be allocated to the upper (stable) levels of frame, if we were to be adhering to Minsky's use of the concept. 92% of the patients (Group A), 71% of Group B, and 62% of the doctors expressed the expectation that the patient would describe symptoms within the surgery. Support, and validation for these figures is found within the video recordings of actual doctor/patient
### TABLE A.4.1  DOCTORS EXPECTATIONS OF DOCTORS.

1. To identify why P there ..................... 62 %
2. To find what P wants,
   and compromise what give ..................... 54 %
3. To communicate well ........................... 46 %
4. To prescribe if necessary ..................... 46 %
5. To explain, and help P understand ......... 30 %

N = 13

### TABLE A.4.2  DOCTORS EXPECTATIONS OF PATIENTS.

1. To say why there and describe symptoms ... 62 %
2. To tell the truth .............................. 54 %
3. To be clear and quick in
   describing the symptom ....................... 23 %
4. To comply with the treatment
   and advice .................................... 23 %

N = 13
<table>
<thead>
<tr>
<th>Expectation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To ask questions</td>
<td>44%</td>
</tr>
<tr>
<td>2. To investigate</td>
<td>24%</td>
</tr>
<tr>
<td>3. To help</td>
<td>20%</td>
</tr>
<tr>
<td>4. To name and explain symptoms</td>
<td>20%</td>
</tr>
<tr>
<td>5. To prescribe</td>
<td>16%</td>
</tr>
<tr>
<td>6. To put at ease</td>
<td>16%</td>
</tr>
</tbody>
</table>

N = 25

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tell symptoms</td>
<td>92%</td>
</tr>
<tr>
<td>2. Assess doctors decision</td>
<td>20%</td>
</tr>
<tr>
<td>3. Be brief</td>
<td>12%</td>
</tr>
</tbody>
</table>

N = 25
### TABLE 4.4.5  PUBLIC EXPECTATIONS OF DOCTORS. (GROUP B)

1. To investigate.............................. 42 %
2. To explain and name symptoms............ 33 %
3. To prescribe................................. 19 %
4. To ask questions ............................. 19 %
5. To help....................................... 9 %
6. To put at ease............................... 5 %

N = 21.

### TABLE 4.4.6  PUBLIC EXPECTATIONS OF PATIENTS. (GROUP B)

1. Tell symptoms............................... 71 %
2. Be brief..................................... 14 %

N = 21.
consultations where it becomes quite clear that the bulk of patients' behaviour does consist of presenting and describing symptoms. The percentages are only to be taken as a guidance to the relative importance of each expectation and need to be assessed in the light of subsequent comments.

For example,

A6: You just tell the doctor what the problem is ... you go through the symptoms.

A7: It's evident ... you just explain what's wrong.

A9: I tell him what I feel, it's simple.

Bll: You just do as you do ordinary ... you just say what's wrong and how you feel.

These four examples are typical of responses to these questions, and it becomes obvious that not only do we see an expectation that the patient will describe his symptoms, but almost a restriction that he will or should, do very little else. Neither patients nor doctors referred to any further type of behaviour and indeed there is constant reference to the acceptance that presenting symptoms is all the patient will do. Further evidence in support of this is contained in the only other expectation which occurred with any measure of frequency i.e. to tell the truth and to be brief in describing the symptoms. A number of adjoiners seem to be attached to the basic behavioural information i.e. present the symptoms as truthfully and briefly as you can - you don't have to do anything else, you shouldn't do anything else, and don't waste the doctor's time.

A3: You explain the symptoms, your not in long.
A4: I'm passive, I tell him what's wrong and come out with medicine.
A5: I tell him the symptoms and I tell him quickly cos there's usually a queue.
A6: You tell him all you know, cos it's not fair to him if you don't.

These four extracts from the interviews help to put the patient's expectations for his/her own behaviour in perspective. The presenting of the symptoms is an expectation which is not only shared between actors within the doctor/patient consultation, but using the strength, and frequency with which this is referred to it can be seen to be shared across the culture. However, there is a feeling that patients should not delay when presenting the symptoms, and A6 makes an evaluation of the patient's role and infers that the patient should be honest, "cos it's not fair to him" if the patient is not honest. Two comments can be made on this last extract. First of all, whatever the patient achieves in the consultation is to a certain extent determined by his or her own behaviour. And secondly, and more interestingly there is an implicit awareness that patients do not always describe the symptoms adequately - they may forget certain details, or they may purposfully lie.

Subject A12 elaborates upon this point,

A12: I tell him what's wrong, if I can.

Subject A20 offers a possible explanation for any difficulty,

A20: I'm worried and I'm nervous ... I'd wish I weren't there and I would try to tell him why I'm there.
Pendleton's study (79) entailed an analysis of patient dissatisfaction and related anxiety amongst patients, and indeed much of the work on teaching doctors communication skills has the implicit aim of reducing patients' anxiety.

Subject B14 offers a further explanation,

B14: I can never say as much as I would like to.

It is becoming clearer as we go through the interviews and look at exactly what it is that the subjects are saying, that although as patients they do know that they are expected to describe the symptoms, they are also aware that this isn't as easy as it may sound. Nerves, lack of time, and ignorance can contribute to the difficulty a patient could experience presenting the symptoms.

Finally, within this section, A22's comments put the present work into perspective. In response to Question 1 - What do you expect to happen in the consultation?, he replied, "What do you mean? ... you know vaguely what will happen, but you don't know specifically". The initial responses which subjects give do refer to the upper levels of frame - the general and stable behavioural expectations. However, when these responses are elaborated upon, a much clearer picture arises.

Expectations for the doctor's behaviour provide more scope for analysis and discussion if only due to the fact that from a behavioural perspective the doctor is seen to do more.

As tables 4.4.1 to 4.4.6 show, both patients and doctors themselves allocate a more extensive set of expectations to the doctor which for initial purposes were outlined to guide the reader to appreciate the major behavioural expectations. To show which behaviours would be
included within the upper levels of frame, as comprising those stable characteristics of the doctor/patient consultation which could be expected to occur time and time again, and judged by the strength and agreement between the groups, can be seen to be the culturally accepted behaviours for the doctor/patient encounter.

However, expectations such as this become meaningful when we look in depth at the interviews to the elaborations which subjects make and how they attempt to put their expressed expectations in perspective. In terms of behaviour, three themes can be seen to run through the expectations for doctor behaviour - that he will investigate, identify why the patient is present, name and explain what the symptoms are and prescribe. These will be discussed in turn.

A25: He'll ask me what's the matter.
A24: To ask what can I do, how can I help.
A22: He'll ask what's wrong.
A13: He'll listen to me.
A20: He always asks me what's wrong ... he's a good doctor.
A12: A considerate doctor will always ask you what is wrong.
B11: He'll help you by the way he speaks ... he'll guide the type of answers you give.

Within many of these replies is an implicit acceptance of the traditional roles of doctor and patient. There is certainly a feeling of acceptance, of taken for grantedness as if there is no other way for the doctor to behave. Indeed A20, and A12 make a fairly explicit statement that it is the good doctor who will ask you what is wrong, it is the good doctor who in this respect adheres to
the traditional role. Furthermore, it is interesting to note Bill's comments upon the investigation as this almost sets the patient up to be more responsive to the doctor-centred style of interviewing so clearly described by Byrne and Long (76).

It is also interesting to note the number of occasions upon which subjects outlined the expectation of an investigation in virtually the same terms that doctors use when they are beginning their investigation (see Chapter 5).

A24: He'll ask, what can I do for you.
B4: They always begin with what can I do for you.
B2: He's liable to say something like, hello, how are you, what can I do for you.

Here we have fairly clear examples of what Biddle refers to as the descriptive mode of the expectations, which unfortunately subjects were unable to elaborate upon, and possibly offer some evaluation of, even after prompting and probing. It did seem to be a pattern that subjects outlined their expectations by actually relating hypothetical verbatim comments by the doctor.

However, to explore this area of investigation, a number of further elaborations will be made.

B16: I expect to be examined if it's necessary.
A9: The doctor will ask and find things out about me. He'll ask about my symptoms. Examine me, if and when he feels it necessary.
A5: He won't necessarily examine me.
Although it comes across that an investigation is an accepted part of the doctor/patient consultation, it is not necessarily the case that the patient expects to be examined. It is necessary here to refer to Fitton's (1972) study of expectations. Within Chapter 2, it was claimed that Fitton did not distinguish clearly enough between investigation and examinations. These three subjects quite significantly use the term 'examined' rather than investigation, and it does appear to be the case that a physical examination is not a necessary expectation and the frequency of the expectation that the doctor 'asks questions' would seem to imply that a verbal investigation is a much more central expectation.

From there we can move on to deal with the issue of diagnosis of the symptoms. This issue relates back to the original maxim of Balint and his observation that one of the most important expectations which the patient has is a name for his illness. To explain and offer a name for the symptoms was referred to regularly by all three groups. However, if, as Balint claimed, this is a crucial expectation, surely it would be mentioned slightly more frequently than was the case in the present study. This begs us to ask the question, which to date seems to have been overlooked and seen as almost to be taken for granted, that maybe the patients do not always expect a diagnosis. The majority of subjects who discussed this expectation did not say they expected a diagnosis - they said they expected the doctor to explain and name their symptoms. There are two parts to this and only the second, naming the symptoms, refers to diagnosis - to explain the symptoms does not necessitate they have a diagnostic label.
A23: He'll explain things.
Al: To explain things.

In fact, it is somewhat surprising considering the previous literature that subjects do not go into a great deal of depth regarding diagnosis. Maybe this is a question mark underlying Balint's work, which can have influenced medical practice in that doctors believe that patients expect them to offer a diagnosis, on the grounds that it justifies their involvement etc. This does not appear to be the case. Certain patients expect a diagnosis and doctors should not be forced into giving one on the assumption that this is all the patient is after.

Certain patients do fit this traditional role, as the following comments clearly illustrate.

A24: I should hope he'll diagnose.
B16: I expect a lot ... he should know exactly what's wrong.
B6: He needs to come up with a diagnosis.

A rather facetious patient offered the following observation.

B3: The doctor says what is wrong. We discuss it ... and then he tells me!

A more articulate subject offered this rather educated observation.

B7: All the doctors know are standard complaints ... they'll try to categorise you into one.

However, the overall point which is being made with regards to the issue of diagnosis is that, yes, to offer a diagnosis of the symptoms is culturally accepted as part of the doctor/patient consultation and
it is possible to find patients who seem to demand that this be part of a consultation. This is though, not necessarily an across the board expectation. Patients are somewhat more discerning than they have to date been given credit.

It is when we move into the issue of expectations for prescriptions and treatment that individual differences amongst patients begin to become more clear. Although the earlier section of this chapter argued that taken for granted expectations would be difficult to verbalise, it was certainly not predicted that expectations for treatment would be as low as they were i.e. 16% of Group A and 19% of Group B expected the doctor to prescribe and 46% of doctors said they would prescribe if necessary. Again, it seems to be unfair to look upon the patient as some sort of over-demanding, ignorant consumer who wants to see the doctor do something, to diagnose and to throw out pills. Patients are indeed much more discerning. However, the stereotype can be filled as illustrated by the following comments.

A1: I expect the doctor to give me what I want.

A2: I won't go if he won't provide treatment.

B3: My mother tells me to lay it on thick, so as to ensure that I get something.

A number of further comments show that there are others who will be looking for treatment.

A13: He's there to help me ... to put me right ... to give me something.

However, this does not convey a totally honest appraisal of the type
of expectations which patients told. This section is probably best introduced by B3, whose comment regarding expectations for the doctor were, "what else ... here's some pills", implying at least a certain amount of scepticism regarding the prescribing practices of doctors. Accepting then that patients are not junkies, who purely and simply live in need of pills, what types of patients do we get, and what issues are important to them regarding their treatment?

Certain patients view the general practitioner as a type of sorting clerk for certain complaints. The following comments clearly illustrate this.

B12: I expect him to give some preparatory medicine unless it is serious.

B13: He should tell me what it is or get me to a hospital.

In actual fact, the doctor here is viewed correctly as an agent of primary care - to sort the sheep from the wolves and refer any complaints which may be serious.

However, certain patients expressed a much more honest, and almost pragmatic approach when it came to expectations regarding treatment, as the following illustration shows.

A8: Doctors are there to do their best for you.

A21: It really depends what is the matter.

A23: If something's wrong, the doctor will treat it.

A23: He'll decide if medicine is required, and he will prescribe if necessary.

A20: The doctor is there to help as much as he can.
Patients do show a willingness to allow the doctor to evaluate whether or not medicine is required and to offer it if it is. However, possibly Al3 provides the most lucid comments here.

Al3: Can he help me?

Lucid on two counts, in that it shows that the subject is aware when the doctor may not feel it necessary to offer any direct help. However, it may show a scepticism regarding the capabilities of doctors.

One final point can be made regarding expectations and that is that patients have broader expectations and aims relating to issues outside the consultation.

B17: He should give me medication to get me back to work.

The patients within this study expressed fairly typical expectations, which on an initial overview correspond with other studies e.g. Fitton (79), Stimpson and Webb (75), and Pendleton (79). However, the aim of the present study was to put such expectations into the perspective of a theory of framing with upper and lower levels of frame. Although behaviours such as investigations, treatment etc form the upper levels of frame, and refer to recurring patterns of behaviour, deeper exploration of subjects responses shows that on many occasions actors foresee, at least the possibility to step out of these upper levels of frame. This now begs the question, in what way do actors step out of upper levels of frame within the doctor-patient situation? The video recordings of consultations will offer observations in this direction (see Chapter 5). However, before
moving on we will continue exploration of the interviews.

**Question 4. Do you know how to behave in the consultation?**

This question aimed to provide further elaboration of the answers contained in Question 1-3.

Group A - 23 out of 25 said "yes", they knew how to behave.
Group B - 20 out of 21 said "yes", they knew how to behave.

This indicates a basic confidence in their own behaviour within the consultation. However, such answers become much clearer and meaningful if we look to some of the responses which subjects offered in support.

- B12: Yes, you just go in and say what's the matter.
- A23: Yes, I've had experience with doctors.
- A8: Yes, by and large I do as I'm told.

These three comments illustrate three of the themes contained within the present thesis. Initially, previous experience with doctors (either via face to face contact or via hearing) is seen to provide us with basic knowledge of the expectations which constitute the patient's role. Subject confirms the point argued in the previous section - that the expectations which constitute the patient's role are fairly straightforward i.e. present the symptoms. And subject gives evidence of the medical framing and diagnostic framing which the doctor will instigate.

**Question 5. What tests can a doctor do on you?**

Of the 46 subjects only one patient said he had no idea as to what tests the doctor could do on him. The other 45 (97.81%) had no
difficulty in calling to mind a whole range of tests and medical instrumentation. Group A naming an average 2.7 tests, Group B naming an average 3.2 tests. Illustrations of examples were,

P.4: Water, blood, heart.
P.5: Blood pressure, temperature, blood, urine, smears.

It is clear that the public are not ignorant of the tests which doctors can use on them. However, attention is called to the fact that the tests are described in lay terms and is claimed that the patient is unaware of the specific implications of blood pressure readings or blood sugar levels etc. This is important in terms of Danziger's (75) and Waitzkin's (84, 85) discussion of the control of knowledge as a source of power, and Goffman's (59) claim that such technology will help to define the situation as a medical situation.

Question 6 - 9.

6. The doctor is not listening, what would you do?
7. The doctor doesn't prescribe the treatment you want? What would you do?
8. The doctor doesn't investigate. What would you do?
9. The doctor doesn't do what you say he will do in 3. What would you do?

The answers to questions 6 - 9 are discussed together as they are investigating the same basic issue i.e. the non-realisation of expectations, and are derived from comments contained within answers to earlier questions (especially Question 3). This technique allowed the discussion of the non-attainment of expectations which the
patient had mentioned in the interview, rather than asking the patient to imagine standard situations and was found to give more validity to this attempt to Garfinke\.

Analysis of the answers noted a number of general patterns in the responses of subjects which were grouped under the headings listed below. However, as was the case with Questions 1 - 3, the supporting comments provide much information concerning the strength of the expectations and the subject's evaluation of expectations.

The responses fell into five general categories.

1. It couldn't happen.
2. See another doctor/change practice.
3. He's the expert, I'd expect I didn't need it.
4. I wouldn't mind/I'd accept it.
5. I don't know.

1. It couldn't happen. Subjects found it hard to accept that certain taken for granted behaviours could not occur. The upper levels of frame for the consultation are fairly stable and the possibilities of disruption are beyond frame boundaries e.g.

   B21: I would go to another doctor, but that doesn't happen.
   B19: It doesn't occur.
   B18: It couldn't happen.
   B17: It would never happen.
   A19: It wouldn't happen.
   A12: It never happened.
Accepting these responses at this level we are once again painting a picture of the expectations for behaviour in the consultation as being fairly stable, and patients find it difficult to imagine how they would deal with situations in which these traditional expectations are not realised. However, the methodology used in the thesis could be commented upon and the nature of questioning. It is highly probable that subjects viewed the interviewer (dressed in suit) as a member of the medical profession and saw the questions as relating directly to situations when the patient was ill. In such situations the non-realisation of expectations would be difficult to handle. However, as was emphasised in Chapter 2, many general practice consultations involve occasions when the patient does not present a tangible illness. It is to be argued, on the basis of evidence to be presented in this section, that the patient does have the ability to discern whether or not he or she is ill, or will allow the doctor to decide this, and does not necessarily demand that the doctor goes through the traditional behaviours i.e. investigate, diagnose and treat. These responses of it couldn't happen, have to be viewed in the same light as subjects' initial response to expectations. The elaborations which subjects make are more revealing and offer a more meaningful picture of events.

2. See another doctor, change practice. A common response by patients, threatened with a doctor who was not confirming expectations was to see another doctor, or to change practice. An initial assessment of such responses would imply that if expectations are not realised, it is likely to lead to a
breakdown in the doctor/patient relationship. This seemed somewhat drastic and in fact, was a common response to the statement, the doctor is not listening. However, if we take into account the supporting comments which patients made, the picture becomes much clearer.

B15: Say, eh, like, eh, I'm off elsewhere, I'd go back though.

B12: I'd go to another one ... but they usually do listen.

B11: Leave or go elsewhere, but if he can't cure you, nothing else can. Who else can?

B14: See others with the same problem!

B6: I'd protest and go for another opinion, but that never happens.

Although the initial response of the subjects was surprise and a desire to leave or gain another opinion, again it seems that such non-realisation of expectations is difficult for the patient to grasp. However, there is also a feeling of redundancy amongst many of the patients. Accepting that the initial response to leave the medical relationship must not be taken out of context it also needs to be noted that the patient may go from one doctor/patient relationship to another doctor/patient relationship. Al3 provides a more explicit illustration of this. "I'd walk out, and make an appointment with another doctor".

3. He's the expert, I'd expect I didn't need it. Here we are seeing quite explicit references being made to a theme which has been
picked out as one of the crucial aspects of the doctor/patient relationship i.e. the power structure. Within Chapter 2, a number of authors were referred to who have at least recognised that power is an important aspect of the relationship. Duff and Hollingshead (68) discuss sponsorship and the transfer of responsibility to the doctor, Illich (76) refers to the mystification of illness, and more recently Armstrong (83) has discussed the power inherent within the medical investigation. It is argued within the present thesis that processes such as these lead to the types of responses subjects gave within these interviews. He's the expert, I'd expect I didn't need it.

B24: I wouldn't know what, I'd accept his judgment.
B23: He maybe didn't need to.
B21: I'd presume I didn't need it.
B20: I'd ask why, but he's the expert.
B19: You don't argue do you, he knows.
B13: Just do as he says ... you can't do anything else.
B10: How would I know ... you don't always expect pills or medicines ... you don't know.
B6: He's the expert.
A22: It really is up to him, he'll know ... you have to take what they say.
A17: He's the boss, but they don't always have time.
A16: I'd leave it to his opinion.

Throughout many of the subjects responses, there is reference to the expertise which the doctor has. Subject B22 was most articulate here. "Within his role as a professional, this means an occupier of specialist knowledge, he knows about illness".
Such responses take on a greater significance when we refer to Waitzkin's ongoing thesis concerning the way in which "doctors may withhold information and maintain uncertainty to preserve power in the doctor-patient relationship" (Waitzkin 72, 76, 78, 79, 84a, 84b, 85).

The patient within the consultation accepts the fundamental structure of the doctor/patient relationship. The doctor is seen as an expert who in terms of behaviour will illustrate this by investigating, diagnosing and treating the patient, if there is an illness. As the responses to questions 1 - 3 clearly indicated the patient does not operate blindly on the basis of some fixed frame for the consultation although this is a powerful guideline. It is clear from the evidence presented within this study that there is a standard set of expectations relating to the doctor/patient consultation but both patient and doctor are allowed to break out of them.

A certain confusion may arise over the definition and implications of the term expert. A general practitioner is seen as an expert in the field of general practice, but this does not imply a 100% commitment to and confidence in his beliefs and findings on the part of the patient. And although patients view the general practitioner as an 'expert' this does not exclude them from making an evaluation of his/her decision. Whether or not the patient's evaluation will have any effect is another matter, which will be referred to again in Chapter 6, but the patient must not be seen as a pawn without power or influence.
4. I wouldn't mind. I'd accept it. There was evidence amongst subjects' responses of a feeling of redundancy, or lack of control should the doctor not engage in expected behaviours. This fits in with the theme of the present discussion. The doctor is viewed as the expert, although not an all domineering expert, who is allowed the facility of refusing to prescribe treatment, should he think it is not necessary. This is certainly moving away from Balint's early observation that doctors feel they need to be seen to do something. There are two possible explanations. On the one hand, if the doctor is viewed as the expert then the patient will allow him not to prescribe on the basis of his judgement, or on the other hand, it may be that the patient is not obsessed with receiving treatment.

All: I'd accept his judgement.
A13: If he gave sufficient reasons for it, I'd accept it because he knows.
A9: I'd think he knew that it wasn't necessary.
A8: Well, the doctor's right, he has his reasons. I have total faith.
A4: If he hadn't prescribed it, I obviously don't need it.

Reference here is made to work on the Health Locus of Control (Lau 82, Wallston 76) and the implication is that such responses indicate an external health locus of control. Regardless of which of the two explanations are applicable in the individual's instance, the point which is being made is that expectations for the doctor/patient consultation do not have to be rigidly adhered to.
5. I don't know. A general feeling of confusion was referred to when the breakdown of the traditional expectations was suggested. This has implications for the nature of frames in that Minsky (75) would claim that a frame also contains information relating to what to do should expectations not be realised. The responses of subjects have already indicated that patients do not need expectations to be adhered to rigidly.

P25: I don't know.
P5: I wouldn't know.
P10: You don't know.

A response such as this might be taken out of the context of the subject's overall responses. One could take responses such as the latter as reflecting an almost frightening confusion and uncertainty. However, part of the analysis has been orientated towards destroying the myth that patients have set expectations which need to be adhered to. The patient may not always know what to do should the doctor not prescribe treatment, or investigate, but this does not imply that he inevitably expects such in the first place.

To offer a brief summary of the interviews there was confirmation of the findings of authors such as Fitton (79), Stimpson and Webb (75) and Pendleton (79), in that patients and doctors do hold gross expectations for behaviour within the consultation. These expectations form the upper levels of frame for the consultation which are guidelines by which doctors and patients behave. Furthermore, although these form the frame for the doctor-patient
situation generally, patients certainly do not see them as invariable aspects of the consultation. Patients express an initial confusion/surprise when confronted with possible deviation from such traditional patterns. However, such a reaction may have been an artifact of the interview situation and subjects allow themselves and the doctor the ability to assess whether or not such traditionally acceptable patterns of behaviour need to be adhered to.

However, a further test of the results of the interviews lies in the analysis of actual consultations to see if upper level frame expectations are adhered to within the doctor-patient consultation generally.

4.5. THE PHASE ANALYSIS

4.5.1. INTRODUCTION TO PHASE ANALYSIS

The previous study investigated some of the complexities of the expectations which patients hold for the doctor/patient consultation, and argued that there is a pattern of expectations relating to the interaction which although shared, in certain circumstances, do not have to be rigidly adhered to. The most obvious example being that patients see the prescription or some form of treatment as an expectation, although under certain circumstances, probably at the doctor's discretion, this may not be realised. However, it was felt that there was a need to validate these expectations which patients were referring to. It may appear somewhat superfluous, but if there is a discrepancy between what is expected and what actually occurs we could argue that the frame for the consultation is invalid, that actors have unrealistic expectations, a finding which would certainly
require explanation.

A technique was required whereby we could investigate the occurrence, or non-occurrence of expectations within actual doctor/patient consultations. It was hypothesised that consultations would contain evidence to show the validity of frames, and that we would see the patient present symptoms, and the doctor investigate, diagnose and treat in that order. However, to date we have been painting a picture of the ideal type of doctor/patient consultation and inferring that any disruption of the ideal types will take the form of the non-realisation of the expectations. However, it is also possible that disruption of the ideal type could take the form of expectations occurring out of sequence in the consultation. Although Weber (66) never intended it, this particular ideal type does contain a certain moral requiredness i.e. that if the patient is ill, he or she will present symptoms, which the doctor will proceed to investigate, diagnose and treat, in that order. It would be interesting to discover reasons why consultations do not follow the ideal typical sequence of events even though basic expectations are fulfilled. The answer may be found implicit within Cartwright's (72) work that the patient may not be ill!

4.5.2. METHOD

Within Chapter 2, a number of studies were reviewed which were attempts at breaking the consultation down into its constituent phases, to allow a clearer understanding of the temporal progression of the interaction between doctor and patient. Byrne and Long (76) and Tanner (76) provided the most perspicious system of classification
describing six phases through which consultations were said to pass. This system of classifying the interaction sequences provided a technique for looking at the consultations as they began, proceeded and eventually reached a conclusion. The systems devised by Byrne and Long, and Tanner are presented in table 4.5.1.

These systems were largely descriptive, and although it was never assumed that all consultations passed through these phases in sequence from 1-6, no attempt was made to map out any of the deviations, from what was in actual fact an ideal typical outline of the temporal progression of the consultation in General Practice. It was necessary, therefore, to video record a number of consultations to analyse them in terms of the occurrence of expectations. (The collection of data is described in detail in Chapter 5).

The studies by Byrne and Long, and Tanner provide the basis for a phase analysis to be applied to the consultations in the present study. Integrating the two systems the final outcome to be applied to the consultations was:

TABLE 4.5.1.

PHASE A: Introduction and Relating to the Patient
PHASE B1: Discovery of Reason for Attendance.
PHASE B2: Verbal and/or Physical Investigation.
PHASE C: Consideration of the Patients Condition.
PHASE D: Detailing Treatment.
PHASE E: Termination.
50 consultations had already been transcribed and were categorized into the above phases on the basis of the predominant behaviours occurring at the time. A slight difficulty was raised for the classification process as non-verbal behaviour could conflict with verbal behaviour eg. whilst taking P's blood pressure the doctor could be discussing P's condition and therefore this sequence could be classified as either B2 or C. However, in this instance phase B2 would predominate as the most important behaviour for the purpose of analysis. The consultations were classified into the phases and a record of the sequence of phases was taken eg. symptomatic consultation 1 passed through the following sequence of phases; A, B1, B2, C, B2, C, D, C, D, E. To check the reliability of the classification into phases, a random sample of 10 consultations was classified by the researcher and an independent observer with an inter-rater reliability of over 90%.

With regard to the investigation of the realization of expectations using the phase analysis, we can return to the expectations expressed in the previous study. By amalgamating the expectations for doctor and patient, as expressed by patients, public and doctors, the following list of expectations was arrived at. (See over page).
<table>
<thead>
<tr>
<th>EXPECTATIONS FOR PATIENT</th>
<th>EXPECTATIONS FOR DOCTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To tell symptoms/describe symptoms.</td>
<td>1. To investigate.</td>
</tr>
<tr>
<td>2. To say why there.</td>
<td>2. To identify why P there.</td>
</tr>
<tr>
<td>3. To be brief.</td>
<td>3. To explain and name symptoms.</td>
</tr>
<tr>
<td>4. To assess the doctor.</td>
<td>4. To ask questions.</td>
</tr>
<tr>
<td>5. To be quick.</td>
<td>5. To prescribe.</td>
</tr>
<tr>
<td>6. To comply with treatment.</td>
<td>6. To communicate well.</td>
</tr>
<tr>
<td>7. To discover what P wants.</td>
<td>7. To find out what is wrong.</td>
</tr>
<tr>
<td>8. To put at ease.</td>
<td>8. To help.</td>
</tr>
<tr>
<td>9. To listen.</td>
<td>9. To listen.</td>
</tr>
</tbody>
</table>

The reader will notice the similarity between many of these expectations and the behaviours which underly the classification of the consultations into phases. Therefore the technique for assessing the occurrence of expectations was to subsume expectations under their phase headings and assess the occurrence of phases, as is outlined over the page.
<table>
<thead>
<tr>
<th>PATIENT</th>
<th>DOCTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHASE A</strong> Introduction and Relating to Patient</td>
<td></td>
</tr>
<tr>
<td><strong>PHASE B1</strong> Discovery of Reason for Attendance</td>
<td></td>
</tr>
<tr>
<td>- To tell symptoms/describe</td>
<td>To identify why P there</td>
</tr>
<tr>
<td>- To say why there</td>
<td>To ask questions</td>
</tr>
<tr>
<td>- To identify why P there</td>
<td>To discuss what P wants</td>
</tr>
<tr>
<td><strong>PHASE B2</strong> Physical and, or Non-Verbal Investigation</td>
<td></td>
</tr>
<tr>
<td>- To tell symptoms/describe</td>
<td>To ask questions</td>
</tr>
<tr>
<td>- To find out what is wrong</td>
<td>To listen</td>
</tr>
<tr>
<td>- To investigate</td>
<td>To investigate</td>
</tr>
<tr>
<td><strong>PHASE C</strong> Consideration of Patient's Condition</td>
<td>To explain and name symptoms</td>
</tr>
<tr>
<td><strong>PHASE D</strong> Detailing Treatment</td>
<td>To prescribe</td>
</tr>
<tr>
<td><strong>PHASE E</strong></td>
<td></td>
</tr>
</tbody>
</table>

By utilizing this technique the purely behavioural expectations were assumed to be realized by the occurrence of the said phases in the consultations. However, a number of the expectations were not purely behavioural or open to analysis as it is argued that to assess whether or not a patient was brief, would be a purely subjective
measure and not possible within the present analysis. To comply with the treatment refers to extra consultation behaviour and to assess the doctor is more of a cognitive process than a behaviour. Similarly with the doctor, to help, to put at ease, and to communicate well are not straightforward behavioural expectations and are therefore excluded from the analysis.

4.5.3. RESULTS

Tables 4.5.3. and 4.5.4. contain the results of the phase analysis applied to the 50 consultations and plot the sequence of phases through which each progressed. (See over page).
### TABLE 4.5.3.

**Sequences of Phases (Symptomatic)**

1. A, B\(^1\), B\(^2\), C, B\(^2\), C, D, C, D, E.
2. A, B\(^1\), B\(^2\), C, D, E.
3. A, B\(^1\), B\(^2\), C, D, C, D, C, D, E.
4. A, B\(^1\), B\(^2\), C, B\(^2\), C, B\(^1\), C, B\(^2\), D, E.
5. A, B\(^1\), D, B\(^2\), D, B\(^1\), B\(^2\), C, B\(^2\), C, D, E.
6. A, B\(^1\), B\(^2\), C, B\(^1\), B\(^2\), C, D, E.
7. A, B\(^1\), B\(^2\), C, B\(^1\), B\(^2\), C, D, E.
8. A, B\(^1\), B\(^2\), C, D, E.
9. A, B\(^1\), B\(^2\), B\(^1\), C, D, B\(^2\), C, D, E.
10. A, B\(^1\), B\(^2\), C, D, E.
11. A, B\(^1\), B\(^2\), C, D, E.
12. A, B\(^1\), B\(^2\), C, D, E.
13. A, B\(^1\), B\(^2\), C, E.
14. A, B\(^1\), B\(^2\), C, D, E.
15. A, B\(^1\), B\(^2\), C, D, E.
16. A, B\(^1\), B\(^2\), C, D, E.
17. A, B\(^1\), B\(^2\), C, E.
18. A, B\(^1\), B\(^2\), D, C, D, C, D, C, E.
19. A, B\(^1\), B\(^2\), C, D, C, D, E.
20. A, B\(^1\), B\(^2\), C, D, E.

**Note:** Symptomatic – only 2 occasions where phase D did not occur
Chronic – only 3 occasions where B\(^1\) did not occur
  only 1 occasion where B\(^2\) did not occur
TABLE 4.5.4.
Sequences of Phases (Chronic)

1. A, B\(^1\), C, B\(^2\), C, D, C.
2. A, B\(^1\), C, B\(^2\), C, D, E.
3. A, B\(^1\), B\(^2\), C, D, E.
4. A, B\(^1\), B\(^2\), C, D, E.
5. A, B\(^1\), B\(^2\), C, D, E.
6. A, B\(^1\), B\(^2\), C, D, E.
7. A, B\(^1\), B\(^2\), C, D, E.
8. A, B\(^1\), C, B\(^2\), C, D, E.
9. A, B\(^1\), B\(^2\), D, C, D, C, E.
10. A, B\(^1\), C, B\(^1\), B\(^2\), C, D, E.
11. A, B\(^1\), B\(^2\), B\(^1\), B\(^2\), B\(^1\), C, D, B\(^2\), C, D, E.
12. A, B\(^1\), B\(^2\), C, D, E.
13. A, B\(^2\), C, B\(^2\), C, D, C, D, E.
14. A, C, B\(^2\), C, D, E.
15. A, C, B\(^2\), C, D, C, D, E.
16. A, B\(^1\), B\(^2\), C, D, E.
17. A, B\(^1\), C, B\(^2\), C, D, B\(^1\), C, D, B\(^1\), C, B\(^1\), E.
18. A, B\(^1\), C, B\(^2\), C, B\(^2\), D, E.
19. A, B\(^1\), B\(^2\), C, B\(^2\), C, D, E.
20. A, B\(^1\), C, B\(^2\), D, C, D, E.
21. A, B\(^1\), B\(^2\), C, B\(^2\), C, D, E.
22. A, B\(^1\), C, B\(^2\), C, D, E.
23. A, B\(^1\), C, B\(^2\), D, C, E.
24. A, B\(^1\), B\(^2\), C, D, E.
25. A, B\(^1\), B\(^2\), C, D, C, D, E.
26. A, B\(^1\), B\(^2\), C, D, E. 

Cont.
27. A, B\textsuperscript{1}, C, D, E.

28. A, B\textsuperscript{1}, B\textsuperscript{2}, D, B\textsuperscript{1}, B\textsuperscript{2}, D, E.

29. A, B\textsuperscript{1}, C, D, C, D, B\textsuperscript{1}, B\textsuperscript{2}, C, D, E.

30. A, B\textsuperscript{1}, B\textsuperscript{2}, C, D, E.
There are two groupings of consultations - symptomatic and chronic - based upon whether the patient was presenting novel symptoms or a complaint which the doctor has investigated at least once before. Of the 50 consultations analyzed 9 symptomatic (45%) and 10 chronic (30%) consultations passed through the sequence of phases in ideal typical order.

However, not all of the consultations passed through the phases in this sequence e.g. Symptomatic 1 passed through the following sequence.

PHASE B1: Discovery of Reason for Attendance.
PHASE B2: Verbal and or, Physical Investigation.
PHASE C: Consideration of the Patients Condition.
PHASE B2: Verbal and or, Physical Investigation.
PHASE C: Consideration of the Patients Condition.
PHASE D: Detailing Treatment.
PHASE C: Consideration of the Patients Condition.
PHASE D: Detailing Treatment.
PHASE E: Termination.

These observations confirm the classification systems established by Byrne and Long (76), and Tanner (76), as being a valid breakdown of the consultation in General Practice. Furthermore, accepting the congruity between expectations and phases, this confirms that both doctors and patients have valid frames for the consultation. As Tables 4.5.3. and 4.5.4. show, there were only 5 consultations in which one of the phases was omitted. Within S.13, S.17 no treatment
The first point which needs to be emphasized is that it is very difficult to offer across the board reasons as to why each consultation moves away from the ideal typical sequence. One can discern possible explanations as are mentioned above but they should not be taken as the total of possible explanations and furthermore more than one reason may apply to one consultation. (Within the following discussion S = Symptomatic, C = Chronic).

1. **Due to the presentation of more than one symptom/complaint.**

   The data contained within the sheets filled in by doctors (see Chapter 5 and Appendix 2) provided the basis for the number of complaints presented. Within the symptomatic group there were 5 consultations in which more than one complaint was presented. Within consultations S4, S5, S6, S7, and S9 phase B1 appear twice, thereby indicating the introduction of a second complaint which accounts for the deviation from the ideal type. However, it is possible to argue that the introduction of a second symptom would lead to a sequence of phases as occurs in S6 and S7 with phase B1, reoccurring after the first complaint has been dealt with/interpreted, after which the consultation would follow the ideal sequence of B2, C, D, E. However, once the fluency of the stages has been affected i.e. by the introduction of more than one symptom, then the ideal typical sequence has been disrupted and further disruption is facilitated.

   Within the chronic consultations, there were 6 which the patient presented more than one condition: C11, C13, C17, C20, C28, C29. As with the symptomatic consultations the presentation of more
than one condition is the basic cause of disruption to the ideal typical sequence of phases. However, within C13, and C20 phase B1 does not occur twice, and this can be accounted for in that the doctor had seen this patient many times (C13 12 times, C20 4 times) with this complaint, and both doctor and patient understood why patient was there and consequently, this did not have to be made explicit. Both were diabetics who neither had or introduced another problem. With C13, the doctor goes straight into an examination and dispenses with Phase B1 and in C20 the blood pressure check is a regular occurrence and does not need to be verbalized as a reason for attendance. This could also be explained in terms of an increase in the level of intersubjectivity between doctor and patient. As a result of the experience of previous consultations which have dealt with this complaint, (diabetes) both doctor and patient became aware of the patterns of behaviour. A type of intersubjective understanding builds up between them concerning the 'diabetic consultation', and as such makes Phase B1 redundant and unnecessary. The additional symptoms, as noted on doctors' record sheets, are introduced throughout the consultation.

2. **The patient disagrees with the diagnosis/treatment.**

Within the chronic group there were a number of consultations in which the patient disagreed with the doctor by questioning the diagnosis or treatment: C1, C2, C8, C13, C15, C22, C23, C25. These consultations were assessed to discover if this had any disruptive effect upon the sequence of phases. The most common effect upon the sequence of phases is to proceed from phase B1 to
phase C where D and P are involved in a consideration of the patient's condition, prior to further investigation and the return of phase B2. This group of consultations provided a valid test of the model of framing, and is returned to at length within Chapter 6 as there was little reference within the interviews to disagreement.

3. **The doctor suggests no treatment.**

Symptomatic consultations 13 and 17 are easily explained as they deviate from the ideal typical sequence in that phase D does not occur. In these two consultations, the patient is a child brought by the parent, and on both occasions the doctor denies the necessity of treatment, and in so doing disrupts the expectation structure of the doctor and patient relationship. Again, the denial of treatment provides a test for the expectations as to deny treatment is a contradiction of upper level expectations (see Chapter 6).

4. **The complaint is serious and, or the patient expresses worry.**

Symptomatic consultations 1, 3, 18, 19 deviate from the ideal typical sequence in that they end with an interchange between phases C and D. Rather than progressing through A - E the consultations seem to drag out towards the end with this interchange of C, D, C, D, E. An explanation for this is that all four patients express worry over their condition within the interaction and the doctor also noted this upon the sheets. Chronic consultations 9, 10, 18, 19, 21, 27 all contained conditions which were noted by doctors to be serious i.e.
hysterectomy follow up (9, 10), poorly diabetic (18), rheumatoid arthritis worry (19), palpitations/hypertension (21), prostate operation follow up (27). Therefore, the claim can be made that consultations which deal with serious conditions or in which the patient expressed worry moved away from the ideal typical sequence. And it is interesting to note that much of the consideration of condition was an attempt to fit the condition into the patient's life style.

5. No phase B1 as both move into consideration of condition.

Chronic consultation 14 sees a move straight into a consideration of the patient's condition. This is a follow up to a broken wrist which doesn't of necessity involve an investigation and does not require the patient stating why he is there. Furthermore, as this consultation dealt with a broken wrist, with a known aetiology and prognosis, there was no need for the patient to offer reason for attendance. Chronic 15 was discussed under reason 2. P expresses worry.

The above discussion has offered reasons as to why the consultations should deviate from the ideal typical sequence of phases A, B1, B2, C, D, E. However, from the perspective of the present thesis one of the most interesting points is to note the type of complaint involved in those consultations which adhere to the ideal typical sequence. In the symptomatic group consultations 2, 8, 10, 11, 12, 14, 15, 16, 20 all deal with what can be described as straight forward tangible complaints ie. allergy, prolapse, contraception, photophobia, cystitis, chest inflammation, ulcer, skin infection, throat infection. The
argument which follows from this is that the frame, expectation structure which actors hold for the doctor-patient consultation in general practice is most applicable to consultations in which a straightforward tangible physical illness is presented and with conditions which don't fall into this category we are liable to witness a breakdown in the fluency of the phases due to the patient expressing disagreement for being worried about a possibly serious complaint. Within Chapter 2, it was claimed that the traditional biomedical approach is not always suitable within general practice due to the abundance of 'psychosocial' complaints, and the evidence relating to inconsistencies in diagnostic patterns can surely explain the patient's expression of disagreement.

Todd and Still (84, 86) have looked at Parsons' (51, 75) formulation of the doctor's role and patient's role, and question the applicability of Parsons' model to consultations with patients with terminal illness. Recourse is made here to the fact that Parsons' model is an 'ideal' type, and it is a weakness inherent in the methodology which facilitates Todd and Still's critique. In the same way, the sequence of phases outlined by Byrne and Long (76) and Tanner (76) form an 'ideal' type, which may not of necessity be found to exist within reality. The one thing which Weber did not want to happen was to have the 'ideal type' take on a moral value, as the 'ideal' state of affairs. But it does appear to be the case in the present thesis. Consultations which flow through the ideal typical sequence of phases are those, certainly in symptomatic consultations, which involve physical illness, the major focus of the medical endeavour.
It is clear that doctors and patients have expectations for the consultation which are shared. Both doctors and patients expect the patient to describe the symptoms, and the doctor to investigate, explain and name the symptoms, and to offer treatment. However, such expectations need to be appreciated in the light of Minsky's (77) analysis of upper and lower levels of frame. It is clear that expectations such as these comprise the upper levels of frame, in that they refer to recurring patterns of behaviour which will occur in the majority of consultations. Surely the reply of any reader will be 'OK', but there is more to the consultation than this. Yes but any further developments, behaviours must take place within this overall pattern of framing. This is the justification underlying the development of a model of framing as opposed to any other theoretical stance. There is an element of power within all behaviour (Kelvin 70) and furthermore once upper levels of frame have been established, then they will recur throughout the majority of consultations, and not only do such frames specify what will and must occur within the consultation, they also specify what will not occur. A claim such as this has powerful implications for attempts to deal with problems of non-compliance (Ley 83), patient dissatisfaction (Pendleton 83) and information exchange (Waitzin 85). Furthermore, it shows how these three practical problems are tied to the processes of the mystification of health and illness (Illich 76), the medicalisation of society (Zola 74, Conrad and Schneider 80), and sponsorship (Duff and Hollingshead 68). If we accept the argument that these gross upper levels of frame must occur, that inherent in such behaviours is a transfer of responsibility to the doctor (Duff and Hollingshead 68),
and a reduction in the ability of the individual patient to understand his own condition, it is no wonder that patients do not feel able to comply with the treatment, are generally dissatisfied, and that doctors find it difficult to offer information as the inherent process of the consultation is to convert the patient's condition into a form which is beyond patient comprehension. (This issue will be returned to throughout the thesis).

Another major finding of the present study is what appears to be a contradiction. The initial responses of subjects were in the direction of traditional expectations. However, upon further exploration it becomes clear that patients do not hold such expectations as invariably binding, and they offered the possibility for 'out of frame' behaviour to occur. This is contradictory in that on the one hand the thesis argues that patients do not have traditionally conceived expectations, but on the other hand the phase analysis shows how consultations follow a traditional pattern. There are a number of possible explanations for this. The literature would confirm that the doctor has the power to direct the consultation along traditional lines and overrides the patient's need not to be offered a diagnosis or treatment (Sasaz and Hollender 56, Armstrong 84, Sankar 86). However, one alternative explanation is that the situation is a more powerful determinant of behaviour, than the individual. Individuals may not inevitably expect diagnosis, treatment etc, but the situation and role requirements override individual variation. This is obviously an area of contradiction which further research could explore i.e. the extent to which individuals can step out of situational role requirements. Chapter 6
of the present thesis is an attempt to investigate how subjects step outside of the traditional patterns of behaviour, and either engage in behaviour which contradicts upper levels of frame, or alternatively engage in behaviour which fills in lower levels of frame.

One point which must be highlighted, as a result of the present study, is that these consultations in the symptomatic group which contained all six phases in the correct sequence, as originally laid down by Byrne and Long (76) and Tanner (76), all dealt with what could be described as straightforward tangible physical illnesses, the kind which medicine is readily oriented towards dealing with. Kennedy's (81) serialisation of the Reith lectures highlighted the biomedical bias of medicine, and it becomes clear that although Weber (33) would not have intended it, there is an 'ideal typical' formulation of the doctor-patient consultation, in which the patient is 'ill' and presents a straightforward physical complaint. There are many reasons as to why consultations will not follow an ideal typical pattern, some of which have come to light.

Within the present study, there are others which are implicit within the literature:
1. The patient may present more than one complaint.
2. The patient may not expect diagnosis/treatment.
3. The patient may be worried/anxious.
4. The patient may disagree with the doctor.
5. The doctor may be uncertain of the diagnosis.
6. The patient may present a psychosocial complaint.
7. The patient may be terminal.
Therefore, although on the surface there is congruity between expectations and behaviour, there are many sources of contradiction within the doctor-patient consultation. However, before moving on to explore one such contradiction (Chapter 6) let us move onto a descriptive analysis of the doctor-patient consultation, as it exists within general practice.
CHAPTER 5

THE DOCTOR-PATIENT CONSULTATION: AN ANALYSIS IN FRAMING
5.1. INTRODUCTION

Chapter 4 contained an investigation of the expectations for the doctor/patient consultation such expectations providing the necessary background to understanding events within the consultation. The two studies described were an investigation of the two aspects of the model of framing outlined in Chapter 3. The work to be described in this chapter is a more direct analysis of behaviour, as it occurs within the consultation and will focus particularly on the latter of the three aspects of frames i.e. that expected behaviours relate a certain type of information, that behaviours restrain the future direction of the interaction and, that there is metacommunication contained within the behaviour.

Reference has already been made to the recordings of consultations in the phase analysis, however, their collection and analysis will be described in more depth here.

5.2. COLLECTION OF THE VIDEO-RECORDINGS

As the focus of the study was the consultation, one of the major problems was to gain access to actual consultations. This involved gaining the co-operation and involvement of a number of General Practitioners in the area. The initial approach to them was by letter, including a request for an interview. This interview was more of an introduction to the doctors, rather than as a source of data for the thesis, and as a result is not included within the present volume. The initial approach was very tentative and tactful as the nature of the research - a social psychologist, investigating medicine - could have proved awkward, and as it was intended to
collect a number of recordings of consultations, the willing involvement of the General Practitioners was required.

The second stage of this part of the research involved 'sitting in', to get a feel for what was happening within the actual interactions as an objective observer, and also to attempt to appreciate the consultation from the perspective of both actors. Again, although this stage provided little documented information which can be included within this work, it was extremely important in formulating early ideas. This 'sitting in' procedure was supported by a number of audio-tapes, which were later analysed as part of a pilot study to test the utility of the phase analysis as developed by Byrne and Long (76), and to clarify and tighten the concepts of specific, medical and diagnostic framing.

One of the major problems involved in taking the research further was the limited time which the General Practitioner has for each patient (Balint 73), and the heavy appointment schedule. It was now necessary to collect a sufficient number of video-recordings of actual consultations which were typical of General Practice, without disrupting the normal routine within the surgery. Two factors were important in affecting the eventual choice of 4 General Practitioners. Firstly, the doctor had to agree to take part and allow the researcher to record a number of consultations in a specified period. Secondly, and equally important, many of the doctors who were approached for the initial interview had consulting rooms which were too small to allow a video-recording of the interaction. Either the visual span of the camera could not
incorporate both the actors, or the design of the room was such that
the video unit would be too noticeable, and may adversely affect the
interaction. Four general practitioners provided a sufficient sample
for the present research.

The procedure for the collecting of the video-recordings was as
follows:

1. The video equipment was set up in the doctors surgery and
adjusted to ensure that both actors were included in the visual
range of the camera, and that they both would be audible.

2. The equipment was then left for 3/4 days to allow the doctor to
get used to having it in his surgery, and for him to assess how
patients reacted, if at all.

3. On the morning or evening, on which the tapes were to be
collected, the researcher sat in the waiting room. When the
doctor called a patient into the consulting room, the researcher
approached the patient asking if they would take part in a study
of doctors and patients, which involved taking a video-recording
of the consultation. If the patient agreed the video recorder
was switched on and the researcher withdrew from the
consultation, allowing it to progress as normal. If the patient
expressed any objection the video was not switched on and the
consultation proceeded as normal. Of the 75 patients approached
only 4 objected (5.3%).

4. The researcher recorded the following details (see Appendix 2):
   a. number of patients approached;
   b. agree/objected to video;
c. approximate age of patient - 0 - 10
    10 - 20
    20 - 35
    35 - 55
    55+

d. sex.

5. The doctor recorded the following details: (See Appendix 2):
   a. name of patient (this was deleted for purposes of confidentiality);
   b. how often, if ever, seen before with this illness/complaint;
   c. diagnostic label for illness;
   d. comments.

These details allowed a synchronization between the video tapes and doctor and researchers records.

6. On leaving the surgery, the patients were thanked for their co-operation.

7. This procedure continued until 71 consultations had been recorded, at which time the video recorder was switched off until the individual surgeries had finished. It was then removed and the next doctor approached.

Of the 71 tapes collected, 13 had to be excluded from the study, for one or more of the following reasons:

1. The tape ended before consultation finished (5);
2. Patient's conversation was muffled as to be inaudible (2);
3. Patient and/or doctor moved around to such an extent that the camera was unable to pick up enough of the consultation (6).
The consultations were then divided into two groups, on the basis of information collected from the general practitioners i.e. whether the general practitioner had seen the patient before with this complaint. The label 'symptomatic' was applied to consultations when the patient was presenting the symptom for the first time. The label 'chronic' was applied to the patients with a complaint which the doctor had investigated at least once before. The justification for this distinction is contained within the literature on the doctor/patient relationship. Many of the previous studies talk about the doctor/patient relationship as some kind of homogeneous phenomena, whereas in actual fact, there is a great amount of diversity from relationship to relationship. An initial distinction which can be drawn is between symptomatic and chronic consultations, which it is hypothesised will develop differently and contain different significant behaviours. Research into the doctor/patient relationship must take account of such differences as even the guidelines offered by Maguire (79) on teaching communication skills must differentiate between types of consultations.

It was felt that 50 consultations would provide more than enough material for this analysis and having divided consultations into symptomatic and chronic, the groups were reduced to 20 symptomatic and 30 chronic by randomly removing a further 8 recordings. The chronic group was larger as it was hypothesised that there would be more variability within such consultations.

The tapes provided a verbal and non-verbal record of behaviours by both the doctor and patient. The only behaviour not fully recorded
was when the doctor and patient retreated to the privacy of the doctors screen for a physical investigation. However, such occasions were still audible and could be included in the study.

5.3 TRANScribing THE VIDEO RECORDINGS

The video recordings had to be transformed into a format to make them suitable for analysis, with a level of detail suitable for the present thesis. Speech provided few problems for the transcription procedure. It was written down, as it occurred with the left hand side margin used to signify who was speaking. The linguistic content of the consultation was placed on the left half of the paper, and non verbal behaviour on the right. The non-verbal analysis presented a problem of what level of detail needed to be included. As with any research of this kind, the aims of the study and the approach used determine the amount of detail required. Too much detail would make the transcripts unmanageable and too little would not facilitate the analysis e.g. to impose a Kinesic analysis (Birdwhestell 70) would provide too much detail, not directly relevant to the study. The chosen level of detail is directly related to the behavioural units being analyzed - in this case, specific, medical and diagnostic framing. The present research necessitated the transcription of gestures, directive hand and body movements and physical constraints. Such detail would be sufficient to support, and provide evidence for, the present thesis.

However, the transcription of the video recordings had a more fundamental mechanical problem. As the equipment used was very old (66), it was necessary to replay each consultation approximately nine
times until the linguistic content was transcribed correctly and a further six times to transcribe non-verbal detail. Such an exhaustive procedure was carried out to provide a thorough record of each consultation.

5.4. DISCUSSION OF SOME OF THE METHODOLOGICAL AND ETHICAL PROBLEMS INVOLVED IN THE COLLECTION OF THE VIDEOS

Due to the nature of the present research there were a number of problems involved in the collection of the videotapes of doctor-patient consultations. The initial distinction which needs to be made is that it was not possible to carry out a laboratory controlled study. The research needed to be carried out in the field with all of the consequent problems of carrying out a field study. The present discussion will concern itself more particularly with the ethical and methodological implications of the use of video recording in a situation such as the doctor-patient consultation in General Practice.

Kendon (79) makes the observation that there must be no bias in terms of one actor or the other. The recording needs to give equal attention to listener-speaker/doctor-patient etc. In addition to this, the recording needs to include all the behaviour of the participants in the encounter. In the doctor-patient consultation this was not possible as many of the consultations involved a physical investigation of the patient. When the investigation was carried out behind the doctor's screen, the privacy of the patient was respected and the positioning of the camera allowed such privacy. However, it must be emphasized that during such occasions,
speech was still audible and provided suitable data for analysis.

There was the possibility of using more than one camera to conduct the recordings as it was expected that a number of patients would disrupt the seating arrangements in the consulting room and move out of the visual span of the camera. However, this approach was ruled out for a number of reasons. Firstly, to synchronise two films would prove a mammoth task for the transcription stage of the research and due to the nature of the equipment, this was totally implausible. A second reason was related to Kendon's claim (79) that participants in the encounter should be allowed to get used to the equipment, to habituate, so as to reduce the possible effects of the camera. It was expected that the presence of two cameras would have a significantly greater effect upon the behaviour of the participants than the presence of one. The act of filming should be as inconspicuous as possible. The presence of one camera did not appear to have too great an effect upon the proceedings as it could stand inconspicuously in the corner of the room. It was possible for the doctors to get used to the equipment as it was placed in their consulting rooms 3 - 4 days prior to filming. However, as the encounter was not regular enough for the patients, they were unable to habituate. Discussion with doctors and patients afterwards indicated that the presence of the camera had very little effect upon the interaction. Having viewed the recordings, the doctors claimed there was very little, if any, difference.

The camera could have been hidden to avoid potential problems. This would have been the most straightforward procedure to avoid
interfering with 'natural' behaviours. However, this raised a consideration of the issue of ethics in psychological research. Pendleton's study of doctor-patient communication (79) used a procedure whereby the camera pointed towards a mirror on the wall of the consulting room so as to conceal the camera (did it!). However the 1978 BPS guidelines for conducting research with human subjects point to the issues of invasion of privacy and deception and the viewpoint of the present researcher agrees that these should be avoided at all costs. Furthermore, patients may be offended to discover the existence of a hidden camera; they may spend their time in the consultation looking for the camera, and there is the totally unacceptable possibility of damaging the confidence and trust within doctor-patient relationship.

One final point needs to be made concerning the making of the recording and this concerns the nature of the relationship between medicine and psychology. In 1976, Byrne and Long pointed to the reticence of medicine to accept anything psychology has to offer and other authors have similarly noted such a reluctance. The present researcher anticipated reluctance and conformed to the wishes of the general practitioners as much as possible. Finally, there could have been occasions on which a patient altered presenting symptom as a result of the camera's presence, e.g. a young girl going for pill prescription could feign headaches, sickness etc.

There were only two occasions when it was noticed by the doctor and researcher, that the camera was felt to have had a possible influence. 1. A teenage girl asking for a prescription for the contraceptive
pill, and the doctor noted that she looked awkwardly at the camera.

2. Elderly man who whispered to the doctor so as not to be heard by the microphone.

5.5 THE ANALYSIS OF THE CONSULTATIONS

The next aim of the research was to devise a methodology for mapping out the said framing behaviours within the consultation to provide the reader with clear evidence of their existence both in terms of how often and during which phases of the consultation they occurred. As was mentioned in Chapter 4, the phase analysis proved a valuable technique for breaking the consultations down into stages, and provides a record of the history of that consultation.

The three types of framing behaviour outlined in chapter III were:
1. Specific;
2. Medical;
3. Diagnostic.

It is now intended to show how each of these was assessed for its occurrence within the interaction.

A form of content analysis was used in which the behaviours were categorized into units, each unit of behaviour representing one of the three types of framing. This approach involved the classification of both verbal and non-verbal behaviours as both are integral to the analysis and an understanding of the framing process within the consultation.
The criteria for the classification of verbal behaviour as a unit of specific, medical or diagnostic framing was a single phrase or sentence.

**MEDICAL**

D: Ok, what can I do for you?

**SPECIFIC**

P: It's my throat doctor.

The above example provides illustrations of units of both medical and specific framing. The doctor's question providing a unit of medical framing, and the patients reply providing a unit of specific framing. We can take this interchange further to clarify the classification system.

**MEDICAL**

D: Is it swollen at all?

**SPECIFIC**

P: I think it may be slightly swollen,

**SPECIFIC**

but it's the irritation which is bothering me, especially at night when my throat becomes really dry.

As the interaction continues, the doctor continues to medically frame the interaction. However, this example is interesting to illustrate the classification of further units. It would have been possible to classify P's speech from "I think ... really dry", as one unit of specific framing. However, this utterance is composed of three
distinct units, all of which frame the interactions in a specific direction, and indeed strengthen the framing as they narrow the symptoms from the patient's throat to a throat which may be slightly swollen, is irritating, and dry at night. "It's my throat doctor" would have the doctor thinking in terms of a whole array of possible complaints ... however, the further specific framing will narrow the doctors thinking to a number of particular complaints.

Classification of diagnostic framing is illustrated in the following example.

```
DIAGNOSTIC
D: You've got Tonsilitis .......It's not serious ....

DIAGNOSTIC
I'll give you something for it.
```

"You've got Tonsilitis", is a clear illustration of a unit of diagnostic framing. However, the subsequent two phrases support the process of diagnostic framing and are classified accordingly.

The classification system also had to take into account non-verbal behaviours as these play a significant part in the framing process throughout the consultation.

A total movement of the body or part of the body scored as a unit of framing eg.

```
SPECIFIC
P gestures to throat with right hand
```
In this example, the patient has supported specific framing on the verbal level with non-verbal behaviour. When this unit of n v b is combined with the specific verbal framing, as in the example above, there is a clear example of powerful specific framing. The non-verbal gesture towards the throat has added to the verbal description. To make this point clear, take two hypothetical examples. The patient who enters the consultation and exhibits the above behaviour and the patient who enters the consultation and does not support the verbal behaviour with non-verbal framing. It provides further support to direct the interaction to P's throat.

Further, examples of the classification of non-verbal behaviour into units of framing are illustrated in the following two examples.

MEDICAL

Doctor moves to patient and
guides P to lift pullover to allow
D to listen with stethoscope.

In this e.g. the doctor is supporting verbal investigation with non-verbal investigation. The unit of behaviour is the doctor guiding the patient to lift his pullover to facilitate the use of the stethoscope.

DIAGNOSTIC

Doctor tears off prescription and
hands to patient.

Here the doctor gives an illustration of a unit diagnostic framing. Tearing off the prescription and handing it to the patient is a unit
of diagnostic framing.

Having shown how the three types of framing were measured it was necessary to devise a technique whereby their occurrence in the 50 recorded consultations could be illustrated. The 50 consultations were analyzed using the said procedure and a record of behaviours within the 20 symptomatic and 30 chronic consultations was made. The consultations were then analyzed in terms of the phase analysis discussed in Chapter 4. The measurement of the occurrence of the three types of framing provided evidence of framing within the consultations. However, by imposing the phase analysis it was possible to show with more clarity where and when each type of framing occurred throughout the consultations and to pick out any major themes in framing behaviours. The occurrence of framing from the introduction (Phase A) to the termination (Phase E) was mapped out and flow charts of behaviour constructed to illustrate more clearly the pattern of doctor-patient behaviour. See Figure 5.1 and 5.2.

Figures 5.1 and 5.2 provide a summary of the pattern of framing throughout the 20 symptomatic and 30 chronic consultations. The figures in each phase illustrate the percentage of total framing behaviours for both groups of consultations and as such we can see whereabouts in consultations particular patterns of framing occur.
FIGURE 5.1. FLOW CHART: SYMPTOMATIC CONSULTATION

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FIGURE 5.2. FLOW CHART: CHRONIC CONSULTATION

Total = 100.098 %
The flow charts provide the basis for the development of 'ideal types' of 'symptomatic' and 'chronic' consultations. The ideal type is a methodological tool to assist in analysis. Originally used and devised by Weber (30), an 'ideal type' is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified analytical construct. The ideal type paints a picture of a 'typical' unit of the phenomena under study. Weber created ideal types of bureaucracy, authority etc. Within the present research, it is intended to construct an ideal type of a symptomatic and chronic consultation. However, there is one crucial difference between Weber's use of the ideal type and its usage within the present thesis. Weber's ideal types were based upon theoretical observation and were not said to exist in reality. They were a yardstick against which to compare actual phenomena. The present ideal types will provide a yardstick against which to compare actual consultations, however its construction is based upon an empirical analysis of actual consultations, and therefore although it is only a constructed ideal type, it is based upon a sound empirical footing and therefore grounded in fact.

The transcripts of the 50 consultations were then analysed and a record made of the occurrence of each of the three types of framing behaviour. The phase analysis described in Chapter 4 was utilised to provide a record of where and when the particular types of framing behaviour occurred, and it was noted whether framing behaviour was
initiated by the doctor, or the patient. When all of the phases and consultations had been analysed for the occurrence of the framing behaviours, this was taken to represent 100% of the framing behaviour within the 20 symptomatic consultations and the 30 chronic consultations. The percentage of framing behaviours which occurred in each of the 6 phases was then computed. This procedure provided us with a record of what types of framing behaviours occurred in each of the phases. From this it was possible to discern what the major patterns of framing behaviour were and to discuss them within the temporal context of the consultation. Figures 5.1. (1-6) and 5.1. (1-12) are a detailed record of the framing behaviours which occurred within the 50 consultations. Figures 5 (1&2) are flow charts to allow the reader to see at a glance the general patterns of framing behaviour.

A certain amount of behaviour within the consultations did not fit into the patterns of framing, and do not contribute to the framing process. Such behaviour is labelled non-functional dialogue, and is illustrated within Appendix 3.

5.6. RESULTS OF THE FRAMING ANALYSIS OF DOCTOR-PATIENT CONSULTATIONS

The first point to be made with regard to the ideal types is that it is assumed that the sequence of phases is passed through:

A Introduction
B1 Reasons for attendance
B2 Physical and/or verbal investigation
C Consideration of the condition
D Detailing the treatment
E Conclusion
It is accepted that not all consultations passed through the phases in that sequential order. However, this was discussed in Chapter 4.

5.6.1. THE IDEAL TYPICAL FORMULATION OF A SYMPTOMATIC CONSULTATION

This is based upon the application of the framing model to the symptomatic consultations, and the reader should consult the flow chart for the symptomatic consultation (Figure 5.1) and the detailed outline of the individual phase (Figures 5.1 1-6) as the discussion is based upon this. To appreciate fully the nature of the doctor-patient relationship, one needs to begin analysis prior to the beginning of the actual consultation. Within all the symptomatic consultations (by definition) it is the patient who makes the decision to consult the doctor and therefore fundamentally initiates the activity, thereby exhibiting metacommunicative control in the initial stages of the encounter.

The format for the discussion of the ideal types is: extract from the flow chart for that phase; description of phase; illustration drawn from consultations and summary.
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**SPECIFIC**

**MEDICAL**

**DIAGNOSTIC**

**SYMPTOMATIC**
PHASE A : INTRODUCTION AND RELATING TO THE PATIENT

Framing occurs in Phase A along medical lines, in that the patient has entered the health centre, passed through the first stage of selection (ie. the receptionist) and is in the waiting room. When the doctor calls the patient into the consulting room, the patient is entering a 'setting' (Goffman) filled with medical apparatus and equipment. The couch, eye charts, blood pressure gauge, stethoscope etc, all form part of the setting. These are all tools of the medical profession, the source of the 'clinical gaze', which only the doctor is legitimately qualified to use, as only he is in control of the medical knowledge upon which there use is based. As such, medical paraphernalia places the doctor in a position of power. Although it is the patient who initiates the interaction within the symptomatic consultations, medical framing begins from the moment the patient enters the surgery. For such an amount of medical technology to be present in the 'setting' of the consultation, the interaction will of necessity be restricted to what is included in the scope of this medical technology.

Many authors have attempted to investigate this issue of the effect of the physical environment upon the interaction, and Argyle and Furnham (81) noted how the focus of social psychological research had shifted to "include contextual orientation in which transaction between people and their sociophysical settings is emphasised", although how successful this has been is open to debate. Stokols (78) comments upon the capacity of the environment to evoke vivid, and widely shared social meanings among members of a setting. Furthermore, to add support to the expectations discussed in Chapter 4
Argyle and Furnham (81) argue that, "behaviours associated with, or considered appropriate to, certain places, govern or direct behaviour in those places ... the layout and ambience of a setting substantially contributes to the way people perceive and act in these situations".

This literature provides support for the theory of framing as we can see how behaviour is guided by expectations, which utilise technology within the environment which will lead to the elicitation of certain types of information i.e. that which the doctor claims to have a monopolistic control over. The doctor is therefore directly ascertaining information concerning the patient's condition, but indirectly exercising power over the patient. Furthermore, studies by Bennett and Bennett (70) and even the Hawthorne (Mayo 39) work confirms the potential effects of the environment upon the interaction.

A central theme within framing is that of control. In terms of framing the technique which the doctor used to invite the patient into the consulting room is unimportant as all initiate the process of the doctor taking responsibility for the patient's condition.

Three of the four doctors within the present study used the personal style of going to the door and inviting the next patient in e.g.

D.2: Mr. Smith please.
D.3: Come in.
D.4: Whose next?

Doctor 1 used a buzzer to indicate readiness for the next patient.
However, all are examples of the doctor medically framing the situation, by directing the patient into the consulting room. Again it is not possible to understand the consultation without stepping back from a direct analysis of behaviour. The consultation functions to improve the patient's condition, the patient attends the surgery to be helped. Upon entering the consultation, he begins the process of relinquishing control for his own condition and the doctor taking over responsibility for the care of the patient (Duff and Hollingshead 68).

Framing within this introductory phase is largely non-verbal, with the patient coming to the surgery and entering the consulting room, and there is no real need for speech. By definition this phase is concerned with introductions and relating to the patient. This may take the form of ascertaining who the patient is exactly eg.

\[ S.10: \text{Miss Davies is it?} \]
\[ S.13: \text{This is your Ralph?} \]

Such utterances could be a genuine request for confirmation of identity or purely phatic communication or even an attempt to reduce anxiety as simple questions tend to provoke minimal confusion.

Another type of behaviour peculiar to this phase, classified as non-functional dialogue is the doctor asking the patient to wait whilst filling in the previous patients records eg.

\[ S.10: \text{Hang on I'll just finish writing.} \]

Behaviours such as these play no direct part in the framing process. However, again they can have an influence upon the affective tone of
the consultation, as the patient may feel distanced by such behaviours (Brown and Freeling '67).

**Illustration and Summary of Introduction and Relating to Patient**

This patient is female, 30's and about to present the symptoms of a threatened miscarriage.

Dr 1 uses a buzzer to call patients from the waiting room.

\[
\begin{align*}
D: & \quad \text{Have a seat} \quad \text{D glances up} \\
P: & \quad \text{Thank you} \quad \text{D stretches} \\
D: & \quad \text{Right} \quad \text{P sits} \\
P: & \quad \text{opens door and enters the consulting room} \\
\end{align*}
\]

Phase A is a very brief part of the consultation, and largely consists of the patient being invited in by the doctor and taking her seat. However, reference was made in discussing Phase A, to the setting (Goffman 59) which places the interaction in a medical context. The only behaviours of interest from a framing perspective is the doctor's utterance "right", which in this instance is a cue for the patient to begin describing symptoms. "Right" performs the same framing function as "OK what can I do for you" and is classified as medical framing as: it refers to the expectation that the doctor will investigate; it does not need to be verbalised because expectations are shared; it imposes constraints upon the interaction in that the patient is restricted to a description of symptoms; and it contains the metacommunication that the doctor has the right and authority to do something to the patient. Figure 5.1.1 contains a record of framing behaviours in Phase A of symptomatic consultations and should be considered in combination with the summary and illustration of Phase A of a symptomatic consultation.
Figure 5.1.2. Phase B1: Reasons for Attendance

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Specific

Symptomatic

Medical

Diagnostic
PHASE B1: REASONS FOR ATTENDANCE

Consideration of the flow charts indicate quite clearly the beginnings of a pattern of behaviour within the symptomatic consultations. The bulk of behaviour is specific framing by the patient (10.497% of total framing behaviours), although there is evidence of medical framing by the doctor (2.651% of total framing behaviours).

In these symptomatic consultations, the doctor often asks the question "What can I do for you", in some form or another, which is evidence of medical framing. This is a standard opening to phase B1, although there are a number of alternatives to this basic format e.g.

S.9: Right then.
S.5: What is it?

Comments such as this are typical of the early stages of many symptomatic consultations. Medical framing begins as such behaviour places restrictions upon the future flow of the interaction as it is the cue for the patient to start divulging symptoms, and also implies that the doctor is in a position to be able to do something, to be able to help. It is also the beginning of the process whereby the doctor accepts responsibility for the patients condition, and contains metacommentary upon the relationship. Although in the symptomatic consultations it is the patient who is presenting the symptoms of her own volition, such utterances by the doctor indicate that the doctor is the person with the authority to do things to, and for the patient.
However, it also needs to be emphasized that this pattern of behaviour does not occur in every consultation. There were a number of consultations in which the patient began to outline the symptoms without a verbal request from the doctor. 5 of symptomatic were patient initiated, 10 of chronic were patient initiated.

The patient's outlining of symptoms is the predominant framing behaviour as indicated on the flow chart for symptomatic consultations (Figure 5.1.) and the most significant feature of phase B1 is the patient offering the reason for attendance in response to a fairly passive doctor. The patient's specific framing of the interaction took a number of forms within the symptomatic consultations. The typical introduction in phase B1 witnessed the patient referring to a particular area of her anatomy e.g.

S.11: She's been having problems with her eyes the past few days.

S.16: Well about a week or so back, I started getting a rash here.

S.4: One, I'm getting a pain in my right elbow and down by my right arm.

Behaviours such as these place inevitable restrictions upon possible future behaviour in the doctor-patient consultation. Within these sequences the interaction is restricted in the specific direction of what is considered to be relevant to eye problems (S.11) face and throat rash (S.16) and elbow and arm pain (S.14).

Patient S.11 is an interesting discussion point. In the bulk of
consultations, the doctor took up the patient's symptom as offered and noted on the sheets that this was the problem. However in this consultation although the patient's father was responsible for specific framing in the direction of eye problems, the doctor noted that emotional problems may be a significant theme, even though his approach takes the form of a rigorous physical examination of the patient's eyes, and he prescribes eye drops as treatment, it is interesting to note his comment upon concluding the examination.

D: I can't see any abnormality ... her eyes look to be OK.

Patients also specifically frame the interaction in phase B1 by referring to some type of dysfunction.

S.12: Well, I've been having trouble passing water.

S.14: I feel alright most of the time, but if I run upstairs or exert myself, my chest's a bit sore.

Although the patient does not refer to a 'specific' part of the anatomy, the introduction of the symptoms in this style will restrict the interaction in a specific direction in that the doctor's investigation will not be totally free and unconstrained. Indeed we have clear evidence of implicit metacommunication when the patient designates the specific symptoms to be discussed. These behaviours make the implicit statement that the patient has the prerogative to determine which area of symptomology will be discussed. Although it is possible that this could be overturned in later consultations.
Illustration and Summary of Phase B: Reasons for Attendance:

Symptomatic

Female, teenage, symptoms - overweight.

D: What can I do for you?

P: I've come about my weight you see. I'm 16, and I thought it was about time I did something about it.

Analysis of Phase B1 of symptomatic consultations reveals a clear pattern of framing behaviours. The doctor medically frames with an invitation for the patient to speak i.e "What can I do for you", which confirms the shared expectation that the doctor will investigate, constrains behaviour in that the patient will describe symptoms and contains the metacomment that the doctor has the authority to do something for the patient, which becomes more interesting in cases where the doctor has the authority to do something to the patient. Patient behaviour in Phase B1 consists of specific framing. The patient confirms the shared expectations that she will present symptoms (weight), provides information which will constrain the future flow of the interaction to weight-related issues and contains the metacommunication that the patient has the authority to determine the content of the consultation. "I thought it was about time I did something about it", shows quite clearly that the patient does have power, and the ability to influence the interaction, and even though later behaviour may fit the patient into what Szasz and Hollander (56) would call a passive role, this is certainly not the case in Phase B1 of the symptomatic consultation.
FIGURE 5.1.3. PHASE B2: PHYSICAL AND/OR VERBAL INVESTIGATION

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MEDICAL

DIAGNOSTIC
PHASE B2: PHYSICAL/VERBAL EXAMINATION OR BOTH

Patient and doctor behaviour increases quite markedly in phase B2, the doctor beginning to play a much increased role in the proceedings. In terms of other phases it is clear that phase B2 is of central importance in symptomatic consultations with a large % of both doctor and patient behaviour occurring in this phase. The clearly noticeable pattern of behaviours within phase B2 is medical framing by the doctor (21.215%) and specific framing by the patient (13.481%).

The doctor continues the process of medical framing with a number of characteristic behaviours, all of which are intended to ascertain further details of the patient's condition. As the definition of phase B2 indicates, behaviours within this phase are based around the doctor carrying out a physical examination of the patient or asking a series of questions relating to the patient's condition. From a framing perspective this phase of the consultation is of crucial importance as the investigation is part of the accepted structure of the relationship as so clearly indicated by the expectations in Chapter 4. However, the investigation is the medium of the clinical gaze (Armstrong 84), the avenue to those intangible states where patients locate illness (Telles and Pollack 81), and as such, is the beginning of the mystification of illness (Illich 76) whereby the patient is losing the ability to comment, with any competence, (Parsons 75) upon his own condition and as such this must be viewed as the occasion when any process of sponsorship and transfer of responsibility is occurring. The patient is beginning to lose power
which is the basis of any metacommunication. e.g.

S.19: Ok, let's have a listen.
S.18: Right, let's have a look.
S.14: Take your coat off and we'll have a listen.
S.9: Alright, I think I'd better have a listen to you.

In these consultations the doctor is medically framing the interaction by directing the patient into a physical examination. However, medical framing becomes more powerful when the doctor supports these verbal utterances with the non-verbal investigations e.g. (S.19).

D: Ok, let's have a listen. D stands, picks up a stethoscope and moves towards P.
P: It's ... I've been X rayed. P stands.
D: When did you last have an X of your chest? D looks back through notes.
P: It's about 5 years I think.
D: We shall find out. I'll tell you .... 5 years ago. P undoing blouse.
Mm
D: No, that's not for your chest. D and P laugh.
P: Oh.
D: Spin round. D listens to P's back with stethoscope.

Medical framing occurs when the doctor listens to the patient with his stethoscope. The stethoscope will provide medically legitimate information which the doctor will use in dealing with the patient, in attempting to place the patient into some kind of medically defined
and 'manageable' category. This is the doctor using medical instruments, to assess intangible internal states, to enable him to reach a competent decision concerning the patient's condition.

The doctor's use of instrumentation is a clear illustration of what Kennedy referred to medicine being a, "Curative discipline in which the model of doctor is that of the engineer/mechanic applying the techniques of medical science to cure a sick engine". However, Kennedy went on to claim that "medicine is thus committed to a process of reductionism", in which symptoms need to be conceptualized in terms of specific diseases, which inevitably leads to a form of tunnel vision e.g.

D: Are you the only member of the family with a weight problem. (S.1)
D: Do your eyes hurt. (S.2)
D: Can you show me where it is in your elbow. (S.4)

Support for this concept of medical framing is contained within work from two quite different backgrounds. Byrne & Long (76) noted how many doctors in general practice worked with the idea that the patient and illness had to fit into a prejudged pattern - some type of medically defined category and that doctor centred techniques such as closed questions and correlational questions facilitate this aim. The work of Telles and Pollack (61) on where patients locate disease and Armstrong's discussion of the 'clinical gaze' contribute to this very clear picture of medical framing i.e. that the doctor will carry out an investigation, that such an investigation will reveal information which is understood only by those with legitimate
competence (i.e. doctors). Carrying out the investigation the doctor is behaviourally restraining the patient, implicit within all of which is the metacomment that the doctor has the power and authority to do this within the relationship. The above three extracts from the symptomatic consultations provide clear evidence of the doctor's attempts to reduce what may be vague symptoms to some type of category which he will be able to manage via medically prescribed techniques.

Doctor behaviour within B2 of the symptomatic consultation is totally concerned with ascertaining via physical and verbal examination, details of the patient's condition which will allow the doctor to place the patient within some medically defined category whereby possible vaguely presented symptoms will become a legitimately defined category. This is the process whereby medicine is able to bring about the many benefits that it does.

As the flow charts indicate, patient behaviour within phase B2 constitutes a continuation of the specific framing process. The patient continues to describe the symptoms and symptom related behaviour. Patient behaviour within phase B2 is often concerned with placing the symptoms into the perspective of his own life circumstances and history.

e.g. (8.4)

D: When does it affect you?
P: It's more painful when I'm tired. Mm sort of at the end of the day. It's not too bad at the moment, but I know by the end of the day.
e.g. (S.5)

D: Have you been in touch with animals?
P: There was a cat came into the room, and there's a strange
dog I try to keep away from.

e.g. (S.7)

P: Well Monday night I couldn't get warm, then I was all sweaty.

e.g. (S.12)

D: So tell me what happens when you go to the toilet.
P: It just hurts.
D: Do you have to go more frequently?
P: Yes.
D: Have you been passing blood?
P: I did on Sunday but not Monday.

Specific framing can be supported again by non-verbal behaviour e.g. S.14.

D: Can you show me where it is in your elbow?
P: Well it's ... all around. P holds out left arm and glides right palm around elbow.

This provides an interesting example of specific framing which may also help clarify the meaning of the term. The doctor's questioning in this interaction sequence is attempting to reduce the patient's symptoms to some manageable category. However, rather than the dictionary definition of specifying exactly where the pain is (pinpointing the pain as the doctor requests), the patient frames specifically by saying that the pain "it's all around" and illustrating that it isn't a sharp pain but more of a general ache.
The patient could have adopted one of two directions 1) by framing specifically in claiming it was as sharp as a pin, 2) by framing specifically in claiming it was a general ache - two alternatives which would frame the interaction in two alternative but specific directions.

Illustration and Summary of Physical/Verbal Examination or both.

Symptomatic.

Female 20's, symptom chesty cough, possibly smoking related.

The following is an extract from Phase B2 and shows quite clearly the pattern of behaviours. The patient has given the reason for attendance as a bad chest.

D: Yes, what do you mean? D looking at P.
P: Well, Monday night I couldn't get warm, ... then I was all sweaty. I put the fire on. I've been coughing up phlegm. P points to chest and throat.
D: Does it hurt?
D: Right ... D stands
D: do you feel feverish at all? D leans forward and takes thermometer.
P: Well yesterday I still felt hot, my head was .. exploding. D moves to P
D: Has there been anything like this at work ... no. D standing
P: I don't think so ... no D puts thermometer in P's mouth
D takes P's pulse
Silence

As figure 5.1.3. clearly illustrates, there is a significant pattern of framing behaviours within the phase with the patient continuing to
specifically frame and the doctor continuing medical framing. The doctor continues to confirm the shared expectation that she will investigate the patient, which imposes constraints upon the interaction in that it is a cue for the patient to continue elaboration of the symptoms, and again contains the metacomment that the doctor has the right and authority, within the relationship, to investigate. These criteria apply to all of the doctor's behaviours within this illustration, both verbal and non verbal. However, within the theory of framing is the clause that by restricting the interaction to behaviours you are restricting the type of information which will be elicited. Byrne and Long (76) carried out an extensive analysis of doctors' talking styles and it becomes clear that in this illustration the doctor is utilising a number of closed questions to reach her diagnosis ... "Does it hurt?" ... "Do you feel feverish at all?" ... "Has there been anything like this at work?". This doctor is working from pre set guidelines and is attempting to fit the patient into a pre-defined medical category. This was what Byrne and Long were referring to as such questions either provoke a one word answer, or an answer which will confirm the doctor's estimates. In terms of broader issues of medical framing, we can see this as the doctor taking responsibility for the patient's condition, transposing lay symptoms into a qualified legitimate category over which the doctor has experience and competence. Armstrong's (84) discussion of the 'clinical gaze' shows quite clearly how verbal investigation is contributing to medical framing with regards to a type of information.

Patient's behaviour in Phase B2 is a specific framing with the patient describing the symptoms, and supporting this with non-verbal specific framing. As such it is similar to Phase B1.
PHASE 5.1.4.  PHASE C: CONSIDERATION OF THE CONDITION

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SYMPTOMATIC
PHASE C: CONSIDERATION OF THE CONDITION

Phase C of the symptomatic consultation shows a marked change from the pattern of behaviour which existed within Phase B1 and Phase B2. As the flow charts clearly illustrate, patient behaviour is greatly reduced within Phase C (6.187% of total framing behaviour). Indeed the videotapes showed that the patient's role in the consultation is very passive from the time the doctor reaches his decision and introduces his diagnosis to the interaction. In terms of previous analysis of the consultation this would be similar to what Szasz and Hollander referred to as the active-passive style of doctor/patient relationship where the doctor is the active (doing) partner and the patient is the passive partner, with a reduced amount of specific framing.

eg. (S.4)

P: Yes, it's butter, potatoes, biscuits.

eg. (S.9)

P: I used to play every two weeks

Description of the actual symptoms has largely finished and the specific framing is concerned with placing patients's symptoms in context of life style. In these two examples above, S.4 has discussed his weight problem in terms of "butter, potatoes, biscuits" and S.9 has discussed her painful elbow in relation to playing badminton every two weeks.

Such behaviours are still referred to as specific framing as it is the patient continuing to offer information which could affect the diagnosis made and treatment offered eg. S.4 - could the diet
incorporate this "butter" etc and eg. could S.9's treatment incorporate playing badminton.

However, the bulk of behaviour in phase C is by the doctor (23.204%). As the flow chart clearly shows the doctor does not totally dispense with medical framing, e.g. (S.15)

D: You get a bad patch for two/three weeks, then it settles down, then it flares up again ...

This rhetorical question is an attempt by the doctor to gain further information from the patient. It is a pattern of verbal behaviour which could be described as clarifying (Byrne & Long), and is a clear illustration of the doctor attempting to clarify that the patient will fit into a defined category.

eg. (S.16)

D: You haven't had a temperature.

P: I haven't had it tested.

D: You don't feel hot and sweaty.

In this example there is further evidence that the doctor is clarifying his position. As a result of the investigation largely carried out in phase B2 the doctor is formulating a decision regarding the patient's condition. The predominant behaviour pattern in this phase of the consultation is the doctor introducing to the interaction his interpretation. The occurrence of the said medical framing behaviours are final attempts by the doctor to clarify his interpretation.
However, the predominant behaviour pattern within this phase of the consultation is the beginning of Diagnostic framing (19.889%) by the doctor, a culmination of the process whereby the patient is removed from the responsibility for his own condition. As the flow charts indicate, this is the last occasion in the consultations when the patient has the chance to have an effect upon the eventual outcome. Patient behaviour is negligible for the rest of the consultation, and if any negotiation is going to occur regarding the patient's condition, it will have to occur within phase C.

Within Chapter 3 the beginning of Diagnostic framing was described as taking the following form.

e.g. (S.18)

D: Ah ... You've got Tonsillitis.

e.g. (S.5)

D: Well it could be one of two things. It could be a type of excema or ringworm.

e.g. (S.8)

D: Well that's a little prolapse ... that.

In these examples, the doctor has reintroduced the patient's presenting symptoms housed within medical jargon. What were vaguely presented symptoms are now classified into some kind of medically defined category, eg. S.18 the patient's symptoms of a sore throat have been reintroduced to the interaction as Tonsillitis. This is described as the doctor exercising power over the patient as the patient is placed in a position of being unable to freely reassess his own condition (see Chapter 2 for a discussion of the work of
Conrad & Schneider (80), Waitzkin & Stoeckle (76) and Svarstad (79).

The implicit metacommunication running through diagnostic framing contains reference that the doctor is not only expected to offer a diagnosis (name the symptom) but within the framework of the doctor-patient relationship he has the authority to do so on the basis of his medical knowledge. He is the doctor charged with responsibility for the patient's condition and in Phases B1, B2 has assumed this, and accordingly has knowledge and authority to name the illness, and as will be shown, has authority to further exert power over the patient. However, before discussing this it needs to be emphasised that the doctor does not always begin phase C, and Diagnostic framing by offering a name for the symptoms.

e.g. (S.19)

D: Shall we give you a little of what you need to make you better?

e.g. (S.2)

D: Right, well I think the only thing you can do is have some ointment... antihistamine stuff if you go.

In these examples, the doctor has not introduced Diagnostic framing by naming the patient's illness, but does impose constraints upon the patient's behaviour by introducing to the interaction the need for a regimen of treatment.

Diagnostic framing such as this in phase C is followed in phase D by a more definite statement of the treatment. However, such behaviour as occurs within phase C is seen as diagnostic framing as it is part
of the process whereby the doctor is exercising power over the patient and (really) preparing the way for more definite diagnostic framing later in the consultation. There is the inherent expectation that this will occur.

A great deal of diagnostic framing which occurs within phase C involves the doctor outlining details of the medical knowledge of that patient's condition.

e.g. (S.8)

D: That's quite common in your age group.

e.g. (S.9)

D: You see, the problem with these types of complaints ... if it's straightforward tennis elbow or golfers elbow we can inject it and give relief. When it's a little different from that, one doesn't like to inject these things into the joint.

e.g. (S.13)

D: The point is children get colds all the time ... viruses are around all the time and children go through this process of building up immunity.

e.g. (S.14)

D: All these infections take a while to improve. I don't think it's anything to worry about.

Such an information exchange needs to be assessed from the perspective of Waitzkin's (85) work on information control.
Illustration and Summary of Consideration of the Condition.

Symptomatic.

Female, 20, presenting cough and painful elbow ... doctor discussing painful elbow. Doctor has just finished physical investigation of elbow.

D: You see the problem with these type of complaints ... If it's straightforward tennis elbow we can inject it and give it relief. When it's a little different from that ... one doesn't like to inject these things into the joint.

P: Mm

D: Mm, mainly because you can sometimes do more damage than good if you don't know what you are doing ... and it probably wouldn't give you that much relief anyway. It's not the same as if you have tennis elbow.

The question is, what do we do about it? How many times a week do you play? (badminton)

Do you play indoors or what?

P: I used to play every two weeks.

This example provides a clear illustration of the predominant pattern of behaviour within Phase C. The doctor is introducing his opinions regarding diagnosis and treatment and therefore confirming the shared expectations. Furthermore, diagnosis and treatment, when sanctioned more powerfully by the doctor will impose constraints upon the interaction, and contain the metacommunication that the doctor has the right and authority to do this. As figure 5.1.4 clearly illustrates, this pattern of behaviour predominates in Phase C. However, it is interesting to note that diagnosis and treatment are not imposed with such force as in this illustration and it is often
case that Phase D sees a reaffirmation of the diagnosis and a clearer outlining of the treatment.

However, figure 5.1.4. also indicates the occurrence of a small amount of specific and medical framing. The present illustration shows clearly how during this phase the doctor can engage in further physical investigation, and the patient can offer further elaboration of the symptoms.
FIGURE 5.1.5. PHASE D: DETAILING OF TREATMENT

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PHASE D: DETAILING THE TREATMENT

The process of Diagnostic framing outlined within Chapter 3 basically involved four steps:

- You've got this (naming the illness)
- Take these (detailing the treatment)
- This will happen (prognosis)
- If not, come back (return clause)

In terms of power and influence, it was emphasised in Chapter 3 that Diagnostic framing allows the doctor a great ability to direct the patient both within the and outside the consultation.

As the flow charts clearly show, the most significant feature of phase D of the symptomatic consultation is the almost totally passive state of the patient. Patient behaviour is reduced to an absolute minimum, whilst doctor behaviour is concerned almost totally with diagnostic framing. In contrast to phase C the doctor does not engage in a significant amount of medical framing (0.331%), indicating that he does not appear to require any further information to help formulate his decision.

Prior to discussing the results contained within the flow charts, it is necessary to place this domination (in terms of amount of active behaviour) by the doctor in the metacommunicative context of the relationship. It was argued within Ch3 that the ability to designate whether an individual is ill or not, to specify what that illness is and to prescribe a course of treatment are implicit aspects of the power structure of the doctor-patient relationship. The doctor has
the authority to carry out these behaviours and the patient accepts that the doctor has such authority. The almost total absence of patient behaviour within phase D of consultation is taken as evidence to illustrate this. Within the theory of metacommunication as put forward by Watzlawick (67) if this was not accepted as part of the nature of the doctor-patient relationship we would have evidence of the patient overtly questioning the doctor's authority (Chapter 6).

Examples of diagnostic framing, taken from the symptomatic consultations are shown below.

\textit{e.g.} (S.4) presented two symptoms of a painful elbow and overweight.

\textbf{D:} I'll give you a six week course of appetite suppression to see what happens.

I don't allow repeat prescriptions of these ... 

It's a mistake ... you just get to rely on tablets to lose weight ... 

Really, the whole idea is just to shart you off.

\textbf{P:} Yes I feel that's what's needed.

\textbf{D:} If your elbow doesn't improve over the next 2-3 weeks come back, but I think it's a temporary thing.

Within this example, we can clearly see the way in which the doctor is framing the interaction. In outlining the treatment, the doctor is designating that the patient adheres to a prescribed regimen of behaviours and furthermore, with regards to the painful elbow although no treatment is offered, the doctor does allow the patient the opportunity to return to the surgery. Within Chapter 3, it was argued that this is a part of the process of medicalisation of
society (Zola 75) whereby whether the decision by the doctor is effective or not he still maintains a hold upon the patient (described as a return clause) as even if treatment is ineffective, any other possible solution is seen as only possibly coming from a legitimate medical source. This is clearly related to Parsons' argument that individuals can only appreciate the 'sick role' if they have their illness legitimated by a medical agency. e.g. (S.5)

D: The cream for these two areas you want to put on twice a day ...
... not too much ... just rub it round quite well ... and
eh, it should clear it. If it doesn't, come back and I'll have another look.

Within this example we have a clear illustration of three of the four aspects of the process of diagnostic framing. The treatment is outlined providing a direct influence upon patient's behaviour. A prognosis is offered implying the treatment should work which will create (or enhance) expectation by the patient that treatment will be effective. Should the treatment not be effective, the patient is given the opportunity to return to the surgery for the doctor to try an alternative, however a medically legitimated alternative.

The existence of such a pattern of behaviours within the doctor–patient consultation provides an extremely powerful interactional explanation of the prevalence of medicine within society (see Chapter 2). It was agreed there that the 'efficiency' of the medical system and inapplicability of approach to many of the problems presented were two factors which could not viably explain
medicalisation. The process of framing as occurring within the doctor-patient interaction is offered as a more, or at least equally powerful alternative.

However, NVB is also an important part of the diagnostic framing within phase D.

e.g. (S.9)

D: Now if you find that these are useful then come back and see me. If not, and your elbows are getting worse, we'll have to try something else OK?

P: That's really nice of you.

Within this example, the tearing off of the prescription and handing it to the patient reinforces the verbal diagnostic framing and is included as part of the process of diagnostic framing. It is also interesting to note that the doctor's behaviour of handing over the prescription and standing up is a powerful cue to the patient that the consultation is rapidly drawing to an end. At this stage, the consultation moves into phase E.

**Illustration and Summary of Detailing the Treatment. Symptomatic.**

This is a teenage girl who has presented a number of symptoms, one of which manifested as some 'scaly dry patches' on hips which the doctor has offered two possible diagnoses for i.e. eczema or ringworm.

D: The cream for those two areas, you want to put on twice a day ... not too much, just rub it round quite well, and it should clear it. If it doesn't, come back and I'll have
another look.

P: Right.

Within this illustration we see a typical pattern of behaviour for Phase D of a symptomatic consultation. Placing the extract in context, the doctor has previously offered two possible diagnoses of exzema or ringworm and therefore at least confirmed that expectation that a diagnosis is part of the relationship, and both doctor and patient have shown tacit agreement that this is acceptable behaviour.

To move backward through the five aspects of the model of framing implicit within the doctor's outlining of the treatment is the acceptance that the doctor has the right and authority to do this. This can be placed in context whereby it becomes quite significant. Both within folklore and within the medical literature (Koran 80, Illich 76) there is an awareness of doctor caused illness as a result of incorrect diagnosis or negative side effects of treatment. Yet treatment continues as an accepted part of the relationship, and as such the doctor is able to impose behavioural constraints upon the patient (Kelvin 70). The doctor is guiding the patient within the immediate interaction, with powerful implications for out of consultation behaviour. The knowledge which provides the basis for this ability of the doctor to influence the patient to behave in a manner she would not otherwise have done provides the basis for this influence and is itself based upon the doctors' training in medicine and the aetiology and alleviation of physical illness. (See Schutz on the properties of professional and lay knowledge). The doctor has ascertained what of his medical knowledge is relevant, as a result of
the previous investigation. Such an investigation and the consequent treatment occur as a direct result of being contained within the expectations for the consultation, which are shared and form part of our culture.
### FIGURE 5.1.6. PHASE E: CONCLUSION

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PHASE E : THE CONCLUSION

The only important behaviour in this phase of the symptomatic consultations, from a framing perspective, is the continuation of diagnostic framing by the doctor. As the flow charts indicate, phase E does not involve a great deal of behaviour (4.419% of the total behaviours). Within certain consultations the concluding phase of the consultation involved only two or three words.

e.g. S.12
D: OK ... bye.
e.g. S.14
D: OK ... right.
P: Thank you.
D: Bye.

The framing behaviours have occurred within the earlier phases and behaviour within this phase is purely concerned with the patient leaving, whereas within other consultations the doctor may re-emphasise the treatment.

e.g. S.20

D: There you are. D hands P prescription
P: Thank you very much. D accepts prescription
D: All the best. I hope that clears up soon. D stands
P: Thank you. Bye.
D: Bye.

Here we have evidence of the doctor using the prescription to end the consultation. From a framing perspective, this is seen as diagnostic
framing but also performs the function of indicating to the patient that service is over.

Illustration and Summary of Conclusion. Symptomatic.

D: Right, that's for you.
    I hope you're soon better and I'm sure you will be.
When you get your voice back you'll be able to shout.
    I hope you're soon better.
P: Bye
D: Bye.

The doctor continues the process of diagnostic framing by offering the patient the prescription. Furthermore, the doctor quite skilfully uses non verbal cues to communicate to the patient that the consultation has finished and guides the patient out of the consulting room. A process which begins with tearing off the prescription and standing up.

Illustration of Symptomatic Consultation (S.20)

This doctor (4) moves to invite the patient into the consulting room. The patient is male 30's.

D: Come in.
    Sit down.

PHASE A  What can I do for you Sir?
PHASE B  Doctor sits.

P: Well, I had a bad cold about two weeks ago and a bad throat.

Doctor stood with door open.
Doctor moving back to desk.
Patient moves into room and sits.
Mutual gaze.
I got over the cold, but the throat ... it doesn't hurt anymore but it still affects my speech. Mutual gaze.

PHASE B2
D: How does it affect your speech?
P: Well, I was a singer in a band as well and eh, I had problems ...
D: Problems with the singing, you tend to get hoarse.
P: Yes, it feels like it's swollen, it doesn't hurt.
D: Have you had any other symptoms which seem to bother you ... such as headache or sore throat. Doctor leans back in chair and reaches for auriscope.
P: No, no.
D: You sound a little blocked up ... does your nose feel a little blocked?
P: No, no.
D: Let's have a look in the back of your throat. Doctor stands.
Open wide.
Say "ah"
Just close your mouth and breath through your nose.
Good. Other side.
I'm just going to press your face.
Does that hurt you? Doctor presses patient's face left.
P: No.
D: Does that hurt? Doctor presses patient's face right.
P: No.
They both feel the same.
D: Yes, good. And how long ago was the cold, you say? Doctor writes.
P: About 2-3 weeks.

PHASE C
D: About 2-3 weeks.  
You say you're living in Brookfield Farm

P: No.  
We've had a change of address.  
It's 42 Jameson Road

D: 42 Jameson Road.

P: Yeh.

D: It may be that you've still got some inflammation of the vocal chords due to the cold that you've had ... but I think also the blockage of the nose on the left side might be important in prolonging it.

PHASE D
I think the most effective thing is to give you some nasal drops to be used on the left side, say three times a day ... Now that should help ... If you're still having a problem in a couple of weeks, you should come back, but I think it should have settled.

PHASE E
Do you have to sing for a long time?

P: Every week, twice a week for about three hours.

D: Yes that's quite an effort I should think.  
There you are.

P: Thank you very much.

D: All the best. I hope that clears up soon.

P: Thank you. Bye.

D: Bye.
Commentary Upon Illustration of Symptomatic Consultation

The process of medical framing begins as the patient enters the surgery. As discussed in Ch3, the medical technology, which is in the consulting room, has the effect of making the interaction between doctor and patient a medical situation. As Goffman (59) notes, the existence of such instruments provides a setting for understanding the encounter, which actors use to make sense of the situation. The presence of medical technology within the setting has the effect of restricting the interaction to what is included within the scope of this medical technology.

The verbal behaviour by the doctor of inviting the patient into the room and asking "What can I do for you" confirms and continues the process of medical framing which the patient accepts by entering the consulting room, taking a seat and beginning to describe his symptoms. The process of medical framing has begun and the patient has initiated what Duff and Hollingshead (68) refer to as the process of sponsorship, i.e. where the patient relinquishes responsibility for his own condition and the doctor accepts this responsibility.

The interaction then proceeds into a negotiation between doctor and patient as the patient divulges details of his symptoms and therefore specifically frames the interaction in the direction of his specific symptomology which is the residue of a cold which the patient had. Parallel to this specific framing is the process of medical framing whereby the doctor is attempting to discover details of the patient's condition which will allow him to fit the symptoms into a medically manageable category. The framing behaviours continue verbally until
the doctor supports this with non-verbal medical framing.

As the transcript shows during Phase B2, the doctor leans back in his chair and reaches for (equipment) allowing further investigation of the patient's complaint. The significant aspect of this, as far as the present thesis is concerned, is that it is a source and symbol of medically legitimate knowledge to which the patient does not have access. The results of this investigation will contribute to the doctor's understanding of the patient's condition and allocation of the patient to a particular medically defined category. The doctor is accepting responsibility for the patient's condition while at the same time housing the legitimate knowledge concerning the condition is a form which excludes legitimate commentary by the patient, as he does not have the training and understanding which is the basis of the doctor's management of the patient.

Even more significant medical framing occurs later in the consultation and the doctor does not require medical technology. The doctor holds the patient's throat and proceeds to press gently upon the patient's nose. This non-verbal investigation of the patient's condition contains evidence of medical framing, i.e. the doctor is causing the patient to behave in a manner he would not have otherwise; the doctor is gaining information to contribute to his management of the patient; whether or not this investigation contributes to the diagnosis it does perform this medical framing function as far as the interaction goes.

The doctor is attempting to structure his decision and we see clear
evidence of the phase 'a consideration of the patient's condition' which, consists largely of the doctor offering his interpretation of the patient's condition. The suggestion that, "You've still got some inflammation of the vocal chords" is the beginning of diagnostic framing by the doctor. And again, as was mentioned earlier, this is the beginning of the end as far as the patient's contribution to the interaction is concerned. Vague and ambiguous feelings of discomfort has been transformed into a possible residue of inflammation of the vocal chords.

The process of diagnostic framing continues as the doctor outlines the treatment for the patient's condition, a treatment which will influence the patient's behaviour and concerning which the doctor is the only one in possession of fully legitimate knowledge. The treatment is outlined which is followed by a comment as to what should happen, i.e. "Now that should help", which in turn is followed by the "return clause" i.e. "If you're still having a problem in a couple of weeks you should come back", which as described in Chapter 3 is a type of fail safe device, i.e. if the diagnosis and treatment I offer you are not fully effective return to the surgery and resubmit to further medical and diagnostic framing.

This consultation continues in phase D as the doctor now needs to write the prescription for the treatment. The termination of the consultation is facilitated by the doctor tearing off the prescription and handing it to the patient. Such behaviour is classified as diagnostic framing as it influences the patient's behaviour on the basis of medically legitimate knowledge. However,
it also performs the purely interactional function of informing the patient that the consultation has reached a conclusion.
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5.6.2. THE IDEAL TYPICAL FORMULATION OF THE CHRONIC CONSULTATION

Before discussing the chronic consultations, a point needs to be made concerning the sequence of phases each consultation passed through. Chapter 4 contains a detailed discussion of the phases each consultation passed through. However, it can be shown that symptomatic consultations adhere to the A, B1, B2, C, D, E pattern to a greater extent than chronic consultations. This needs to be kept in mind when considering the ideal typical formulation of a chronic consultation.

PHASE A: INTRODUCTION & RELATING TO THE PATIENT

As within the 'symptomatic' consultations, we need to note how the 'setting' of the consultation includes a great deal of medical technology, which will have the effects discussed in outline of symptomatic phase A. However, one important difference needs to be noted. The patient may be attending the surgery at the direct request of the doctor, and accordingly already incorporated within medical framing, as the choice to attend the surgery is at the doctor's direction.

As Phase A of the chronic flow charts indicate, behaviour within this section is very limited, as was the case in the symptomatic consultations (.204% total framing behaviours). If attendance at the surgery results from doctor's direction, the patient can be seen to be still guided by diagnostic framing from a previous consultation. However, this does not enter the verbal interaction until Phase B1.
Of the 30 chronic consultations ...  
15 patients arrived as a result of doctor's diagnostic framing.  
15 patients arrived as a result of own initiative.

Illustration and Summary of Introduction & Relating to Patient.

Chronic
This patient presents symptoms of stomach upset and nerves. Male, mid 30's.

D: Come in, sit down. D invites P in at door  
P enters.  
P sits.  
D takes out notes.

This illustrates the typical pattern of behaviour in Phase A of chronic consultations. The patient has either arrived at the surgery as a result of recall by the doctor or of his own volition. The doctor invites the patient into the consulting room, into a setting which is primarily medical. This phase is very similar to Phase A of the symptomatic consultation, is very brief, and includes a small amount of medical framing by the doctor, inviting the patient in, although the framing process may have been operating prior to this, if the doctor called the patient back to the surgery.
### Phase B1: Reasons for Attendance

#### Chronic

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- Doctor: 6.807

#### Medical

- Patient: 4
- Diagnostic: 4.016

#### Diagnostic

- Patient: 2
- Doctor: .749
**PHASE B1: REASONS FOR ATTENDANCE**

The flow charts of framing in chronic consultations immediately show a marked difference from the symptomatic consultations. Within phase B1 we see evidence of diagnostic framing, this time by the patient; whereas within phase B1 of symptomatic consultation, the patient only engaged in specific framing. Within the chronic consultations the patient can introduce his specific symptom but housed within a medical context.

e.g. (C.1)

P: These tablets you gave me.

e.g. (C.5)

P: I've come to the end of my pills and would like a new prescription.

... 

e.g. (C.9)

P: I've come to see if you'll give me another sick note for a week.

Within these three examples, the patient places the condition within the context of the treatment offered by the doctor. Therefore the patient's discussion of the condition is in terms of the medically prescribed treatment, or in C.9 the sick note.

Patients are also able to frame medically in chronic consultations.

e.g. (C.4)

P: You wanted to examine me.

... 

e.g. (C.22)

P: Well this is the regular visit you asked me to do.
The distinction between diagnostic and medical framing by the patient in chronic consultations proved to be a grey area in terms of classification. Common to both types of utterance above is that the patient introduces his symptoms/complaint as a result of previous diagnostic framing of the type described within symptomatic consultations. However, the emphasis is slightly different in that the first type of utterance adheres directly to the treatment as outlined. Whereas the second type directly provokes a re-examination and clear medical framing.

The patient can return to the doctor and diagnostically frame the interaction by commenting upon some aspect of the treatment specifically designed for him. Or the patient can medically frame the interaction by referring to the doctor's requirement to medically assess his condition. It is not intended to dwell at length upon whether or not the patient returns at the request of the doctor or upon his own initiative. The important point is that he introduces his specific condition housed within a medical context. This indicates that the patient's condition is still influenced by diagnostic framing from a previous consultation and the patient is willing to allow the doctor further medical framing.

However, the patient can engage in purely specific framing (6.807% of total framing behaviour), as figure 5.1.8. indicates.

E.g. (C.18)

P: Well I don't know, nothing seems to be going right ...

Short of breath ...

No appetite ...
Here, the patient is framing the interaction in the specific direction of shortage of breath, lack of appetite. The process is similar to that typical of the symptomatic consultations.

Phase B1 does show a similarity between both symptomatic and chronic consultations in that patient behaviour is greater than doctor behaviour within this phase. Doctor behaviour illustrates a small amount of medical framing.

e.g. (C.2)

D: Right, how are you?

e.g. (C.7)

D: What can I do for you?

These two examples of medical framing are almost identical to those discussed at length within symptomatic.

However, the doctor can also frame diagnostically in phase B1 of chronic consultations. The following illustration provides an interesting example due to the manner in which verbal and non-verbal behaviours can work together.

e.g. (C.8)

D: This is about your eyes ... Doctor opens letter (re patient) from specialist.
yes ... Patient and doctor look to letter.

Doctor reads letter.

The doctor has introduced the patient's specific complaint. However, the letter from the specialist places this behaviour within the
diagnostic category, as the doctor is using information which results from the specialist's investigation. Again, it is also interesting within this example to note the doctor's reluctance to divulge the information contained within the letter to the patient as this fits in with Svarstads (79) and Waitzkin's (72, 85) analysis of doctor's control of specialist knowledge. Such behaviours diagnostically frame the interaction in that they restrict future behaviour within the consultation to a consideration of the patient's eyes, a consideration based upon the knowledge contained within the specialist's letter. It is possible that both doctor and patient will ignore the letter and this appears to occur within this example as the doctor calls for another opinion. However, the behaviour by patient to seek another opinion is subsequent to the specialist's investigation and the consultation interaction is largely concerned with a discussion of the letter and the specialist's opinion.

Illustration of Summary of Reasons for Attendance. Chronic
Female, elderly returning of own volition, dissatisfied with tablets for blood pressure.

P entering room ... sits down.

P: These tablets you gave me ... they're not making happen what they're supposed to.

This extract provides an excellent illustration of how Phase B1 of a chronic consultation differs from a symptomatic consultation. Within symptomatic consultations, behaviour in this phase was almost totally specific framing by the patient as he or she provided details of symptoms. However, as the above illustrates, the patient's behaviour
in chronic consultations can describe the symptoms in terms of the treatment offered at a previous consultation. The interaction is still based on the expectation that the doctor has provided treatment and that treatment constrained the patient's behaviour in that she adhered to the regimen to some extent, and the patient's behaviour is still influenced by this expectation in that she has returned to discuss the treatment. Such behaviour is categorised as diagnostic framing because the patient's symptoms are discussed in terms of the doctor's prescribed treatment. We still see acceptance of the expectation that the doctor has the right and authority to influence the patient's behaviour in this fashion. It is interesting to briefly trace the development of this consultation in terms of the parallel metacommentary (although this will be returned to extensively in Chapter 6). Within the medical literature, outlines of the 'sick-role' and expectations for the doctor/patient relationship are based upon the patient being ill, and the doctor being able to help (Parsons 75). However, within the present illustration, it is clear that the patient accepts the traditional structure of the relationship, and does not overtly question the doctor's power and authority to impose behaviour upon her, even though she claims, "I was dizzy when I took those". There may be an element of attributional error in such a claim but it is interesting all the same.
FIGURE 5.1.9.  PHASE B2: PHYSICAL AND/OR VERBAL INVESTIGATION

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DIAGNOSTIC

- 261 -
PHASE B2 : PHYSICAL AND/OR VERBAL EXAMINATION

(It is noted that not all of the chronic consultations pass straight into Phase B2, but may go straight into phase C. This difference will be highlighted in the illustration of a chronic consultation which follows).

As the flow chart (Figure 5.1.9.) indicates, unlike the symptomatic consultations behaviour in phase B2 is not simply a continuation of B1. There are a bulk of behaviours classified as specific framing by the patient (11.369%) and medical framing by the doctor (13.819%). However, diagnostic framing by both doctor and patient (to a lesser extent) also occurs (i.e. 4.221% and 1.09% respectively).

The existence of a significant amount of behaviour within phase B2 indicates clearly that a reassessment of the patient's condition is an important feature of 'chronic' consultations. The initial investigation carried out in 'symptomatic' or previous 'chronic' consultations is under reassessment for a number of possible reasons. However, when considering the sequence of phases, it can clearly be shown that many consultations pass through stage C prior to B2, therefore indicating that investigation does not naturally follow the ascertaining reasons for attendance phase.

The patient has returned to the doctor for a regular Blood Pressure check.

P: I've had one or two dizzy turns, but nothing serious. D sat looking at P. P stood.
I haven't blacked out or anything yet.

D: No ... good. No bad attacks.

P: No ... I've had head colds.

Here, the patient is framing the interaction in a specific direction, similar to that which occurs within symptomatic consultations.

Medical framing by doctors within phase B2 of chronic consultations also takes a similar form to that within symptomatic consultations. e.g. (C.4)

D: Would you like to undress behind the screen. Do you want to play with the racing car? Yes ...

P: I've brought him a car to play with.

D: What's that then? Whoops! Could you go behind there take your tights off?


This example is included because it provides an illustration of verbal and non-verbal medical framing. The doctor is medically framing the patient by verbally directing her behind the screen. This is supported with non-verbal gesturing to move behind the screen.

Illustration and Summary of Physical and/or verbal investigation.

Chronic

This patient has returned for a check-up of a painful knee and other joints.
D: Take your boot off.  
P: It's still very stiff. 
   I can't bend it. 
D: Can you stand? 
P: I wonder whether there's any cartilage problem there as well perhaps. 
D: No ... just sit down. 
   Just straighten your knee. 
   It's not swollen at all. 
P: No, it's not. 
D: Is it a week or a fortnight. 
P: It was about three weeks in July it went. 
D: I think it's unlikely to be a cartilage problem. 

Phase B2 of chronic consultations adopts a similar pattern to symptomatic consultations. Much of the doctor's behaviour involves carrying out a physical and/or verbal investigation and thereby giving realisation to the expectation. In the present example the doctor is medically framing the patient with both verbal and non-verbal behaviour, which will provide a particular type of information, imposes behavioural constraints and contains the metacomment that the doctor has the power and authority to do this. One interesting aspect of this illustration is that the patient allows the doctor to manipulate his injured knee, which could be painful. This conveys a similar point about the nature of the relationship, as does the ability of a male doctor to investigate female patients. Within the relationship, the doctor has the power and authority to manipulate knees, examine women etc.
The second interesting point in this illustration is the attempt by the patient to offer some diagnostic interpretation of her own condition, and the manner in which the doctor deals with such an attempt. The theory of framing is based upon the premise that to act in someone's presence imposes behaviour upon them (Watzlawick 67). In terms of the present build up of a framing perspective, this is focusing upon the fourth point i.e. that behaviour imposes constraints upon the interaction. The patient attempts to offer diagnostic framing by referring to the cause of her symptoms, which the doctor does not respond to whilst carrying out a physical investigation. It is interesting to note that whilst the general practitioner is carrying out a physical investigation, this is the occasion in many consultations (see Appendix 3) for the doctor and the patient to engage in general conversation, often not related to the condition. The doctor's immediate response is to counter the patient's suggestion "no" and later in the consultation offers, "I think it's unlikely to be a cartilage problem". The nature of the relationship is such that it is possible for the patient to talk about his own condition in terms of diagnosis and treatment, and even to infer a possible diagnosis. However, the taken-for-grantedness of the relationship is such that the doctor does not respond sharply to the patient's suggestion and does not need to emphasise his authority overtly. The patient's suggestion of a particular diagnosis is not contained within the expectations for the consultation, and should the patient attempt to sanction a diagnosis this is one such occasion when there would be a likelihood of overt metacommunication, as the doctor needs to re-assert his authority and power to offer the diagnosis. As will be discussed at more length in Chapter 6, the
doctor handles this conflict on the information level.

This should illustrate one aspect of framing - that it is a process, as opposed to an event. Although it is possible to discern individual units of framing, whereby on the basis of shared expectations the interaction is constrained to certain behaviours, within which there is an implicit element of power, it is only possible to appreciate the effects of framing if one traces it as a process running through the consultation, and indeed through the relationship. Although the patient introduced diagnostic framing to the interaction, this was not sanctioned, whereas the doctor's imposition of treatment and reaffirmation of the osteoarthritis diagnosis were sanctioned and the patient accepts the prescription to treat this complaint.
FIGURE 5.1.10. PHASE C: CONSIDERATION OF THE CONDITION

CHRONIC
PHASE C: CONSIDERATION OF THE CONDITION

The most significant departure from the pattern of behaviour seen within symptomatic consultations during phase C is that there is a marked increase in the amount of diagnostic framing carried out by the patient (6.059%), whereas such behaviour is almost negligible in symptomatic consultations (1.215%).

Although the phase is concerned primarily with a consideration of patient's condition, the doctor continues to engage in a certain amount of medical framing (4.697%).

E.g. (C.2)

D: Do you get irritable with the kids or don't you just feel well?

Is it because you're at it all day and then ...?

In this example, we have a patient who has returned to the surgery of her own volition as a result of suffering negative side effects having recently begun a new regimen of treatment. The occurrence of medical framing is part of the doctor's attempts to reassess the patient's condition. This stage of the consultation was described as phase C as it does not involve the doctor in any notable amount of investigation and examination and is largely composed of patient making comments upon the previously offered treatment and the doctor glancing through this patient's notes. This is described as medical framing as the doctor is working to place the patient within some type of manageable category to enable the doctor to deal with her efficiently and is influencing the patient's behaviour within consultation.
It is also interesting to note the metacommunication implicit within such behaviours. The doctor is not just graced with the authority to examine the patient within the initial consultation (symptomatic), he also has the authority to carry out further investigations even if the initial diagnosis and treatment offered is seen to be ineffective.

Incorrect diagnosis or treatment is unfortunately an acceptable part of the doctor-patient relationship and does not lead to a breakdown in the relationship as one would possibly expect. It would be interesting to discover how many occasions of incorrect diagnosis/treatment were required to lead to a breakdown in the relationship and for the patient to end the relationship. For the doctor to carry out medical framing of this nature illustrates clearly this aspect of relationships. This will be investigated further in Chapter 6.

e.g. (C.17)

D: I assume you've had it for a long time.

This example of medical framing illustrates that even though many authors (Byrne & Long 76) describe doctor as having reached a decision at the end of phase B2, this may not be the case. Phase C is largely concerned with consideration of condition but doctor doesn't really introduce decision to the interaction until phase D. "I assume you've had it for a long time" illustrates that during phase C the doctor may not have yet formulated a firm decision.

Specific framing also occurs by the patient as is the case in
symptomatic consultations (9.394%).
e.g. (C.17)

P: Well normally I'm capable of doing exercises without panting or puffing but ... it's only at night that this wheeziness occurs and tends to keep me awake when I cough.

e.g. (C.19)

P: I was involved in a road accident in 66 ... this side. I had cracked bones, shoulder, hip etc.

Within these two examples, we see the patient describing symptom-related behaviour which specifically frames the interaction in the direction of the specific condition the patient introduced within earlier consultations. Indeed, patient C, 19 continues at length to specifically frame in this way.

P: Well to be honest, it's ... I work in the income tax office and ... as soon as you've got a bad back, people say you ought to do this ... that etc.

It's only since last Thursday, Friday that all the other bits have gone wrong. When I wake up I think 'what else isn't going to work'.

Considering the redundant conversation to be discussed, this does not appear too surprising. Probably due to letting the patient witter whilst formulating decision.

It is the pattern of diagnostic framing in Phase C of chronic consultations which most readily differentiates it from Phase C of the symptomatic consultations. As the flow charts clearly show, the
doctor engages in a significant amount of diagnostic framing within Phase C (17.09%). However, the patient also engages in a lesser, though significant amount of diagnostic framing (6.059%).

However, the discussion of diagnostic framing within chronic consultations needs to emphasise different aspects of the diagnostic process. Dealing with the doctor first, we can take a few examples from the consultations.

e.g. (C.20)

D: And you're a diabetic ... and you don't take anything but X?

e.g. (C.1)

D: Now were you on these originally for your blood pressure?

   Yes, you were."

e.g. (C.2)

D: If you've still got an infection we'll have to give you something.

   You've had these before?

   Yes ... you have had X before.

These three examples are included to allow the thesis to differentiate between medical framing (as these are medical questions) and diagnostic framing. Such examples are classed as diagnostic framing because the patient's specific condition is being referred to in the context of the prescribed treatment. Therefore, the doctor is asking the patient questions which require information over which the doctor in reality can exercise almost monopolistic control. As discussed in Chapter 3, keeping the patient in ignorance of relevant knowledge provides the basis to the exercise of power ...
one aspect of power being the ability of A to influence the behaviour of B. What needs to be asked of these examples is 'can the patient really answer the question'. All three of the quoted examples show the doctor asking a question and then subsequently answering it himself. Although the thesis presents no conclusive data to support such a claim, it is very likely that the doctor is clarifying his own perception of the patient's condition and is almost pushing for time until he can formulate his plan of action. Yes, the patients can answer the question, if they remember or are articulate enough to deal with terms such as 'antihystemine' etc. However, the doctor should have a record of such details and if so is asking a very superficial question. Furthermore, if the patient's answers were such as to question the doctor's records and the answer was correct, we would be dealing with an even more fundamental issue than is the focus of the present thesis.

The present thesis argues that the patient is not competent to answer fully such questions. The patient can provide a limited amount of relevant information, sufficient to maintain the interactions consideration of a tangible complaint which can be legitimately treated by medicine and is sufficient to maintain diagnostic framing of interaction ... but in terms of doctor-patient relationship, to what extent is the patient aware of the meaning of information discussed with the doctor? Obviously, the level of patient knowledge varies, eg. woman on contraceptive pill will be more qualified to answer the question, "How long have you been on the Pill?" than will another person who has diabetes and is asked, "What were the results of your urine test ..." In both examples, the patient's specific
condition is being discussed from the perspective of treatment. (However, as an aside it is also interesting to note that in essence, the patient does not need to answer these questions. The doctor, if anyone, will have documented answers to these questions. The process of diagnostic framing is enhanced by the behaviours, e.g. "How long have you been on the Pill" ... as there is absolutely no need for this question, it serves no purpose as part of an investigation of the patient's condition. It is in fact serving an interactional function as part of the diagnostic framing process in that it influences the future direction of interaction in that if the patient responds she will be discussing her specific complaint in terms of the treatment of it.

e.g. How was your urine test?

How can the patient answer that with the same competence as the doctor?

e.g. You're still taking these horrible tablets then?

Well surely it's the doctor who prescribed them ... he knows.

e.g. I can't remember if you've been to the eye people or what.

The patient can offer a short term answer to this question but when looked at within the context of the doctor-patient relationship, it is the doctor who can provide the only documented and legitimately acceptable answer as she should have such information ... regardless of what the patient says, the doctor should check details re any visit to the 'eye people'. Therefore, this question is redundant as far as the investigation of the patient's condition is concerned.
e.g. (C. 2)

D: Maybe I could give you some tablets ...
   If they're no good, we'll change it.

e.g. (C.22)

D: So right ... we will undertake what they say here ... 'The single most important factor in the future management of this patient is to keep his blood pressure under control'.

These two examples of diagnostic framing by the doctor are similar to those found within symptomatic consultations. The doctor is diagnostically framing the interaction and exercising power over the patient by suggesting the need to adhere to a particular regimen of treatment which the doctor will outline. As this is only phase C the doctor has not rigidly imposed the diagnostic framing.

To a certain extent, this allows the patient a certain freedom to continue the consideration of the condition phase.

Illustration and Summary of Phase C Consideration of the Condition.

Chronic.

This is an elderly, female patient who is presenting a complaint of very high blood pressure. The patient has complained that the tablets were not doing "what they're supposed to be".

D: Oh ... they're not. D&P sit down.
P: No. D leans forward.
D: So eh ...
P takes tablets out of pocket.
P: I don't think they were doing me any good, so I haven't taken them since. D leaning forward, reading notes.
D: Now you were on them originally for your blood pressure? Yes you were.

This illustration was chosen because it shows diagnostic framing by both doctor and patient, and should clarify another aspect of the theory of framing. As the previous illustration showed, the patient was able to offer diagnostic framing (cartilage) even though it wasn't heavily sanctioned. Within the illustration, the patient diagnostically frames by introducing her own condition in terms of the treatment. Framing is an interactive process. For example, for the doctor to introduce a diagnosis, the expectation that this is possible has to exist, otherwise there could occur a metacommunicative battle. Diagnosis is part of the doctor/patient relationship, as is the investigation, as is the treatment etc. In the present illustration, it is the patient who is introducing the treatment, which both doctor and patient accept as an expected part of the consultation, expectations relating to treatment are more complex than percentages of patients expecting treatment would indicate. Indeed the patient has the power and authority to comment upon the efficacy of the treatment in follow-up consultations. Upper level expectations are being confirmed in that there is a discussion of treatment, and the patient can take a more active part in this than was previously implied in studies of the power structure of the consultation. Indeed within the present example, the patient brought about a change in the treatment.
**FIGURE 5.1.11. PHASE D: DETAILING THE TREATMENT**

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PHASE D: DETAILING THE TREATMENT

As Figure 5.2. clearly shows, the most and indeed only, significant pattern of behaviour within phase D of the chronic consultations is diagnostic framing by the doctor (11.919%). (There is also a certain amount of diagnostic framing by the patient (1.225%) which will be discussed at the end of this section). In this way, the chronic consultations are very similar to the symptomatic consultations, and as the phase analysis shows, phase D tends to occur at the end of the sequence of phases, prior to the end of consultation, and is therefore similar to symptomatic consultations in this respect.

e.g. (C.24)

D: That's for you. You've got some at the moment you say.

P: Yes, we've just collected the last lot

D: Smashing, great, keep it up. Use it only if he gets a cold in winter. With a guy his size, don't bother... If he does get tight, take 20 puffs per day.

e.g. (C.25)

D: Right, one three times per day... OK? And come back and tell me how you get on.

P: When?

D: Next week... Yes, that'll last you for a month, but come back next week... One three times per day.

Doctor tears old card. Doctor hands patient prescription.

Doctor glances up from writing. Doctor holds prescription. Doctor hands patient prescription. Patient puts prescription away.
These two examples of doctor behaviour within Phase D of chronic consultations illustrate that diagnostic framing is similar to that discussed within the symptomatic consultations. The doctor hands the patient the prescription, (diagnostic framing) outlines the treatment and adds what was described as the return clause (e.g. C.25) whereby the patient is given the opportunity to return to surgery to assess the outcome of the treatment. The only notable difference in e.g. C.25 is that the doctor actually specifies when the patient should return. This has implications for the nature of the doctor-patient relationship as it specifies that the patient needs to return to the surgery and that the doctor has the authority to call back patients to surgery on more than one occasion. This will also influence the early stages of the next consultation as was discussed in phase A outline of chronic consultation in terms of the doctor calling the patient back.

C.25 also provides an illustration of the type of diagnostic framing which the patient can engage in during Phase D. Below is a direct continuation of previous extract.

D: What about these other things?

P: I'm on water tablets you know, and all this business ... and my X ...

In this example, the patient describes his condition to the doctor in terms of the various treatments for the different complaints he has. As mentioned in previous section, much of the patient's conceptualisation of his illness is in terms of the treatment he receives for it, and will diagnostically frame the interaction
towards a medical consideration of the patient's condition.

Illustration and Summary of Detailing the Treatment. Chronic.

Female, 20's with eye problems.

D: If you fill in the form and I'll get you to see the specialist at the infirmary, about your eyes. If you could pop in at the beginning of next week, I'll do a form and a letter. Just call in at the receptionist.


As the flow chart shows, the pattern of framing behaviour within Phase D of chronic consultation is similar to that in symptomatic consultations, with diagnostic framing by the doctor. The expectations that treatment will be offered, thereby imposing behaviour, and making an implicit metacomment that the doctor has the power and authority to do this is confirmed. Here the doctor is referring the patient to another eye specialist for further examination.
### FIGURE 5.1.12. PHASE E: CONCLUSION

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**SPECIFIC**

**MEDICAL**

**DIAGNOSTIC**

- Specific: 0.408
- Medical: 0.340

3.744
PHASE E : CONCLUSIONS

As was the case within the symptomatic consultations, very little behaviour occurs within Phase E of chronic consultations.

e.g. (C.28)

D: There you are Philip

P: Yes.

D: OK.

Doctor writing.
Doctor tears off strip.
Doctor touches prescription.
Patient stands and moves to door.

Doctor stands and sorts out notes.

Doctor writes.

This is a typical end to a consultation with the doctor framing diagnostically by tearing off the prescription, handing it to the patient and outlining how to use it. The clear effect of this is shown by the patient almost immediately standing and moving to the door to leave.

The above is a clear illustration and summary of Phase E.

Illustration Of Chronic Consultation

Doctor utilises the buzzer to call the patient from the waiting room which is about 20 yards away near the main entrance to the surgery.

Mother enters bringing two sons (P).

Mother enters consulting room, ushering two children before her.

D: Hello.

Mother sits and pulls child in front of her.
M: Hello ... Come on Stevie!
D: Steven ... hello. Boy (P) stood in front of mother and doctor.

PHASE A
P: Hello.

PHASE B1
M: Right ... his excema's playing up again. Doctor looks to patient.
P: Me chin hurts.
M: And his legs are the worst. He wanted to wear a shirt, 'cos he wants to be a doctor when he grows up. Doctor writes.

PHASE B1
D: Do you think all doctors should wear a shirt? Does it itch? ... Has it itched? Do you want to scratch it all the time? Doctor moves forward on chair and looks at child.
M: And turn around and show the doctor this. This is what worried me most, it's just here. Doctor investigates patient's legs.
D: Right, are you putting anything on it at the moment? Patient pulls up pants.
M: I put this on ... last time he was not well. Mother holds out tube of cream.
D: Yes.
M: It didn't seem strong enough. Doctor writes.
D: It didn't do the trick. Right.

PHASE B2
M: He's a bit highly strung at the moment. I don't know what he's like at school. He talks all day and ... he's talking in his sleep ... he wakes up two or three times per night usually ... he has a lot of nightmares. Doctor stops writing and looks at patient and mother intermittently.
D: It could be related.
M: He's beginning to dream you see.
D: Yes, yes.

M: I think he gets physically worn out.

D: Does he go to playschool? Mother and doctor looking at children playing around.

M: Yes, yes.

D: I think it may be a fact that the exzema is related to his hyperactivity at the moment. I think he is a bit active ... I think all I can do is ... we'll give him some cream ... we can get it a lot better than that ...

M: During the day he'll watch a cartoon and then he'll dream about it afterwards ...

P: And every time I watch telly. Patient looks to doctor. I dream about it at night.

M: You have a lot of nightmares don't you?

Phases:

**PHASE C**

D: He's still four isn't he?

**PHASE D**

So use this twice a day ... just sparingly ... rub it well in ... then let me see him in a few weeks. You should get quite a good result. If not, I'll change the treatment. Doctor points to prescription. Doctor tears prescription off. Doctor hands prescription to patient.

**PHASE E**

OK? Mother stands and moves to usher children out.


M: Thank you. Mother leaves with children.

Commentary Upon Illustration Of Chronic Consultation

This chronic consultation begins with roughly the same framing as occurred within symptomatic consultations, ie. the patient (in this
case the mother) has decided upon her own volition to attend the surgery and sets in operation the process of medical framing. However, as the consultation proceeds, we see evidence of diagnostic framing. As a result of previous interaction with the doctor, the mother already has a diagnostic label for the child's condition and uses this to frame the interaction, i.e. she influences the future flow of the interaction by restricting discussion to what is included within the broad frame of enema. The child contributes to the interaction with specific framing: "me chin hurts".

The consultation then enters a short stage of non-functional dialogue with the mother and doctor's comments upon the child's dress. However, within the discussion of non-functional dialogue (see Appendix 3), it was claimed this largely occurs when the doctor is carrying out a non-verbal investigation. Within this example, the doctor is leaning forward and looking at the child, which allows her to maintain her medical framing of the interaction.

As the consultation proceeds in Phase B2, the doctor supports the non-verbal investigation with a verbal investigation and we have a situation whereby the doctor is medically framing both verbally and non-verbally. The questions and investigations influence the patient's behaviour and the doctor in his attempt to reassess his allocation of the patient into a particular medically defined category and to provide treatment upon the basis of that.

However, this consultation also provides evidence of the patient's ability to diagnostically frame the interaction, as opposed to
specific framing. The mother begins to specifically frame the interaction with comments such as "This is what's worried me most...", as could have occurred within a symptomatic consultation. The mother then proceeds to refer to a treatment previously described by the doctor. In this way, she is diagnostically framing the interaction by referring to the patient's condition in the form of the treatment offered for it. As occurs in symptomatic consultations, the doctor can refer to the patient's condition by prescribing a regimen of treatment as part of the process of diagnostic framing. The mother's discussion of the patient's condition is in terms of that treatment and maintains the diagnostic label which was initially the result of medical framing.

The consultation then proceeds into Phase C, a consideration of the patient's condition which largely consists of interaction between the doctor and the mother. The mother specifically frames the interaction by describing symptom-related behaviour. However, the doctor parallels this with diagnostic framing with comments such as "It could be related" and "We'll give him some cream". The process of sponsorship is implicit in a great deal of this interaction as the doctor accepts responsibility for the patient's condition. However, from the perspective of the present thesis the discussion of the complain in terms such as excema and treatment ensures that the doctor is the only person legitimately competent to comment upon the condition.

Both mother and child then contribute to the interaction with specific framing, ie. "During the day he'll watch a cartoon..." and
"and every time I watch telly I dream about it ...".

However, the power structure of the consultation manifests itself at this late stage in the consultation as the doctor moves into an outline of the treatment. As far as the main aspects of diagnostic framing are concerned, the diagnosis of eczema has already been offered and phase D is concerned with directions relating to the treatment. If recourse is made to the initial outline of the main aspects of diagnostic framing, i.e. "You've got this", "Do this", "This should happen", "If not, come back". Within phase D, the doctor says do this, ("So use it twice a day ... just sparingly ... rub it in well"), this should happen ("You should get quite a good result") and offers the patient the ability to come back ("Let me see him in a few weeks").

The full process of diagnostic framing has operated and the process of sponsorship has continued with the doctor not only taking responsibility for the patient's condition but the doctor maintains responsibility by recalling the patient and imposes influence upon the patient by directing his life style to adhering to the treatment.

As in the symptomatic consultation, the doctor utilises the technique of tearing off the prescription to indicate that the consultation has finished.

5.7. DISCUSSION

One of the pitfalls of carrying out qualitative research of the type described in the present thesis is that the author may be tempted to
use his data, solely as an illustration of a theoretical model developed in an earlier chapter. Silverman (85) levelled this very criticism against the work of Waitzkin (79), who does not allow theory to grow out of his data, but instead imposes preconceived ideas and structures. Waitzkin knows what he is going to find, and his approach does not facilitate the opportunity for alternative structures to emerge. Having read Chapters 3 and 5 of the present thesis, the author recognises that such a failing could be levelled again. However, a number of points can be made in defence of such a claim.

1. Chapter 4 included an analysis which was both willing, and successful, in questioning the model of framing described within Chapter 3. Although initially the data did indicate that the model of framing was readily accepted by patients, further exploration within the interviews showed how patients were willing to question traditional expectations.

2. Chapter 6 is concerned with occasions in which the model is directly questioned within the consultation. It is primarily patients who seem to step out of the constraints of the patterns of frame described within the present chapter, and the thesis calls upon alternative literature to attempt to explain such events.

3. The third point is a more general one which relates to a felt need to present a lengthy descriptive analysis of consultations, guided by a theory which is compatible with other contemporary work in the area (e.g. Strong 79, Silverman 84, Andreoff - Evans 86, Sankar 86), and which should facilitate the growth of a stock of knowledge re the consultation.
One of the most insightful approaches to understanding events within the doctor-patient relationship has its roots in Strong's (79) model of the "ceremonial order of the clinic". Discussion of the work of Strong has been kept until this stage in the thesis as it contains both an ideal typical analysis of the consultation, and an analysis housed in 'framing' theory. Strong was looking at the bureaucratisation of medicine and the effect this was having upon the doctor-patient relationship, and concluded that, "in each clinic, most consultations were framed by the bureaucratic format, most of the time". According to Strong, there are established patterns of behaviour, and rules, which relate to "most consultations, most of the time", e.g. the moral worth of the parent is never overtly questioned; every doctor is a good doctor, as a result of allegiance to collegiate authority and expert power etc.

Early on in his thesis, Strong gives the hint that he is not too interested in how individual consultations vary, when he says that it makes sense to talk of a general form which most consultations hold in common. Although the present thesis has also utilised the ideal type as a research tool, to create an outline of 'symptomatic' and 'chronic' consultations, it has not ignored the possibility, and indeed tendency towards individual variation (see Chapter 6). However, although Strong criticises role theory for going too far and overlooking the ability of individuals to construct the situation, his emphasis upon the commonality of the "bureaucratic format" must be seen as leading to the occlusion of individual variation.

Yes, it is highly insightful and useful to describe and outline
typical features of the phenomenon under study, but there is a need to guard against such descriptions almost 'objectifying' themselves (Berger and Luckman 67). The bureaucratic format seems to grow in its attempt to be interesting and useful. In highlighting certain rules of the bureaucratic format e.g. mothers' moral status is never overtly questioned, mothers are competent but subordinate, fathers are loving but incompetent. Strong is using the interesting and anecdotal to illustrate structure.

Two parallels can be drawn here. Firstly, recourse is made to Balint's (73) observation that one of the most immediate requests of the patient is for a diagnosis, for a name for the illness. To what extent has this observation by one of the most respected researchers in the doctor-patient area permeated into clinical practice? Has the practicing doctor accepted Balint's description of the patient and structured his own behaviour around this? Secondly, Strong's work is similar to Goffman's in this tendency to use stimulating anecdotal description, which at times requires further empirical development. The present author accepts the irksome and tedious nature of the present chapter but feels that processes as specific, medical and diagnostic framing are more fundamental aspects of the encounter, and as such need to be presented in what may appear, monotonous detail.

Strong (79), and more recently Silverman (84) utilise a technique of either note taking during consultations, or making notes from memory after the consultation. When confronted with the difficulties surrounding the collection of video, or even audio-tape recordings of
consultations, such a procedure provides highly insightful data. However, one interesting observation from the perspective of the present thesis would be to argue that such data would be influenced by upper level frames. Although it is possible that influences such as these work across all kinds of work, the researcher needs to accept the possibility of inherent subjectivity. A similar influence was probably in operation within interviews outlined in Chapter 4. It is very likely that subjects construed the researcher as affiliated to the medical profession and that their answers were, to some extent, affected by rules which surround the consultation.

Chapter 5 can also be appreciated from the perspective of another attempt to apply frames to doctor-patient discourse (Andreoff Evans et al. 86). These authors used the notion of frames to look at the doctor's comprehension of not only patients' medical problems, but also the conceptual structures that underlie the doctor and patient's understanding and perception of the problem, and argued that communication difficulties may arise from the doctor and patient having grossly different structures of knowledge, and notions of causality relating to illness. Evans quotes the example of a doctor wishing to prescribe a treatment, and a patient who doesn't appear to want it. The problem is located in the doctors belief in the almost total efficacy of the treatment, and the patient's belief that the treatment may lead to an allergic response, and Evans traces this confusion within the interaction.

Evans' notion of frames is based upon Minsky's (75) model and describes a structure which doctor and patient bring to the
encounter. The present author feels there is a need to appreciate the dynamic nature of framing, the process involved, and within which such knowledge structures will be expressed. This is not to deny the credibility of Evans' work but to state the need to build it into a comprehensive theory of social interaction. The confusion which Evans points to takes place within the constraints of the patterns of framing described in the present chapter. The example quoted of 'Hives' is surely a description of events within Phase C, 'a consideration of the condition', and must be viewed as the last opportunity, within the consultation, for the patient to attempt to influence the outcome. When we look at the standard package of behaviours which constitute 'diagnostic' framing and which inevitably occur within Phase D, where only the doctor engages in behaviour of any significance, it would appear to be the case that although confusion may be an inherent aspect of Phase C, the doctor is liable to over-rule this as the consultation progresses. Furthermore, transfer of responsibility (Duff and Hollingshead 69) and the control of knowledge (Waitzkin 85), inherent in the processes of specific, medical and diagnostic framing, lead us to appreciate the need to accept the interactional context within which such 'confusions' occur.

There are many factors which make it difficult to escape from what Strong would refer to as the ceremonial order of the clinic, and what the present author would describe as the processes of specific, medical and diagnostic framing. Evans makes the observation that to improve the efficiency of the management of certain conditions, it is necessary for physicians to understand what is fundamental in their science of medicine, and they must relate this to what is fundamental
in their patient's comprehension of the problem. However, to achieve such an aim, it is also necessary for physicians to be made aware of what is fundamental in their interactions with patients, and to appreciate that any attempt on their part to come to terms with the patient's conceptual structure, and to be influenced by such, is going to be restricted by an approach to the consultation which necessitates specific, medical and diagnostic framing. Two points can be made to clarify this.

1. It is not beyond the bounds of conjecture to anticipate that should physicians begin to not only accept, but also take into account, the conceptual frameworks of patients, this would involve their lessening the utility of their own present conceptual framework, and a stage would be reached whereby specific, medical and diagnostic frameworks would not be applicable to the consultation, as its medicocentric nature had been removed.

2. The work of Sankar (86) has shown how doctors, who are taken away from the security of the consulting room or hospital, experience a loss of control. As Sankar puts it, "loss of control in the home reflects a fundamental aspect of medical practice, the loss of a context designed to facilitate physician control ... a context designed to concentrate the focus of the encounter on the patient's biological dysfunction." To support the existence of specific, medical and diagnostic framing within the consultation, Sankar notes, "communication is focussed on the narrow task of gathering data, relevant to diagnosis and cure". However, in the patient's home the physician is forced to acknowledge information about the patient, his life and his
adaptation to his illness, which he can avoid in the traditional consultation.

The home setting is not conducive to the traditional frames, and yet the doctor is confronted with the need to at least begin to appreciate the patient's conceptual knowledge and experience regarding the illness. If we accept that the patient's lifestyle and adaptation to the illness are a causal factor in prognosis (see Radley and Green 84, 86) then although doctors may resent being taken away from the security of the medical environment, it may be of longterm benefit to the patient. The doctor should not view it as purely dangerous to step out of traditional frames, but should view it as a source of additional information. Furthermore, it shouldn't really be necessary to have the doctor brought into the patient’s home to appreciate this additional information. If doctors become aware of the possible constraints upon their own efficiency, of the frames, within which they operate, they may begin to explore lower levels of frame behaviour, or indeed out of frame behaviour. Eventually, a new pattern of framing may emerge within the consultation, with teaching, and the transfer of social information taking a central role, or indeed the open acceptability of overt and sanctioned patient questions. The following chapter will now proceed to investigate such behaviours within the context of the current patterns of framing.
CHAPTER 6

FURTHER STUDIES USING THE IDEAL TYPES AS A YARDSTICK
6.1. **INTRODUCTION**

One of the crucial aspects of the theory of framing is that it provides a truly interactionist approach to the consultation. One actor's behaviour cannot be understood, or be seen as meaningful, in isolation from the other actors within that situation. Expectations relate to the situation, power is an attitude of two individuals, not one. Although the patient is the prime initiator of specific framing, and the doctor is the prime initiator of medical and diagnostic framing, these three processes are features of both actors, features of the situation. The behaviour of the patient is meaningless when viewed in isolation from the doctor, and in turn the doctor's behaviour is meaningless when viewed in isolation from the patient.

In setting the scene for the present chapter, recourse is made to Bateson's (73) proviso, that frames are 'exclusive' and 'inclusive'. Behaviour within the consultation is constrained within the processes of specific, medical and diagnostic framing. However, before we can accept this claim or at least clarify what we mean by 'constrained within', we need to ask further questions of the model of framing. And at this juncture it is wise to recall Weber's (30) initial intention that ideal types should be used as a yardstick, against which to compare actual occasions of the phenomena under study, and as a basis for further analysis. Accepting this, it is now necessary to look to actual consultations to analyse how they may move away from the ideal typical format and display a 'unique' pattern. On the basis of a review of the literature it is possible to discern two ways in which individual consultations will vary, initially within
the upper level patterns and secondly beyond these upper level patterns.

Utilising Minsky's (75) differentiation between upper and lower levels of frame, and Kaye's (82) highlighting aspects of the parental frame to include the nurturant frame, the protective frame, the modelling frame etc, it is possible to look for lower level frame behaviours to see how individual consultations move around within the constraints of the three upper level framing processes. On the basis of factors peculiar to the individual doctor, patient or illness, we are liable to witness lower level patterns of behaviour, within upper level frames. Chapter 3 highlighted possible lower levels of framing behaviour e.g. compliance, pedagogic, social etc, and the first study within the present chapter is an attempt to investigate the occurrence of such behaviours within the fifty consultations.

However, the possibility exists that individual consultations may exhibit 'out of frame' behaviour. The literature is choked with evidence to suggest disruption within the consultation, and the interviews outlined within Chapter 4, imply that we need to ask questions of the traditional structure of the doctor-patient consultation. The second and third studies to be described in the present chapter involve an analysis of occasions when, on the one hand, expectations are not realised, and on the other hand, expectations are exceeded. The existence of such occasions inevitably raises questions for the model of framing.

6.2. AN EXPLORATION IN LOWER LEVELS OF FRAME
One theme which has been reflected throughout the present thesis is the need for a qualitative approach to the problems of the doctor-patient relationship to support the wealth of quantitative data which is available. Chapter 5 comprised a qualitative exploration of upper levels of frame, and the study to be reported within the present section is an exploration of lower levels of frame, as they occur within the consultation.

Kaye (82) used the concept of frames to describe the development of the child, and the effect of interactions with the parent upon such development. Kaye postulates the existence of a 'parental frame' which facilitates mother-child interaction, facilitates the child's sensori-motor development, and ultimately contributes to the child's education. According to Kaye the "mother creates a microcosm or 'frame' within which schemes can function". However, there is no real need to differentiate between 'frames' and 'schemas' to explain this point. Kaye sees frames as units of behaviour which provide a facilitating context for the operation of cognitive activity. Within the recent paper Evans et al (86) use the concept of frame to indicate, "a set of associated facts or ideas about a central concept". For Evans the notion of frame is sufficient to incorporate whatever cognitive aspects are necessary, and indeed such frames may be the basic building blocks of knowledge and human memory may be a network of interrelated frames. To integrate the cognitive and interactional aspects of frames could pre-empt an extremely comprehensive approach to social psychology.

However, of relevance to the present thesis is Kaye's (82) exploration
of a number of different types of frame that adults provide for children. Within the parental frame, can occur nurturant frames, protective frames, modelling frames etc. Having consulted the literature within Chapters 2 and 3 and looked at some of the elaborations recorded in Chapter 4, one can devise a number of types of frame which may occur within the doctor-patient consultation. These were referred to within Chapter 3, and the present study will comprise a primary investigation of lower levels of frame within the doctor-patient consultation. Due to the need for a qualitative exploration of doctor-patient transcripts it is not possible to explore the multiplicity of possible frames which may occur within the consultation. Consequently, the study will focus upon the existence and operation of a pedagogic frame, and offer observations upon the occurrence of education within the consultation; the extent to which individual doctors are consistent in their practices; and to consider some of the factors which will affect such a frame.

According to McClellan (86), "Education is an essential part of medical care and must be conducted properly for the patient to obtain optimal benefit." However, it is interesting to note that even within such a recent paper there is an acknowledged need, "to understand how patient education is used by practitioners". Much of the work which exists to date is quantitative consisting of estimates and measures of the length of time spent in patient education (Bergman et al 66, Parrish et al 67), or measures of the number of items of information exchanged (Freemon 71, Joyce 69, Anderson 86). Indeed much of Ley's classic work in this area has involved looking at quantification of units of information. However, there is still a
dearth of qualitative descriptive analysis of education within the consultation, and furthermore a lack of appreciation of the complexities of the education process. It is not sufficient to equate information exchange with patient education. Education involves an assessment of the needs of individuals, the exchange of information and the reinforcement of desired behaviour to say the least. It is a qualitative analysis of educational frames within actual consultations which will show whether or not such aspects are present.

On the basis of the studies discussed within Chapters 4 and 5, it is clear that any major educational interventions will occur within Phase C. This is where doctor and patient engage in a 'consideration of the condition', and as the flow charts show (Figures 5.1 & 5.2), patient involvement is negligible after Phase C, and any further education would very much be unidirectional. The following analysis will involve an exploration of education as it occurs in Phase C of the doctor-patient consultation. Consultations will be compared to highlight similarities and differences.

Symptomatic consultations 15 and 19 provide an interesting illustration of one doctor's educational interventions. Both patients are mature males presenting 'ulcer type', 'indigestion type' symptoms, and yet the operation of a pedagogic frame is not consistently used. The thesis will now present Phase C of both consultations.

S.15 D & P sat down.

D: Now I'm sure this is a recurrence of the pain you've had
before ... OK ... It's in the right place, the right character, and if Rennies takes it off after half an hour ... I'm sure it's ulcer type pains. Now ulcers tend to come and go, OK. You get a bad patch for 2/3 weeks ... then it settles down, and then flares up again.

P: Mmm.

D: Now there are things you can do like ... no smoking, no alcohol, resting, and white medicines. Now then, I can advise you to give up smoking ... Do you smoke now?

P: Mmm.

D: When it's really bad, hop into bed and get a glass of milk, and literally it will get better. It will get better as fast like that ... rather than any other treatment. I advise you to give up smoking, cut down drinking and hot curry foods. Do you have them?

P: Only once a week.

D: Oh, that's OK. Basically, you've got to do your homework ... a lot of it is what you do ... Another thing is stress and aggro at work. If people say you're going to lose your job, that makes ulcers worse ... are you with me?

P: I am a bit on the nervous side.

D: Why should that be?

P: I am nervy. I do generally tend to worry.

D: Do you remember when you had pains before, did you have a Barium meal.

P: Yes I did.

D: That proved you had an ulcer, did it?

P: I had a course of tablets and had no more bother.

D: Was it a duodenal or gastric ulcer.

P: Mmm.
Within this illustration we have a clear example of the doctor attempting an educational intervention. Within the constraints of the upper levels of frame this doctor is establishing what Kaye (82) would refer to as a 'microcosm' or 'frame' within which he is attempting to educate the patient. However, two points must be made at this stage. First of all 'frames' are interactive, features of the situation, and this pedagogic frame must not be viewed as something which the doctor attempts to impose upon the patient, but as a mutual experience with both doctor and patient contributing. Secondly, education needs to be viewed as interactive with, in this case, the doctor needing to elicit patient involvement, needing to assess patients' needs and life circumstances, and needing to assess patient comprehension of any advice given. Although the above illustration shows quite clearly the existence of a pedagogic frame with the consultation, its operation seems to be dominated by the doctor regardless of the need for mutual patient involvement. Advice, such as "don't drink", "don't smoke", "go to bed", take no account of the patient as an individual. Evans et al (86) point to possible confusions between the cognitive representations of doctors and patients. The present thesis highlights confusions within the interaction.

However, let us move on to symptomatic patient 19. The patient had presented symptoms of bronchitis (which the doctor notes may be worrying the patient "if it's asthma") and heartburn.

P: This heartburn really bothers me. If I have a meal, immediately after it ... ooh ...

D: What do you take for it?
P: Well nothing really. I've had the odd Milk of Magnesia tablet.
D: And does that help?
P: No ... I don't believe in it ... (silence).
D: Now, there are three things.
     (Doctor goes on to outline treatment).

Within this example the doctor has not called upon a pedagogic frame and does not establish the possibility for the doctor and patient to discuss the ulcer type problem. Indeed the patient also has not called upon a pedagogic frame. However, a tentative suggestion can be made here concerning the operation of frames within the consultation. In this example the doctor needs to outline three individual medications and there may be a limit to the amount of framing, or diversity of framing. The doctor has to outline, "yellow tablets", "pink tablets" and "white medicine" and the operation of what may be called a 'compliance' frame prevents the operation of a pedagogic frame. However, the tentative conclusion which can be drawn at this stage is that this doctor does not operate consistently on his usage of the pedagogic frame.

To clarify this point, attention is drawn to two further conclusions in which female patients are attending for a prescription of the contraceptive pill.

Symptomatic patient 5 has presented two conditions, Exema and a request for the pill. The doctor has taken the patient's blood pressure and has just sat down.
D: You've not got high blood pressure ... Right... A years supply.

The doctor continues to write the prescription and the pedagogic frame does not come into operation. However, Symptomatic Patient 6 is a totally different consultation as the following extract illustrates. This patient is uncertain about the functioning of the contraceptive pill and doesn't know when to take it.

D: I think your best bet is to play safe, rather that not.
P: Yes.

D: All it's doing is to stop your period ... but your not bothered about that ...
P: Am I ovulating with this one?
D: No, you're not ovulating.
P: Well I've heard ... I know it's only hearsay ... I thought if I got the wrong tablets I could get pregnant ... well, I gathered there are all different doses.

D: Yes ... mmm.
P: Well I sort of thought I could get pregnant, and ovulate ... so I'll just carry on.

D: I think your best bet is to take it rather than not.
P: So it's all right if I take it. Say take it six weeks out of six ...
D: Yes.
P: Crikey ... I thought if your anything short of intelligent ... you've had it ... Am I safe on this ... I'm thirty next year.
D: I don't think anyone knows about that ... 35 is the time we should start to think ... should some other method be useful.

P: So, I'm alright.

D: Yes.

This consultation concludes with the doctor quickly writing a prescription.

Again, the educational intervention of the doctor is most clearly understood within the interactive context of the pedagogic frame. In the latter illustration the patient is the initiator of the pedagogic frame as she almost demands knowledge and clarification, and any intervention by the doctor is only appreciated in light of this. This is the same doctor who was very matter of fact with the previous patient, and does not display a consistent pattern in consultations dealing with the contraceptive pill. One of the interesting asides of the second contraception consultation is the picture of a mother with a baby on one knee, and a young child by her side. Again there is a hint of the idiosyncratic influence upon framing behaviour.

Unfortunately, there is not scope within the present thesis to develop this notion of lower levels of frame in the doctor-patient consultation. However, it is clear from the illustrations presented that individual variation is very prevalent and that many factors will influence whether or not a pedagogic frame is evident. The present analysis has shown how both doctors and patients vary and that it is only if we look to the interaction that we can hope to gain an adequate understanding of the consultation, and whether or not it attempts to be an educational situation or not.
However, the latter study (6.2) is only one way in which we can explore the model of framing. The following two studies (6.3) also suggest ways in which frames for the consultation can be explored.

6.3. OUT OF FRAME BEHAVIOUR

6.3.1. INTRODUCTION

There is definite recognition within the literature that the doctor-patient relationship is not problem free, but there is a dearth of attempts to look at problems as they arise within the interaction. This is not in fact surprising considering the dearth of analysis of interaction which permeates the literature in this area.

Bloor and Horobin (75) noted that although "the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with each other, relatively little attention has been paid in the sociology of medicine to the possibility of conflict between doctor and patient". The present chapter proceeds to present evidence which suggests that conflict and disagreement may occur, even within the interaction, and the recorded consultations will be analysed for the existence of conflict with the aim of ascertaining how and why it follows the path it does.

In her review, Fitton (79) comments that, "analysis of the power structure of the doctor-patient relationship shows clearly that, although in terms of social systems maintenance, the roles may be reciprocal, the dyad is inherently one of inequality and conflict." Although the power structure of the relationship has been analysed at
length (Szasz and Hollender 56, Browne and Freeling 67, Friedson 70, Strong '79, Silverman 84), little attention has been paid to the possibility of conflict within the interaction. The aim of this study was to examine potential conflict as an example of 'out of frame' behaviour.

Many of the studies have looked at patient dissatisfaction and communication difficulties (Pendleton 83) or non-compliance with the treatment (Ley 83). Non-compliance and dissatisfaction imply that there are significant problems within the relationship which may become apparent within the interaction, and as such potential conflicts must be analysed. Much of the non-compliance literature infers that patients do take an active role in their treatment, or more so, an active role in not adhering to their treatment. An interesting question which as yet have not been investigated concerns whether or not patients are liable to comment upon their treatment within the consultation, and the related question of whether or not there is any evidence within the interaction that patients may be dissatisfied. Both common sense and a more educated knowledge illustrates the potentiality of conflict. Furthermore, studies by West (83) have suggested that doctors do not like patient initiated questions. This needs to be investigated.

Stimpson and Webb (75) pointed to a number of aspects of the doctor's knowledge which could provoke conflict. The doctors knowledge is never complete for a number of reasons.

1. Medicine operates at the level of probable causes of an illness and the probable effect of treatment.
2. The individual doctor never has a complete monopoly over the relevant medical knowledge.

3. The doctor is never in possession of all the information that may be relevant to a particular illness, especially information held by the patient. Issues such as these are pointing to the fact that medical knowledge does not operate at a 100% level of efficiency.

Furthermore, the patient is not as ignorant as certain studies imply, and it is unfair and misleading to view the patient in this way. The competence gap between the doctor and patient may not be as severe as is implicit within a great deal of the literature. And, yet, according to Stimpson and Webb, "doctors and patients act towards each other as though they personified these opposite attributes" i.e. the patient appears as more ignorant and the doctor appears as more competent. The present chapter intends to deal with situations which on the face of it question the traditional structure of the relationship.

Bloor and Horobin (75) argue that, "the source of conflict lies in two basic assumptions held by doctors as to how patients should behave". They believe patients should use their own judgement as to when it is appropriate to seek medical advice, however, patients are later expected to defer to the doctor's judgment when undergoing medical treatment. They continue - "this example serves as a caution against accepting too readily the assumption that the professional/client relationship is necessarily reciprocal and unproblematic". Following this, it is possible to see the patient
existing in a 'double-bind' situation whereby he needs to take an active part in the decision making process in initially assessing the symptoms, but is then required to defer to the decision of the doctor. Bloor and Horobin utilise such a confusion to raise a question mark against Parsons' (51) description of the reciprocity which exists between doctors and patients. There is a potentiality for conflict.

Friedson (62) attempted to take this explanation of conflict further. "Conflict occurs especially when the patient on the basis of his own lay perspective tries in some way to control what the physician does to him". Following on from this we can expect that any attempt by the patient to take an active part in deciding the treatment programme is a potential conflict situation. The interesting question relates to the ways in which doctor and patient will attempt to deal with this, if such occasions do occur in consultations.

We can, at this stage, refer back to the pioneering work of Szasz and Hollender (56) who identified three ideal-typical models based on the differing power relationships between the doctor and patient (see Chapter 2). French and Raven (59) point out that the doctor, in the majority of cases, does hold the balance of power ... expert power. Patients do not usually possess the appropriate scientific knowledge to question the doctor's ability, and will accept the doctor's recommendations because they believe he/she has expert knowledge which is unavailable to them. Rodin and Janis (79) contribute to this view, saying that not only do patients feel that they lack
knowledge, but doctors themselves view patients as having no significant knowledge to input. Again this provokes the present author to question whether or not patients will question the doctor, and what affect this will have upon the interaction.

One final area of medical literature which needs to be considered as a precursor to the present analysis relates to the efficiency of the medical endeavour in and of itself. As Friedson notes, "professional knowledge is never complete, and so diagnosis, made with the greatest of care and the best of contemporary skill, may turn out to be inappropriate for any particular case" Fox (75) notes how the "doctor is regarded as an expert, a man professionally trained in matters pertaining to sickness and health, and able by his medical competence to cure our ills and keep us well ... but such a utopian view of the physician is at variance with the facts ... his knowledge and skill are not always adequate ... the life of the modern physician is still full of uncertainty".

Mechanic (78) notes how medical assessments have a very low reliability, and the literature on diagnostic variability can only confirm this. Studies by Bakwin (45) noted the variability in diagnostic patterns for children with symptoms of tonsillitis, Fletcher (52) showed substantial variation in the clinical assessment of pulmonary emphysema, Kilpatrick (62) noted the variability amongst doctors in reading and interpreting X rays, and Koran's more recent work (80) continues to note substantial diagnostic variability. When we combine these studies with the observations of Illich (76) on iatrogencic disease, it appears to be very wise to at least be ready
for potential conflict within the interaction, and to have a technique of analysis which allows the exploration of conflict within interaction. On the basis of the literature presented on the previous pages, maybe we should expect open hostility.

Within the model of framing, being developed within the present thesis, is the notion that expectations place limits upon possible behaviours, and that implicit within every behaviour is a metacomment concerning how that behaviour is to be taken and how it fits into the broader relationship. It is possible to look at problems within the doctor/patient relationship as resulting from a deviation from the traditional role expectations for doctor and patient. This could take the form of the non-attainment of expectations or even the exceeding of expectations. Furthermore, according to the model of framing such disruption of expectations will be reflected with the metacommentary which runs parallel to the interaction.

At no stage within the interviews (Chapter 4) was any reference made to the possibility of the patient questioning the doctor concerning the treatment. However, analysis of the consultations showed that this clearly occurred, and this can be taken as a patient exceeding expectations, which may have repercussions for the power structure of the relationship, as for one thing the doctor may not be willing to accept this patient behaviour and it may establish a deep conflict. On a basic level, the occurrence of such disruptions need to be illustrated, and more importantly the way in which the actors deal with it must be analysed and explained. To do this, a detailed descriptive analysis of the transcripts is required.
6.3.2. METHOD

To explore this issue recourse is made to Watzlawick's (67) differentiation between the content and relationship levels of communication. "The content level of the message conveys information, and is therefore synonymous in human communication with the content of the message. The relationship aspect refers to what sort of message it is to be taken as, and therefore ultimately to the relationship between the actors". To illustrate the distinction between content and relationship levels of communication, consider the following hypothetical example. Husband A returns home from work and tells Wife B that he has invited guests for dinner. Wife B is happy with the content of the communication as she likes guests, however, she is not happy with the comment which Husband A's behaviour has made concerning the relationship between them. She perceives it as going against the nature of their relationship in that he does not (and should not) ask guests around without asking her opinion first. The two levels of communication become clearer if we consider possible responses of the wife. She may question on the relationship level and say that 'you have no right to ask guests to the house without asking me', which could provoke a pragmatic solution. However, the wife may confuse the content and relationship levels and instead of questioning on the relationship level (which is the source of conflict) and giving vent to overt metacommunication, she may question on the content level and say that she does not like having guests. The reader can easily imagine how such an interaction could develop until the relationship totally broke down.

However, from the perspective of the present thesis, the point being
made is that when the traditional expectations relating to a relationship are disrupted, conflict may occur and the previous literature has indicated there are enough factors liable to provoke a disruption of expectations. Furthermore, Watzlawick notes how, "phenomenon of disagreement provides a good frame of reference for the study of disturbances of communication due to confusion between content and relationship" (67). As such, Watzlawick's notion of communication allows us to explore the development of conflict within interactions. According to Watzlawick, conflict is liable to lead to an overt discussion over who has the right and authority to do what to whom, within the confines of the relationship. Within the fifth aspect of the model of framing, attention was drawn to the metacomment which is implicit within every behavioural act e.g. the ability of the doctor to impose treatment upon the patient and affect his life style accordingly is accepted by both doctor and patient as comprising the frame for the consultation, and both accept that the doctor has the right and authority to do this. However, the situation may arise in which doctor and patient disagree. This disagreement may be over the treatment which a doctor has prescribed or it could be over the right, and authority of the doctor to prescribe any treatment.

To facilitate the analysis Watzlawick supplies, (rather unfortunate from the perspective of the present thesis) the distinction between 'sick' and a 'healthy' relationship, has to be made clear.

Watzlawick defines a 'healthy' relationship as one where those involved are agreed upon the nature of the relationship between them.
and the majority of communication focusses upon the passage of information. In the doctor/patient consultation outlined within the ideal types this is very much the case as the interaction does adhere to the frame of patient presenting symptoms, doctor investigating, diagnosing, treating etc. However, should there be uncertainty or disagreement concerning the nature of the relationship and expectations for behaviour, with actors unsure of or unhappy with their own role, a 'sick' relationship can develop characterised by a constant struggle about the nature of the relationship with the content level of the relationship becoming less and less important. Assuming Watzlawick's model to be correct, we can look at doctor/patient interaction for evidence of a power struggle when expectations are exceeded or not realised. This is an interesting avenue of approach to the doctor/patient situation as it is clear that in a 'sick' relationship the flow of information would be of reduced importance and the efficiency of the encounter greatly reduced.

However, Watzlawick's (67) notions exclude the possibility of impression management as highlighted by Goffman (59, 61, 74). Goffman has argued that when actors are engaged in interaction they may collude to make the encounter appear as harmonious as possible, suppressing immediate feelings to stress accord between them. The maintenance of a 'veneer of consensus' is facilitated by a 'division of labour' in which each participant is allowed to establish a tentative official role regarding matters which are important to him, and in exchange for this courtesy, he remains non-committal on matters which are not an important part of his role. In this way an
interactional Modus Vi Vendi is established whereby agreement exists as to who has the right to make claims, on what issues. However, to this is added a 'working consensus' to avoid open conflict. The existence of such a working consensus may inhibit the 'metacommunicative explosion' as implicit within the work of Watzlawick.

Furthermore, one cannot deny the possibility of 'fabrication' whereby "one or more individuals ... manage activity so that a party of one or more others will be induced to have a false belief about what it is that is going on" (Goffman 74). Although the evidence points to the possibility of great conflict, the actors may collude to maintain a harmonious relationship. When we look at conflict within the relationship, there is a need to look at attempts to cover it up.

The concept of the two levels of communication received its clearest investigation in an unpublished PhD thesis by Young (78). As was mentioned within Chapter 3, Young was interested in mother/child interaction, and particularly in the way in which the mother used her power and authority to influence the child so that the child engaged in playing a simple ball and shapes game according to the mother's rules and expectations. The focus of Young's research was that the child often did not want to play the game 'the mother's way' and indeed maybe did not want to play at all. However, the mother charged with responsibility for the child's development, defines the situation for the child as one in which the object of the game is for the shapes to be slotted into the correct holes. Young is pointing to the mother's use of her power and authority to ensure that the child accepts her
rules and expectations. Young describes in depth how the mother "uses her eye contact", the more personal contact with the child, to redirect the child's attention back down to the ball and shapes with "that one" ... holding out the shape ... "in there" looking at the hole and pointing to it - then tapping the "correct" hole. The mother expects the child to respond and play according to her rules ... she creates a vacuum into which the child's behaviour is drawn. In these mother/child interaction sequences it is clear that the mother is building the child's understanding of rules and the need, or almost inevitability, to conform to expectations. Young describes a situation in which the mother physically moves the child's hand back to the "correct" hole when the child does not perform in the correct way.

The child is playing a novel ball and shapes game and cannot know what is expected of her. The mother uses her power and authority to frame such expectations and impose them on the child. However, the doctor/patient situation does not readily conform to this picture as Chapter 4 has shown that both actors within the encounter understand what the expectations for behaviour are. Consequently, it will not be necessary for the patient to behave as Young's mother and guide the doctor towards an investigation of the symptoms, and the doctor similarly to force the patient to present the symptoms. At this level the expectations are shared.

However, Young's emphasis was upon the mother's attempts to behave in accordance with the basic rules (expectations) for the situation. The encounter exists at a different level and deals with problems of
a different level of sophistication. Young saw the conclusion of the mother/child framing as the stage when the child acted in accordance with the mother's expectations.

The doctor/patient encounter exists at a higher level of sophistication, if only in terms of more sophisticated knowledge and language. Furthermore, the conclusion of the process of framing is not when the actors are seen to behave according to shared expectations. We need to take the analysis further and investigate in depth the implications of such expectations. This has already been done quite extensively in Chapter 5, where reference was continually made to the fifth aspect of the model of framing i.e. the power and authority which is implicit within all behaviour.

Young was concerned with conflict in mother/child interaction i.e. when the child did not conform to the mother's expectations described how the mother dealt with such conflict. The present investigation intends to focus upon such conflict within the doctor/patient situation and to see how such occasions are dealt with by both actors.

Young's thesis adopted an approach of outlining how such conflict could manifest itself, and then substantiated this by referring to illustrations taken from his data. The present thesis intends to accept Watzlawick's proviso that conflict is a most interesting occasion to investigate the relationship between content and relationship levels of communication and will make a tentative hypothesis that conflict will not lead to explicit metacommunication within the doctor/patient situation. Explanations for this will be offered.
50 consultations had been video-recorded as part of the earlier analysis. It was necessary to look at consultations in which expectations were disrupted and to analyse the interactions in terms of the content and relationship levels of communication. According to Watzlawick, disagreement could lead to the emergence of overt metacommunication. The present investigation is an analysis of whether or not Watzlawick's prediction is relevant to the doctor/patient encounter. It is predicted that metacommunication will not become explicit, and there will not be a breakdown in the relationship. The findings will be discussed from the perspective of Watzlawick's pragmatic approach and with particular reference to the social psychology of the doctor-patient encounter, and the influence of Goffmanesque processes.

The approach to be adopted within this chapter is as follows. Initially it is necessary to outline what explicit metacommunication would look like. To do this we return to the transcripts of consultations and to indicate how it would be possible for metacommunication to become explicit as a result of a conflict concerning power and authority within the relationship. It is assumed that an occasion such as the patient questioning the authority of the doctor to impose a regimen of treatment is a conflict concerning power and authority in the relationship, a conflict which is closely tied to the expectations for the situation.

The chapter will then move on to the consultations and look at instances of conflict or disagreement, where Watzlawick would predict we would witness the emergence of explicit communication.
The results of the analysis will be discussed in terms of the theory of framing, and the doctor/patient relationship.

**Explicit metacommunication outlined.**

Patient Cl has returned to the consultation of her own volition to comment upon tablets for blood pressure.

P: These tablets you gave me.

They're not making happen what they're supposed to.

This fills Watzlawick's criteria as an occasion in which the two levels of communication may become most interesting. The patient has raised a topic which is potentially problematic and could lead to disruption within the relationship. If the patient was to support this initial communication with further utterances which were more directed towards the doctor's authority to prescribe tablets, especially tablets which aren't having the 'supposed effect', there could arise a situation in which metacommunication becomes explicit e.g. the dialogue could continue with any of the following possibilities.

P: Are you sure you know what you are doing ... to be honest I thought you were supposed to make me better rather than worse.

P: I was really ill when I took them. I really don't feel like listening to what you tell me in future.

P: To be honest doctor I don't think that you have got the diagnosis of my condition correct.

Within these three hypothetical examples we can see how there are
questions being asked concerning the structure of the doctor/patient relationship. However, as Young pointed out, it is unwise to detach communication from the context within which it occurs. These three patient comments need to be viewed in the context of what precedes and what follows. As they stand, they give an indication that the patient is not happy with the consultation and were he/she to support this further, we could have a situation in which the relationship moved from being 'healthy' to 'sick', to use Watzlawick's somewhat unfortunate terms. To illustrate this we will continue the hypothetical in the example below. The patient continues,

P: I'm sorry doctor but I think I'm going to have to consult somebody else.

Here, we have a clear indication of metacommunication becoming explicit. The patient is questioning explicitly the basic format of the doctor/patient relationship and is actually preparing the ground for a breakdown in the relationship, possibly total. At this stage reached in the hypothetical example so far outlined, the patient is raising a whole array of interesting questions which if we look back to the expectations for behaviour in the consultation, questions the relationship. The patient is questioning the doctor's right and authority to carry out a further physical and/or verbal investigation, to offer a diagnosis, and to prescribe treatment. The patient is in fact questioning what was described in Chapter 4 as the frame for the consultation. To continue with this particular hypothetical example, the doctor could resort to explicit metacommunication. For example,

D: I think you would be wiser to listen to me. I am your doctor ... I am trained in medicine.
Here, the doctor is making explicit reference to the fact that he is the doctor, charged with responsibility for the patient, and his training is the basis of the power and authority he has to determine the patient's treatment.

It is wise to include only one hypothetical example of how the patient's relationship can begin to breakdown as an abundance of hypothetical examples will mislead the reader. However, it does provide an illustration of how such a process could occur and sets the scene for a metacommunicative analysis of where conflict does occur.

The following studies present an investigation of occasions within the 50 consultations when either: a) expectations were not realised. This was taken to refer to consultations where the doctor denied the presence of an illness. There were three such consultations, all taken from Group A, who were presenting their symptoms for the first time; or b) expectations were exceeded. This refers to situations where the patient questions the doctor's decision and raises a question concerning the efficiency or suitability of the treatment. (See 6.3.3.1 and 6.3.3.2).

The results of these studies will take the following format.
1. The name of the complaint, as offered by the doctor.
2. Type of patient.
3. Detailed discussion of transcripts.
6.3.3. RESULTS AND ANALYSIS

6.3.3.1. THE NON ATTAINMENT OF EXPECTATIONS

1. The name of the complaint as offered by the doctor.

In all of these cases, there was a hesitancy on the part of the doctor to ascribe a diagnostic, medical label to the illness. Patient S.11 was described as having 'photophobia', emotional problems in which the doctor questions his diagnosis and in doing so offers a broad psychosocial diagnosis. Patient S.13 is described as having a 'cough', and patient S.17 as having 'spots'. In comparison to other names offered by the doctor, such as 'tonsillitis', 'asthmatic', 'URT', it is clear that the doctor has difficulty in ascribing a medical label for the illness, which concurs with his behaviour within the consultation.

2. Type of patient.

Patients 11, 13, 17 were all children accompanied by an adult. This is interesting in that the only three consultations in which illness was denied or treatment refused happened to be the only three cases in which the patient was a child accompanied by an adult. One explanation which can be offered for this is that parents are involved with responsibility towards children and may be more likely to take their child to the doctor with a 'trivial' complaint. This could have led to a disruption in the consultation as one of the assumptions underlying the internal frame is that the patient is ill and requires treatment. Should the doctor deny this, he is essentially denying the validity of the expectations.

3. Detailed Metacommunicative Analysis of Transcripts.

Watzliwick's (67) metacommunication analysis will now be applied
to three symptomatic consultations. The analysis will take the form of a brief review of the events within the consultation i.e. Phase A, B, B2; the extract from the consultation in which the possibility of conflict arises, followed by a detailed commentary upon the transcript.

**Patient 11 (Symptomatic)**

The father has attempted to direct the doctor towards an investigation of the girl's eyes. The doctor has carried out both physical and verbal investigation. This extract begins with the doctor reaching the end of his examination.

D: Does this light hurt your eyes?

P: No.

D: Look over this way now. Okay. Turn around again. Good girl.

**PHASE B2 ENDS**

**PHASE C**

D: I can't see any abnormality. They look to be OK.

I can't honestly say I think she needs glasses. It may be that the symptoms she's having are just ...

The soreness and irritation caused by the light is not that uncommon to children of this age. I think what perhaps we should do is put some drops in her eyes so we can see how it goes. I don't think it's anything to worry about.

How are things around the corner since we left?

The doctor is standing, investigating the patient in front of the window.

D moves P around.

P sits

D continues to look at patient.

D sits.

Father comes back into field vision of camera, leaning on doctor's desk.

D looks at P.

D looks to notes and P intermittently.

P stands.

Father still leaning on desk.

D continues to look at P and begins to write.
F: Oh, not too bad at all.

D: I see you've got the physiotherapist there now.

F: Yes we get on quite well.

PHASE C ENDS

PHASE D
D: Just put two drops in each eye, three times a day for the next two weeks. If she's still having problems come back again.

D tears off prescription and hands to P.

F and P move to door.

PHASE D ENDS

PHASE E
D: Alright.
   Bye, Claire

F and P leave.

F&P: Bye.

CONSULTATION ENDS
Commentary on patient S11

As the transcript begins the doctor is coming to the end of his investigations. As the doctor moves from the patient and sits down he expresses his initial interpretation of the symptoms: "I can't see any abnormality .... they look to be OK". At this stage the father comes back into the interaction by leaning upon the doctor's desk, but he does not speak. The doctor is denying the presence of an illness .... and continues ...., "I can honestly say I think she needs glasses", thereby denying treatment. Here we have a perfect example of expectations relating to the consultation. The doctor has denied the presence of any abnormality and has questioned the need for treatment. Accepting Watzlawick's claim that disagreement is an opportunity for overt metacommunication one could expect disruption. However, within S11 there is no evidence of overt metacommunication as there is no explicit questioning of who has the
right to say and do what to whom and indeed the child and father offer very little more in the way of verbal contribution to the interaction. It is possible that this patient and father could walk out of the surgery and immediately attempt to consult another doctor which would certainly question the nature of the relationship. However, this did not occur and metacommunication did not become explicit.

Comment can also be made concerning the functioning of frames within the interaction. Having denied the presence of any abnormality, the doctor then proceeds to prescribe some 'drops' for the patient's eyes. "to see how it goes". Here, the doctor is dealing with the disruption of expectations, introducing the contradiction of admitting there is nothing wrong and then going on to offer treatment for it. Such behaviour is likely to reinforce the part which treatment plays in the doctor-patient relationship, and could reinforce the frame which the patient holds for the consultation. Furthermore instead of a frame whereby the doctor will prescribe when something is wrong, the patient may now assume that the doctor will prescribe even when there is nothing wrong.

**Patient 13 Father and Son**

This young boy was brought by his father who described the child's symptoms as a bad cough and sickness. The doctor then carried out an investigation of the child's throat, and listened to his chest with a stethoscope. The transcript begins as the doctor is coming to the end of his investigations. Both the doctor and father are sat down, and the child is stood in front of the doctor.
D: Pop your tongue out. D holds child's head. F puts tongue out.

F: Well, he doesn't really wake up ... he's sort of in a daze ..... Just choking up and pukes up, and then lies down again.

D: It's the time of the year. D allows child to move away.

F: The thing is, we've got a little boy with convulsions ... He was at Leicester a couple of weeks ago.

D: The point is children get colds all the time. ... viruses are around all of the time and ... children go through this process of building up immunity as they get older ... he's just doing this. What's happened is he's caught a cold, which inflamed all the passages at the back of the throat. This makes you produce a lot of phlegm and mucus. The trouble is he gets rid of the virus but one continues to produce mucus afterwards. They go on coughing, because when you lie down it collects at the back of the throat and tickles. D point to throat. There is no sign of infection in the throat. This is one of the things he's got, that he's going to have to get over on his own. As he is not contagious now, he's not going to pass anything on.

F: You see the little one has a throat and a temperature.

D: Yes. mm.

F: There's nothing I can get him that's going to loosen him up a little?

F puts coat back on child.
D: No, ... you see if there's stuff on your chest you can ... but it's not coming from up his chest ... it's all coming from up here, and it's draining downwards. The reflex is to stop it going further and so he's coughing. So, really, during the night prop him up with a pillow, give him Vic and some hot lemon ... and that's all you can do. In general terms if the child is well, he'll lose it himself. He's healthy enough in himself ... apart from the cough.

The consultation then proceeds into the final stages as the father and child stand and move to the door.

Commentary upon Patient S13

Within this consultation the father has described the patient's symptoms of coughing and being sick, and the doctor has carried out the expected investigation. So far, behavioural expectations have been confirmed with the patient presenting symptoms and the doctor carrying out an investigation. The doctor gives an early indication of his interpretation of the symptoms with, "It's the time of year". However, the crux in terms of the non-realization of expectations occurs when the doctor claims that, "There's no sign of infection in the throat ... , this is one of those things he's going to have to get over on his own." As in the previous consultation, although P is presenting symptoms, the doctor has denied the presence of an illness, and questioned the need for treatment.

The father reacts to the disruption of expectations, and clear evidence that the prescription of treatment was something he expected. "There's nothing I can get him that's going to loosen him
up a little?" In face of the doctor not offering treatment, and not even offering some type of cough mixture, the father explicitly asks for this. However, the communication is still focussed upon the content level, and the father does not sanction this with overt metacommunication. However, this must not be seen as a breakdown in the relationship as we need to place any communication in its context. If the father was to continue with such behaviours, we could witness a breakdown in the relationship.

However, it is interesting to note, as was the case with the last consultation, that the doctor does support his interpretation of the condition, and the need for no medical treatment, with advice for the father ... "prop him up with a pillow, give him Vic and some hot lemon." Within the context of the present thesis it is claimed that such behaviour exemplifies the strength of the expectations for behaviour within the doctor-patient consultation, and although the doctor has denied the need for any medical treatment he still feels obliged to recommend commercially available medication. Furthermore, the doctor has already said, "this is one of those things he's got that he's going to have to get over on his own", and in response to the father's request for "something" he says, "No" and yet the doctor goes on to offer a 'type' of medical advice, although there is no prescription for treatment as such.

Patient 17 Mother and Daughter

This young girl was brought by her mother, who was concerned about a rash developing all over her body. The doctor proceeded to investigate the spots and is coming to the end of his investigation as the transcript begins.
D: Turn around please.

This is a condition called *** but it will go away by itself ... it may take 2 months.

M: Two months! Gosh.

D: It doesn't affect her does it.

M: No, no. She doesn't complain.

D: It's not infectious, and people don't know what causes it ... but it goes away quietly on its own. Very often you get a patch which comes up first, and then you get blotches ... and everyone says she's got cyrhiasssis, but she hasn't.

M: So I should quietly forget about it. It's put my mind at rest though. I don't like to make a fuss, but I like to see they're right.

D: I'm very happy to see you. OK, cheerio Debbie.

M: Bye ...

Commentary upon Patient 17 (Symptomatic)

Again reference is made to the interviews in which major expectations of patient's were to gain diagnosis and treatment. In consultation 17, the doctor strengthens/confirms such expectations by actually naming the patient's illness. "This is a condition called "*****". However, the doctor continues with "it will go away by itself", and "it may take two months". In the space of one sentence the doctor
has confirmed one expectation i.e. that the doctor will provide a name for the patient's symptoms, and yet he denies the related need for any treatment, and in so doing disrupts/questions the expectations.

The mother reacts with "two months gosh", in which she expresses surprise that the doctor is not going to prescribe treatment and that the condition will take two months to go away by itself. This is another situation in which there could be a disruption of the nature of the relationship and the onset of explicit metacommunication. However although the mother is shocked, and expresses this on the content level, she does not go on to question the nature of the relationship on the metacommunicative level, eg. had the mother supported her initial surprise with an attack on the doctor's ability as a medical man, this would be an illustration of explicit metacommunication and lead the interaction onto the relationship level, and the development of a 'sick' relationship in which actors are uncertain of their own, and each other's roles, and in which a power struggle overtakes the flow of information.

6.3.3.2. DISRUPTION OF THE IDEAL TYPES IN TERMS OF THE EXCEEDING OF EXPECTATIONS.

The non-occurrence of expectations was not the only way the frames could be disrupted. There were a number of possibilities for the actors to exceed expectations, and could the model account for such occasions in which frame boundaries are exceeded. As with the previous study it was necessary to carry out an analysis of consultations when this occurred. A common occurrence in the chronic consultations was the patient questioning the doctor regarding the
diagnosis or treatment. Chronic consultations 1, 2, 8, 11, 13, 15, 22, 23, 25 contained evidence of the patient directly questioning the doctor. Such occasions provide an ideal situation for an analysis of the disruption of communication. Watzlawick's criteria of 'the phenomenon of disagreement' is certainly fulfilled and these consultations will be analyzed for the existence of explicit metacommunication. However, only 6 of these consultations will be included within the thesis due to restrictions of space.

To illustrate a hypothetical interaction sequence which could result from P questioning D, we can utilize Cl and continue the interaction sequence.

**P:** These tablets you gave me, they're not making happen what they're supposed to ...

**D:** Oh, they're not.

**P:** No ... So eh ..... I don't think they were doing me any good so I haven't taken them since.

In terms of a pragmatic (Watzlawick) analysis of this interaction sequence we can see that the actors are approaching a situation whereby overt metacommunication is a possible behavioural outcome eg.

**P:** I thought you were supposed to be able to make me better doctor.

I feel worse now than before I came to see you.

Here we can see how the patient has began to question the nature of the doctor-patient relationship.
D: You do, do you.

P: Yes, doctor .. to be honest .. I don't wish to complain but if you can't help me I'll go elsewhere.

Here we have explicit metacommunication which could lead to a breakdown in the relationship. The patient is questioning the doctor's competence and responsibility to treat his condition. Further, the doctor could contribute to the collapse of the relationship eg.

D: Well, if that's the way you feel, there's very little I can do for you.

Both patient and doctor have reached a stage whereby the patient has questioned the doctor's authority and ability to provide a suitable treatment, and the doctor has replied by offering the patient the ability to escape from the relationship. The expectations that the doctor will investigate, diagnose and offer treatment are being questioned and the interaction is more concerned with whether or not the doctor has the ability to provide such services and whether the patient wished to use such services. The relationship is becoming 'sick' and about to collapse as the interaction is more concerned with the relationship level of communication.

The study now goes on to look at Chronic consultations in which the patient did question the doctor regarding the diagnosis/treatment, and to look for overt metacommunication.

1. The type of complaint.

The majority of these complaints were longterm, 1. high blood
pressure, 2. urine infection, 8. eye problem, 11. knee, rheumatism etc., 13. acute red eye, back pain, sinus, 15. painful knee, 22. stroke follow-up, 23. eye cist, 25. asthma.

There was no pattern amongst the types of complaint in terms of them all being serious, life-threatening etc. However, the complaints did have disruptive effects upon the patient's life-style, although this did not make them particularly different from other chronic consultations.

However, the most interesting factor here is implicit in the criteria for selecting these consultations, ie. there was some kind of problem in the management of the case, at least as perceived by the patient. This implies that one of the assumptions underlying the construction of the ideal type of a chronic consultation, is that there is no dysfunction with regards to the treatment or diagnosis. In this sense the 'ideal type' begins to take on a moral aspect in that it does describe an ideal state of affairs but one which is not always adhered to.

2. The type of patient.

There was no pattern to be observed here as patients varied in age and sex.

3. Detailed metacommunicative analysis of transcripts.

The disagreement by the patient provides the perfect situation for the study of disturbances in communication. The thesis will now consider examples, taken from the consultations of occasions when disagreement occurred.

Patient 1 Elderly Female

This patient has chronic high blood pressure, and was placed upon new
tablets to control it, the last time she came to the doctor, because her old tablets were no longer manufactured.

D: Come in.  
P opens door.

P: Hello.  
P comes in.

These tablets you gave me, they're not making happen  
they're not supposed to . . .

D: Oh, they're not?

P: No ... So, eh . . .  
I don't think they were  
doing me any good  
so I haven't taken them since.

D: Now you were on them originally  
for your blood pressure.  
Yes, you were.  
Right now I think I'd like  
to take your blood pressure.  
P stands.

This consultation now progresses into an investigation of the patient's blood pressure. The doctor takes the patient's blood pressure and then takes off the arm band and both actors return to their seats. The interaction continues.

D: I don't think you need  
tablets.  
Your blood pressure is  
perfectly OK.

P: Is it ... Do you know I was  
dizzy when I took those ...  
so shall I leave them here.  
P still standing puts on her coat.  
D continues to write notes.

Commentary on Cl

In this consultation, the patient questions the treatment which the doctor prescribed in a previous consultation. The patient wastes no time in expressing her opinion of the treatment, and does not wait for the doctor to ask her how the tablets were affecting her. Immediately after being invited in by the doctor the patient opens
with "These tablets you gave me, they're not making happen what they're supposed to". It is interesting to look at the way in which the doctor reacts to the patient. "Oh, they're not", thus allowing the patient to elaborate details of the effects of the tablets, whilst the doctor is able to reconsult her notes, to begin a reappraisal of the patient's condition.

The consultation has reached a stage of disagreement which could give rise to explicit metacommunication should either of the actors wish to question the nature of the relationship, eg. Had the doctor reacted to the patient's initial comment with "I think you'd better let me be the best judge of that", we would have witnessed the onset of a possible crisis in the relationship as there was uncertainty over the patient's right to question.

The doctor decides to conduct the physical investigation of the patient's blood pressure. This could be taken as the doctor accepting, or not accepting, the patient's opinion. By reacting in this manner the doctor leaves her options for future behaviour fairly open and is allowed to do so as the patient does not overtly sanction her discontent by questioning on the relationship level. Having listened to patient and conducted her own investigation, the doctor agrees that there is no need for treatment and the relationship is able to continue without major disruption. However, it is interesting to hypothesise what would have occurred had the patient had high blood pressure and required further medication. This would have required a different strategy by the doctor, who may have had to call upon her control of specialist medical knowledge to justify the
patient's need for tablets, which may have taken a style similar to the hypothetical example outlined above whereby the doctor did utilise overt metacommunication.

Patient 8 Female 20's

The patient has been having problems with her eyes, and has been to see a specialist. However, she has returned to her doctor having had a disagreement with the specialist. The consultation begins.

D: Come in. It's Mrs Daly isn't it?
P: Yes.

D opens a letter from the eye specialist.
P: Ooh God!
P and D look to letter. P sits.

D reads letter. (Approx 30 seconds lapse whilst D reads).

D: Yes, I think we should get another opinion - a hospital opinion.

The consultation continues with the doctor carrying out an investigation of the patient's eyes, and her old and new glasses, and the patient is eventually referred to another specialist.

Commentary C 8.

The nature of the question in this consultation is different to that in consultation 1. Here the patient has returned to the doctor having gained no satisfaction from a specialist. The patient does not need to introduce the nature of the complaint as the specialist's letter does this. The interesting aspects of this consultation are that in face of dissatisfaction the patient does not resort to explicit
metacommunication and question the doctors authority, and secondly the ease with which the doctor is willing to offer the patient the opportunity to get another opinion. However, as this involves sending the patient to another doctor it seems slightly unnecessary for the doctor to carry out her own investigation, as the specialists advice will provide the basis to any future treatment. A possible explanation is that 'investigation' is part of the frame for the consultation, and the doctor carries out her own investigation to reassure the patient she was taking an active interest, to confirm expectations and to reassure herself.

Patient 13 Male Elderly

This patient is an elderly man who has diabetes. The doctor is investigating the patient's urine sample for signs of sugar, at which time the patient introduces a 'new' symptom.

D: So your feeling well are you?  D testing urine sample.  P puts tongue out.

P: Yes, not too bad ... but my feet.  D and P glance at each other.

D: What goes right to your feet? D and P in mutual gaze.

P: Pain ... It's the pain. As soon as I get into bed ... perhaps the circulation stops. These tablets aren't strong enough see.  P leans back in seat. I tried to take em two hours before they're not strong enough. How's that? Mutual gaze continues. Refers to sugar test.

D: Well, there's no sugar in it. D puts urine sample down on sink.

The consultation continues with a discussion of the patient's diabetes. At the end of which the doctor begins.
D: Right, I want to see your feet.  
P stands.
D directs P to couch.

P: Oh, I've got awful pain in my feet.  
P moves to couch.
D follows.

Commentary on Patient C 13.

This patient is an elderly man who has returned to the doctor for a regular check-up on his diabetes. Whilst the doctor is carrying out a sugar test upon the patient's urine sample, the patient introduces another complaint for which he is already receiving treatment, "but my feet" is the start of the patient's attempt to direct the interaction to the pain in his feet. Whilst the doctor continues the urine test, the patient questions the treatment, "these tablets aren't strong enough see." This was discussed in chapter 5, where it was noted that whilst the doctor is carrying out a physical examination, he is able to maintain control over the patient, and allow the patient to introduce whatever topics he wishes, whilst still maintaining this non-verbal control. (See Appendix 3).

However, from the perspective of metacommunication, we see the patient exercising his ability to introduce the symptoms, but moreover he is questioning the treatment, disagreeing with it, and this must be taken as an opportunity for the onset of overt metacommunication. So far, the 'power struggle' between the patient and doctor has been restricted to the content level, and the lack of sanctioning by either side prevents the occurrence of overt metacommunication.

Patient 22 Male Elderly
This patient had only recently had a stroke, and the purpose of his visit was for a 'check up' at the doctor's request.

D: Take a seat. D offers P a chair.

P: Well, this is the regular visit you asked me to do. P sits.

D: Yes, I did. D stands and looks at notes.

P: Regarding my progress in the last 6 weeks. D stands and looks at notes. Apart from that recent spell of heavy wet weather, which played me up a little I'm still getting a little twinge. D sits. D listens to P and reads notes. I've got nothing to report. But eh.. I wonder if some sort of therapy would help. I don't mind calling at the local hospital if you think it would help? P leans forward and back.

D: You get days off? I've got your piece of paper. D still looking to notes.

P: I had to go to the Royal Infirmary in Leicester in March for a fortnight. Your co-partner saw me before I went there.

D: Yes. Yep, you had a mild stroke.

P: Well, as I was saying. Apart from the recent spell of wet weather, which seemed to affect me, and occasional twinges, which make it look as if I'm struggling... I'm carrying on quite nicely. P leans forward onto desk.

D: So right... we will undertake what they say here... "The single most important factor in the future management of this patient is to keep his blood pressure down under control." Now, from your point of view,
you want to be able to do as much of everything you want to as you can ... Now, is there anything you can't do?

P: Yes, run, but I've no necessity to run.

D: Let's put it another way ... is there anything you want to do that you can't?

P: No...

D: Right then, there's no need to go to therapy cos they're not going to improve you to any extent, cos you can do everything you want to do now.

P: Would it strengthen me?

D: No, it'd be more likely to put your blood pressure up. Let's check your blood pressure. Look your never going to be as good as you were when you were 25 ... assuming you were good at 25.

Both move to couch.

The consultation continues as the doctor takes the patient's blood pressure and proceeds to prescribe a number of medicines, some of which are different to those he is presently on.

Commentary on P.22 (Chronic).

This patient has returned to the surgery at the doctor's request for a reassessment of his condition following a mild stroke. Early on in the consultation, the patient is in control of the content, and suggests to the doctor that some sort of therapy may help him. By doing this, the patient is questioning the doctor's management of the case and this could lead to a power struggle should the patient sanction this question with explicit metacommunication, e.g. P continues,
P: But, eh .... I wonder if some sort of therapy would help ... I'd like to get back to how I was before, and if you won't help me then I'll go elsewhere, as doctors are supposed to help you!

This is a hypothetical example of the patient moving to question the nature of the relationship. He is questioning the nature of the role of the doctor and the doctor's authority to prescribe treatment. However, this does not occur and it is interesting to note how the doctor deals with this suggestion by the patient. He makes recourse to a letter from the specialist and by calling upon this specialist medical knowledge the doctor is able to exercise control over the patient by referring to knowledge over which he, as part of the medical profession, is custodian, and in doing so deals with the question on the content level.

Patient 23 Male, Middle Aged.

This patient has returned to the doctor with cyst on his eye which he cannot remove. The consultation begins.

D: Come in sir. P enters room.
P: Thank you.
D: Take a seat. What can I do for you? P sits.

D stands and puts down notes.
D moves to look at eye.
P: It's no different.
D: The same again.
P: I apply the ointment twice a day right ... and it's just the same as it was before.
D looking at page.
D: Shall we see if we can get the eye boys to sort it out for you?

P: Yes.

D sits. P leans forward.

D writes.

This consultation continues with the doctor arranging a visit to the hospital for the patient, and reassuring the patient that treatment isn't urgently required ... if at all.

Commentary on patient C23

This patient has returned to the doctor with a cyst on his eye, and comments that the treatment has been ineffective. This consultation provides an interesting illustration of the non-occurrence of explicit metacommunication in that the doctor forstalls any such behaviour by immediately allowing the patient the possibility of a further opinion. Had this not occurred, the patient may have introduced obvious dissatisfaction with the specialist in the present relationship which could have taken the form of explicit metacommunication.

6.4. DISCUSSION

The analysis presented in Chapter 6 is based upon the results of the interviews described in Chapter 4 and a review of the Medical literature. A model of framing was constructed in which certain higher order (upper level) frames were seen as applicable to the doctor-patient consultation. That the patient should describe the symptoms, and the doctor investigate, explain and name the symptoms, and offer treatment is compatible with Kennedy's (81) description of the medical endeavour, and Parsons' work (51, 75) on the doctor's role and the sick role. However, the model of framing contains
Bateson's (73) proviso that if expectations are not adhered to there will be some form of interactive disruption. Therefore we are not just talking about expectations as possibilities, but from a framing perspective expectations as probabilities. The extent to which such upper level frames are adhered to was the justification for the studies described in Section 6.3.

Having made the assumptions that the expectations contained within upper level frames were valid for the doctor-patient consultation, it was necessary to test this, by looking at consultations when 'out of frame' behaviour occurred. The model of communication put forward by Watzlawick et al (67) would predict that if actors disagreed as to the nature of the relationship between them this would reflect the interaction, and a 'sick' relationship could develop. However, within the present thesis it was clear that the non-attainment of expectations or the existence of conflict did not of necessity lead to overt metacommunication.

A Goffmanesque type explanation can be offered for the lack of overt metacommunication. Perhaps the doctor, and particularly the patient engage in a whole array of impression management techniques. Stimpson and Webb (75) wrote: "there is an assumption that the doctor is the possessor of special knowledge, and hence both patient and doctor collude in setting a scene in which the doctor can act like a doctor, and the patient can act like a patient". By utilising techniques of impression management, a working concensus is maintained - the interaction 'looks good'. Bloor and Horobin (74) note that such techniques are employed simply because their use is
part of the learned 'ceremonial order' of things and this does not need to reflect a genuine trust in, or respect for, the competence of the doctor. However, this question must be taken further. OK, the patient colludes to maintain a working consensus, but why?

Silverman (84) pointed to a number of reasons, such as, professional dominance and expert power (see Friedson 74) and a politeness ethic, which interestingly enough was not addressed to the patient but more to the doctor's politeness to avoid exploring 'awkward' or 'embarrassing' aspects of patients' situations. Goffman (59) and Stimpson & Webb (75) would probably put the boot on the other foot and explain the lack of disruption in terms of the patient's desire to please the doctor and emerge from the encounter without 'loss of face'. Although, on the basis of the evidence, such face saving techniques are probably more beneficial to the doctor than the patient.

To take this discussion one step further, the lack of overt disruption can be explained in terms of the principles of self-justification (Aronson 72). The doctor has undergone at least six years of intense medical training and yet is confronted with a typically dissonance provoking possibility (Festinger 57) - that he/she is unable to deal competently with many patients. To deal with the dissonance created by this, the doctor may act in the manner which Balint (73) pointed to i.e. to act like a doctor. Even though the doctor's knowledge is never complete, the doctor acts 'like a doctor' should and the patient colludes, because the dissonance which would result from overt disruption would be psychologically
disturbing. When we look at the broader social process which Kennedy points to in "The Unmasking of Medicine" (82), whereby "a social institution has developed in which our symptoms must be related and referred to medicine, it is not surprising that collusion is maintained in face of conflict.

From a theoretical perspective, reference can be made to the work of Parsons (51, 75) on the sick role, and the doctor's role. Recent studies by Todd & Still (84) and Todd (86) have questioned the ability of Parsons' formulation to fit the doctor-patient relationship in cases of terminal illness. The present thesis must offer another observation in this direction that Parsons does overestimate the reciprocity and complementarity between the doctor and the patient. Within the present work, 9 out of 30 'chronic' consultations contained instances of potential conflict, and although it has been argued that doctors and patients work to avoid such conflict having a disruptive effect upon the interaction, the possibility must be incorporated into any model of the relationship. The need of the patient to seek competent help is questioned if we raise doubts about the competence of medicine.

This issue of whether or not patients are willing to question the doctor is an important one. French and Raven (59) and Rodin and Janis (79) claim that patients feel they lack the knowledge to question the doctor. The hypothesis was generated that private patients may be more willing to question, but as Silverman (84) observes, "private patients do not challenge the clinical judgements of the doctor". However, the qualitative approach of the present
thesis has shown how patients do question the doctor, and not just on the structure of the agenda. Granted the questions are not taken to the extent of disrupting the relationship but if we look to one medical outcome of patients questioning the doctor's judgment, e.g. in the second study, although the doctor found no signs of physical illness he did offer some treatment and in the third study when the patient questioned the treatment it was sufficient to bring about re-evaluation and change. Hopefully the myth that the patients demand diagnosis and treatment was destroyed in Chapter 4. The present chapter has certainly shown how the patient is more able to take an active role in the management of his condition and is not only capable but also willing, to be actively involved in assessing the efficiency of treatment - an active involvement which does not lead to open conflict.

Furthermore, whether or not the lack of overt conflict is the consequence of actors attempts to maintain a working consensus (Goffman) or individual self justification (Aronson 80), such processes introduce an element of fraud into the relationship. The doctor-patient relationship is based upon false foundations, and social psychological processes have as much to do with the veneer of efficiency which surrounds medicine, as does the inherent efficiency of medicine. At this stage, we can look to the work of George Kelly whose personal construct approach to human psychology noted how man was a rationalising being rather than a rational one. We look for consistency rather than truth.

Within the constraints and restrictions of upper levels of frame,
there is the opportunity for individual consultations to contain lower level framing behaviours. Study 6 was an initial investigation of the extent to which education interventions can operate as lower level frames. In naming and explaining the symptoms the doctor certainly has the ability to elaborate further details of the patient's condition, and possibly help avoid it in future etc. Although a study of this size can only make tentative suggestions it does appear to be the case that there is great variability in the use of lower levels of frame. The occurrence of a pedagogic frame varied in consultations involving different doctors, and more interestingly in different consultations involving the same doctor. Studies by Byrne and Long (76), Tate (83) and Buijs, Sluijs and Verhaak (84) have investigated the notion of doctors' styles, and whether or not it is viable to look for consistencies in the way doctors behave. The occurrence of the pedagogic frame showed itself to be influenced by actors peculiar to the individual doctor, patient and illness. As such, the variability of this must certainly question the possibility of a consistent doctor's style.

One direct question, which arose from the study and relates to the educational function of the consultation, argues that education interventions are a crucial aspect of the medical process (McClellan 86). However, Balint (73) noted that the average length of six minutes per consultation places restrictions upon possible behaviours. The present thesis adds to this by noting how the existence of one lower level frame may exclude the operation of other lower levels of frame. For example, the operation of a pedagogic frame may exclude the operation of a compliance frame. As such any educational
interventions by the doctor may exclude the possibility of avoiding non-compliance, and vice versa. It follows that if medics are interested in educational and compliance related issues they need to be made aware of the need for a structured approach to any interventions they may make.

The present thesis has shown how we can isolate Phase C (Consideration of the Condition) as the location of educational interventions, and we could isolate Phase D (Detailing Treatment) as the place for compliance interventions. A more structured approach to such problems would benefit both the doctor and the patient in overcoming many of the problems highlighted within the literature.
CHAPTER 7

DISCUSSION AND IMPLICATIONS
One of the fundamental observations made early on in the thesis, was that if we approach the doctor-patient relationship from a different perspective, we are liable to observe a different kind of problem than has been the focus of more traditional studies e.g. Byrne and Long (76), Ley (67, 83), Pendleton (79, 83). The present thesis noted that there were a number of contradictions in the literature on the doctor-patient relationship which needed to, at least, be taken into account, when attempting to explain events within the consultation.

Kennedy (81), in his serialisation of the Reith Lectures, confirmed the observations of other authors, e.g. Friedson (75), Fox (75), that medicine is not an objective science. Repeated reference has been made to those who have looked at diagnostic inconsistency within the medical profession (Fletcher 52, Koran 80, Mechanic 78) and authors of a more theoretic persuasion have looked at conflict within the relationship (Friedson 75, Bloor and Horobin 75).

The work of Zola (75), Conrad and Schneider (80) and Illich (76), has pointed to a process of medicalisation, and how medicine somehow 'mystifies' the experience of illness, and furthermore monopolises legitimate medical knowledge (Waitzkin 85, Waitzkin and Stoeckle 72). Implicit within the work of Verhaak (86), Williams & Clare (79), Cartwright and Dunnell (72) and Shepherd et al (69) is an awareness that many of the problems presented within general practice may not be 'medical' and as such, the biomedical perspective (Robinson 73) may not be the most suitable approach to use.
Although the present thesis cannot evaluate the scientific credibility and relevance of the above literature, it accepts that they will exert an influence upon the doctor-patient relationship, an influence which may be able to account for some of the difficulties encountered by authors such as Pendleton (83) and Ley (83). Although Pendleton makes explicit his awareness of possible inherent weaknesses within the medical approach, he does not think that it is legitimate for behavioural researchers to offer any observations on what are purely medical matters. However, we must not ignore such fundamental concerns and go ahead to reduce our analysis of the problems of the relationship to the interaction between doctor and patient, and to focus upon communication difficulties and a dearth of communication skills, in our attempts to explain events within the consultation, implicit within which, are suggestions for change.

This approach finds support in the work of Strong (79), who argued that the communications approach of people like Pendleton and Byrne and Long, by emphasising the individual, renders the organisation transparent. Strong argues for the need to widen the perspective and to look at the structural context, within which individual action occurs. The present thesis is almost a logical development of the work of Strong (79) in that it has attempted to explore the structure of expectations, and has commented upon the reflection of structure and context within the interaction.

Before moving further into the discussion, a number of points need to be made concerning the structure of the thesis, and structure of this discussion. The thesis has moved away from the traditional approach
within social psychology, and has questioned the utility of positivistic, experimental studies of a topic such as the doctor-patient relationship. Furthermore, the lack of quantitative analysis and emphasis upon interpretative explanation reflects a belief in the qualitative approach within social psychology. However, the present author has supported a largely interpretative thesis with a small amount of quantitative data, where it was felt to benefit the analysis and add depth to, for example, the expectations of patients and the incidence of framing. It cannot be denied, however, that such an approach presented problems in terms of organisation of the thesis and it is hoped that the reader was not too confounded by an integration of qualitative and quantitative data.

The discussion which follows is basically divided into three parts: theoretical, methodological and applied. However, due to the implications that each has for the other, they are often discussed together.

The major thrust of the present thesis lies implicit within the processes of specific, medical and diagnostic framing, as is clearly illustrated by the almost compulsive exploration and elaboration within Chapter 5. The argument is that these three processes are fundamental and crucial to our understanding of events within the relationship. The theory of frames and framing places a constraining influence upon the possibilities for development and modification of social situations. Within the doctor-patient relationship there are established patterns of behaviour, which actors conform to, and furthermore find it difficult to go beyond. When we delimit such
behaviours e.g. the presentation of symptoms, the investigation, naming and explaining the symptoms, and offering some form of treatment, it becomes clear that some of the innovations suggested within the literature are going to be extremely difficult, if at all possible, to implement.

Not only is the medical profession itself very conservative and reluctant to change (Hudson 67), but the social psychology of the consultation also functions to oppose change. As Kelvin noted in 1970, there are "subjective probabilities" and those expectations which have a very high subjective probability are almost certain to be realised, regardless of whether or not they are suitable, applicable etc. When we delimit the upper levels of frame, as we have, there appears to be little scope for further, alternative development.

However, the present thesis can contribute a certain amount of optimism to those attempting to restructure the consultation. Within Chapter 4, it was shown that it is only on the surface that the patients adhere to such traditional expectations, and that deeper exploration showed how many patients were able to question and elaborate upon their initial response. In light of this evidence, one can expect patients to be more flexible and amenable to change than doctors and researchers may believe.

The aim of many attempts to restructure the consultation is to facilitate the ability of the general practitioner to deal with psychological problems, and the psychosocial aspects of physical
illness. However, Branthwaite (86) recently noted how the style which many doctors use is governed by the history of the practice, within which they operate, and as such there are further difficulties in initiating change. Moreover, a number of studies have shown how doctors tend to be happier dealing with organic illness. The most noteworthy of these is McDonald and Patel (75) who showed that even psychiatrists preferred organic to functional complaints.

There are, therefore, many factors to be found within the present thesis, and within other literature which point to the difficulties of initiating change within the consultation. However, one question which needs to be asked is whether or not general practitioners should broaden their skills to be able to deal with 'psychosocial' problems. The present thesis has shown how the ideal typical formulation of a symptomatic consultation fits those types of conditions which the medical endeavour is traditionally oriented to dealing with. Maybe we should not attempt to bastardise a profession for the sake of omnipotence. Such developments may only enhance the 'Apostolic' function of the medical practitioner (Balint 64).

The notion of frames and framing, has until recently, found a more compatible 'bed-fellow' in the study of mother-child interactions, rather than the study of doctors and patients. However, including the present thesis there are three studies which have attempted to apply the notion of framing to the doctor-patient situation. All are compatible with each other, although as was highlighted within Chapter 5, they focus upon different aspects of the framing process. Strong's (79) analysis of the 'ceremonial order' focused upon the
'artificial' or 'rule-governed' aspects of the situation, although it was pointed out that his approach seemed to have more in common with Goffman's earlier formulations (56), and as such is compatible with the explanation offered within Chapter 6 for the lack of overt metacommunication.

The conflict and confusion surrounding the operation of Andreoff-Evans (86) frames, will take place within the constraints of the processes of specific, medical and diagnostic framing. In the same way that attempts to modify the structure of the consultation are constrained by these upper level frames, so will be the effect of the individual physician's attempts to be more appreciative of the cognitive representations of his patients.

Within the present thesis a frame was taken to refer to a recognisable unit of recurring organised behaviour, which may be reflected within the expectations which actors hold for a situation, although for various reasons actors may find it difficult to express such frames due to their being 'unconscious' or, as is more likely, taken-for-granted. Such frames are further distinguished by the power inherent within the behaviour, and the ability to influence the behaviour of another. Kaye (82) noted how there was a gross parental frame whereby the mother created a 'microcosm' within which the child would function. This parental frame is comprised of lower level frames e.g. nurturant, protective, instrumental etc. The present study noted three upper level framing processes within the doctor-patient consultation, within which it may be possible to discern lower level frames e.g. pedagogic.
One possible question at this stage is why 'frames' as opposed to a more commonly used notion such as 'roles'. Within the present thesis is an implicit critique of explanations which present a rigid expose of role theory and the use of the ideal type. To attempt to explain social behaviour by singularly referring to 'roles' appropriate to a situation occludes individual variation.

However, it may not be the concept of role or ideal type, which is wrong, but the particular form which a theorist has outlined e.g. it is possible to argue that 'role theory' is the most useful way of conceptualising the doctor-patient relationship, but that Parsons' (51, 75) elaboration of the 'doctor's role' and the 'sick role', do not represent a valid description. Todd and Still (84, 86, 86) have used role theory to develop the Parsonian analysis, and suggest the need for a "role for doctors which parallels the patient's dying role, as distinct from the sick role" (Todd and Still 84). However, it is felt that this will still occlude individual variation amongst consultations dealing with terminally ill patients e.g. a patient who has suffered gradually worsening diabetes at 75 years of age is liable to react differently to the diagnosis of a treatment for cancer, than is a 'healthy' 40 year old. Yes, the 'dying role' must be acknowledged, but as was mentioned in Chapter 5, it must not become 'objectified'. Furthermore, Kent (86) in a study of "patient preferences for information" found that there was "substantial variation in replies" and a wide range of preferences. He concluded that there is not a typical patient, and subsequently we will not find a typical patient within the consultation.
A second factor promoting the use of 'frames' as opposed to 'roles', is that frames allow us to appreciate the interactive nature of the situation. Within Parsonian type models, there is a reference to the doctor's role, the sick role etc, as if they were features peculiar to the individual. Although within the present thesis the processes of specific, medical and diagnostic framing tend to have their origins in either doctor or patient, their existence within the consultation is very much an interactive one. In the same way as we should not detach the behaviour of actors from the social context within which it operates, so we should not study the doctor and patient in isolation from each other. As Kaye (82) notes, meaning is something which is shared, and finds itself manifest in the interactions between partners.

Recent work within developmental psychology has moved away from the 'tabula.rasa' picture, to one where the child plays more of an active role in its own development. Although the extent of this active involvement is still questioned as is reflected in the sub title of Kaye's (82) book, "How Parents Create Persons", a similar theme can be detected in work on the doctor patient relationship. It was recently suggested (Kent 86) that research in this area has swung in the direction of patient-centred studies, as was illustrated by the number of papers at a recent conference (The Doctor, The Patient, The Illness July 86) which were studies of patients rather than doctors e.g. Robinson (86), Addington-Hall (86), McGhee (86), Kent (86), Kat (86), Anderson (86). However, in the same way that Kaye seems reticent to drop the banner of parental influence, the present author would argue that patient-centred studies still take place within the
constraints of mainstream medicine, and as such patient responses will be governed by the framing processes described above.

One final justification for the use of 'frames' as opposed to 'roles' is contained within the heritage of frames. Both Goffman (56) and Waitzlawick (67) allow us the facility of looking at how individuals may interpret and express themselves, and bring a limited amount of individuality to their behaviour.

It is possible at this stage in the thesis to outline some of the functions which frames perform within the doctor-patient relationship. As within the mother-child situation, they guide the interaction, so as to avoid constant questions such as "What do I do now?", "What do you want me to do?" and in this way are similar to roles. Furthermore, they offer commentary upon the nature of the relationship between the doctor and patient e.g. inherent within the medical frame is that the doctor, on the basis of expertise, and collegial authority (Strong 79), has the right to carry out an investigation of the patient.

One of the directly applied functions of frames is to return the patient to health within the traditional channels. By this, it is meant that within the doctor-patient relationship in general practice, any attempts to restore the patient to health (assuming he is ill) must take place within the constraints of specific, medical and diagnostic framing. Interesting questions arise if the patient does not have a physical illness. Frames also function to restrain the occurrence of behaviours which may be detrimental to the
relationship (detrimental to the relationship rather than the patient) e.g. to avoid the patient asking disruptive questions, and sustaining such questions, to an extent that may undermine the very fabric of the relationship.

One of the more contentious of the functions of these frames is that it is argued that frames will restrict the development of knowledge and understanding with regards to health and illness. The inability of the patient to 'learn' about his illness has already been extensively documented by Waitzkin (85), and the present thesis highlighted the variable nature of pedagogic interventions. Furthermore, the ability of the doctor to learn about the social aspects of the patient's illness, is not only limited by the lack of social context (Sankar 86), but also by the difficulty of stepping out of a frame, which is oriented towards biomedical understanding.

Continuing this discussion of framing, David Young (78) claimed that when the child was able to operate spontaneously in terms of the frame as offered by the mother, this was said to indicate adult competence in framing. However, Young's work was often value-free and he, (never mind the child) did not question the correctness of the rules surrounding the ball and shapes game. Within the doctor-patient situation adult competence in framing may be indicated by both actors operating simultaneously in terms of the three directions of frame outlined. For the patient this may include what Parsons (51) described as the need to contact competent agencies. However, surely there is a further development whereby the individual begins to question the competence of such agencies.
Stimpson and Webb (75), in their classic analysis of 'going to see the doctor', began on the assumption that, "for the purposes of description of the consultation process, the person has come to see consultation with the doctor as appropriate for the problem". It may be useful to begin analysis with such a view of the patient, but this does not deter the possibility that the doctor may not be the most appropriate person for the patient to see. Theorists sympathetic to the work of Illich (76) could argue that patient development is optimal when he/she realises that the doctor is not the appropriate person to see.

Throughout Strong's (79) analysis of the 'ceremonial order' of the clinic there is reference to patients 'living up to' and fulfilling the bureaucratic format. However, one question which Strong did not explore at length is the extent to which the doctor fulfilled the requirements of the bureaucratic format. Doctors were described as accepting the moral worth of the patient. However, what would happen if patients engaged in 'character work' and began to dig below the doctor's ceremonial display? According to Strong (79), "medical incapacity did not ... present a major challenge to medical authority". The studies outlined in Chapter 6 of the present thesis pointed to occasions whereby conflict could have arisen. However, patients did not follow up their questions and did not threaten the relationship. In this sense, competence seems to facilitate the status quo, and optimal development would involve achieving a Piagetian style of questioning the rules. Strong accepts that "there are many instances where something rather better than the standard bureaucratic package is desirable". The present thesis observes that
whether you call it the bureaucratic format or a framing process, it is difficult to escape from. Indeed the assumption is made that the processes of specific, medical and diagnostic framing are more wide reaching than even the bureaucratic format, and that they will also function within private medicine.

One of the main conclusions of Chapter 4 was that patients do have a valid set of expectations for the consultation. This concurs with Fitton's (79) observation that the patients in their study, "appeared to have a realistic set of expectations". However, the present thesis adds the proviso that there is an element of mutuality between the expectations of patients and doctors which acts as a bond between them, and furthermore provides the backcloth against which the meaning of the consultation will be expressed.

The studies described within Chapter 4 showed how it is possible to construct a traditional picture of the consultation, in which patients present symptoms, and doctors investigate, diagnose and treat. However, further explorations of the interview, clearly showed that the traditional structure of the consultation is not necessarily what patients expect or want. Recent work by Biddle (79) and Harre (79), has pointed to the need to question the initial responses which subjects make within interviews. Taking this into account the present thesis has shown that on the surface there is a reciprocity between doctors and patients, in their descriptions of what they expect to happen in the consultation, and that this acts as a suitable guide for behaviour. However, patients certainly expressed a willingness to move away from this traditional structure, and as
was mentioned earlier, if given the opportunity, they would probably do so.

One further conclusion of the present study is that it suggests that there is greater individual variation in expectations than has been suggested to date e.g. in Stimpson and Webb's study (75), it was noted that, "nearly two thirds (of patients) said they expected they would be given a prescription". Within the present study the figure was well below 20% for patients expecting prescriptions. The present author would argue that theorists such as Stimpson and Webb (75) and Balint (73) have created a picture of the patient which is somewhat discrepant with the facts. Initial responses may create the picture of a 'typical' patient, but typical patients are rarely found in reality.

One question which was raised in Chapter 1, was whether or not there is any evidence within the consultation of the processes of sponsorship (Duff and Hollingshead 69), medicalisation (Conrad and Schneider 80, Zola 75) and mystification (Illich 76). To answer this question we need to call upon the theory of framing which states that certain patterns of behaviour are invariant aspects of the consultation. To argue that the processes of specific, medical and diagnostic framing invariably occur across the majority of consultations, and to further claim that inherent within such processes is the transformation of the patient's symptoms into a form which only the doctor can comment upon, is a clear indication of the process of medicalisation within the consultation. The work of Armstrong (83) on the "clinical gaze", and Telles and Pollack (81) on
where patients locate illness supports the operation of medicalisation on the micro as well as the macro level.

A side issue here concerns a research project currently underway in Britain (Taylor 86). In attempting to train doctors as psychotherapists, one of the main difficulties so far experienced, is the reluctance of doctors to relinquish responsibility, and to allow the patient to re-accept responsibility for his own condition. That doctors are finding it difficult to relinquish responsibility may be related to an observation of Stimpson and Webb (75) that, "any attempts at educating people about medicine will face the problem of doctors' attitudes to patients displaying such knowledge in a face to face encounter". Any such knowledge is liable to make the patient more questioning, and as has been noted, doctors do not particularly like that (West 83) and they are reticent to give information away (Waitzkin 85).

Perhaps this issue of the transfer of responsibility and the possible development of a dependence upon medicine, is clarified by referring to the work of Seligmann (75) on "learned helplessness". To relate this to the doctor-patient relationship one could argue that a patient learns that the management of his condition is primarily governed by medical interventions. Whether or not the patient's assessment is correct, he learns that he is helpless in attempts to manage his own condition. Any individual doctor's attempts to relocate responsibility for the condition is going to be difficult because the one consultation they attempt this in, or the condition they attempt this with, is part of a history of the doctor-patient
relationship in which the process has been the other way round. As Kat (86) noted, "people who have symptoms or illness are no longer responsible for their own life condition ... it's not my life ... it's my illness". Again this is going to hinder the attempts of those developing the C.A.R.E. project whose aim is to return to the patient responsibility in conditions of rheumatoid arthritis (Balmer 86).
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APPENDIX 1

1. What do you expect to happen in the consultation?  
   What next.....what next.....anything else?

2. What do you expect of yourself? (patient/doctor)  
   What next.....what next.....anything else?

3. What do you expect of the other? (doctor/patient)  
   what next.....what next.....anything else?

( The following questions were not administered to doctors )

4. Do you know how to behave?

5. What tests can the doctor do on you?

6. The doctor is not listening to you....  
   what would you do?

7. The doctor doesn't prescribe the treatment you want.  
   What would you do?

8. The doctor doesn't investigate ..............  
   what would you do?
9. The doctor does not do what you mention in Q.6....
What would you do?
APPENDIX 2: DETAILS / DOCTORS COMMENTS RE 50 CONSULTATIONS.

1. PATIENT NUMBER.

2. PATIENT SEX.

3. PATIENTS AGE, (APPROXIMATE)
   - 10YRS (1)
   - 10 - 20YRS (2)
   - 20 - 35YRS (3)
   - 35 - 55YRS (4)
   - 55 + YRS (5)

4. WHICH DOCTOR....THERE WERE 4 DOCS IN STUDY

5. NUMBER OF TIMES SEEN BY DOCTOR AT ALL.

6. NUMBER OF TIMES SEEN WITH THIS COMPLAINT.

7. SYMPTOMS.

8. DOCTORS WERE ASKED TO NOTE ANY SIGNIFICANT COMMENTS OR THEMES.

9. CONSULTATION INTERACTION INITIATED BY DOCTOR OR PATIENT?

   (see over)
<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Age</th>
<th>Doc</th>
<th>Time Seen</th>
<th>Symptoms</th>
<th>Significant Themes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>Obesity</td>
<td>Obesity in 16 yr old girl. Encouragement offered, and seemingly gratefully accepted.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td>Allergic to animals</td>
<td>Allergic response. (this D girl has been before with early anorexia nervosa. I should have looked at this again.)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>Bleeding in pregnancy</td>
<td>Depressed...perhaps she is worried about the meaning of her bleeding on the baby.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>Weight prob</td>
<td>Weight problem</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>Eczema Wart Pill</td>
<td>Eczema, wart, request for oral contraception.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>Eczema Pill</td>
<td>Anxious about oral contraception</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>Chest pain Water tabs Cough</td>
<td>Smoking issue. 20+ per Told to stop.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>Prolapse Minimal prolapse...also required cardiac check and blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>Cough Elbow pain</td>
<td>Missed consultation</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>Pill</td>
<td>Contraception request</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>Photophobia,</td>
<td>Irritating eyes. Photophobia.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Emotional problems</td>
<td>7 emotional problems Avoided discussing this.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>Cystitis</td>
<td>Painful passing urine. Wanting relief.</td>
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<tr>
<td>13</td>
<td>M</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>Cough</td>
<td>Worried cos brother had D infantile condition.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>F</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>Chest pain</td>
<td>Unwell, Chesty, Possible D on exertion stress at work. Wanted something to make her feel better.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>M</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>Indigestion Ulcer before. Didn't ask D Stomach and why...passed the buck. abdominal pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>M</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>Face rash</td>
<td>Spots on face Acne. just wanted reassurance as going to America.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>Rash, spots</td>
<td>Mother worried.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>F</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>Sore throat</td>
<td>Desire for sick note Neck Tonsillitis. May have glandular fever.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>M</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>Heart burn</td>
<td>Worried may be Asthma Ulcer type pain.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>M</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>Sore throat</td>
<td>Due to U.R.T.I Sings with band.</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td>AGE</td>
<td>DOC NUMBER</td>
<td>TIMES EVER PRESENT</td>
<td>SYMPTOMS</td>
<td>SIGNIFICANT THEMES</td>
<td>COMMENTS</td>
<td>START</td>
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<td>F</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>Blood press</td>
<td>Tablets for blood</td>
<td>P</td>
<td></td>
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<td></td>
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<td></td>
<td>Usual tabs</td>
<td>pressure not needed</td>
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<td>no longer</td>
<td>84 yr old who enjoys</td>
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<td>made.</td>
<td>life.</td>
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<tr>
<td>F</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>Follow up</td>
<td>Tired ? Due to long</td>
<td>D</td>
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<td></td>
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<td>urinary</td>
<td>hours...not kids or</td>
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<td>infection</td>
<td>marriage.</td>
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<td>M</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>Eczema</td>
<td>Also hyperactive child</td>
<td>P</td>
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<td></td>
<td>Mother suggesting needs</td>
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<td></td>
<td>school.</td>
<td></td>
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<td>F</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>Periods</td>
<td>Examination because of</td>
<td>P</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Pill</td>
<td>prolonged bleeding</td>
<td></td>
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</tr>
<tr>
<td>F</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>Pill</td>
<td>Repeat prescription</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>Hypertension</td>
<td>Blood pressure check</td>
<td>D</td>
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<td></td>
<td>Gaining weight</td>
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<td></td>
<td>Mentioned cough as aside</td>
<td></td>
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<tr>
<td>F</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>Pill</td>
<td>On oral contraception</td>
<td>D</td>
<td></td>
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<td></td>
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<td>for adolescent dysmen-</td>
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<td>26</td>
<td>M 1</td>
<td>4 2</td>
<td>Ear ache</td>
<td>Had whooping cough earlier this year. Father works nights</td>
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<td>27</td>
<td>M 5</td>
<td>3 3</td>
<td>Prostate op follow up</td>
<td>Discomfort on passing water. Removal of prostate gland 5 weeks ago.</td>
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<td>28</td>
<td>M 2</td>
<td>1 1</td>
<td>Spots, boil on face</td>
<td>For repeat course of tablets which helped before.</td>
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<td>29</td>
<td>M 3</td>
<td>7 5</td>
<td>Nerves Repeat of stomach medicine</td>
<td>Generally nervous disposition. Wife thought she might be expecting twins.</td>
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<td>M 4</td>
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<td>Rash</td>
<td>Eczema? Rash</td>
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APPENDIX 3. A THEORETICAL AND METHODOLOGICAL ADJOINDER.

One of the problems for the analysis outlined within chapter 5, was the occurrence of a group of behaviors which did not readily fit into one of the three upper level patterns of framing process. Comments such as 'gosh its a nice day isn't it', and 'did you come on the bus' required some form of explanation.

In terms of the theory of framing such behaviors were ascribed to a category entitled 'Non - Functional Dialogue', and it proved an interesting exercise to ascertain where such occasions occurred within the consultations.

This appendix will present an analysis of non - functional dialogue as it is incorporated within the present thesis, and then relate it to broader concerns, not 'directly' related to the theory of framing. The analysis will take the form of commentary upon extracts from the consultations.

eg 1. Symptomatic 5 : Female. pill, ezcema, wart.

D : You're going on for 18 ?

You feel o.k ?

D moves to P

P : Yes.

D places

D stands.. takes

D places

sphygmononometer on P

arm.

P : I was a chambermaid.

D stood.. takes
D : Ah yes. All summer?
P : Yes.
D : Do you like it?
P : Yeh its not to commercial.
It's a good place.

...this conversation continues.....

eg 2. Symptomatic 9 : Female. cough, painful elbow.

D : I think I'd better listen to you. D stands up.
It's probably nothing more P stands up.
than an irritant. P lifts pullover.
Pull it up.
It's a bit cold out isn't it? D moves to P with
This is probably cold stethoscope.
P : Ahh...
D : Ha ha..

Within these two examples we can see how the doctor has
allowed the content of the consultation to move into a
consideration of issues not directly related to the
condition. From a framing perspective this could be
explained in that the doctor already has control over the
patient via the investigation and therefore the medical
frame is operating. This is more interesting when we note
the absence of social conversation in general.
P: I sit like a zombie at work. D writing notes.
D: Wired up for sound. D glances up.
P: Shorthand was the best...no one knows shorthand these days.
D: My sister does shorthand.
P: I'm the only one in our office who can do shorthand. If anyone wants it it's me who has got to do it.
D: It gives you a feeling of power.
P: Court work or out like that... I hate it.............

This interchange continues.

D: And hows Kelly?
P: I wouldn't say no but she has got a terrible cough.
She was sobbing her socks off.
she makes us all laugh......
she likes you!

Within these two interchanges the significant non verbal behavior is the doctor writing notes or a prescription for the patient. Again from a framing perspective the patient is almost allowed to control the content of the consultation, because any such control is only a token
gesture as the doctor is getting on with the business at hand, i.e., investigation and treatment. The upper level frames are in control.

eg 5. Chronic 1. Female. Hypertension.

P: I was 84 in April... I'm so sorry... P stood dressing only it's so cold standing at the bus stop....
D: Sat.
You'll never believe this, but I came out without my pants...
That's cos I was in such a hurry.
D: You shouldn't hurry.

The above is an interesting example because it shows us how a patient can, to an extent, control the content of the interaction by dressing slowly. This is one of the few occasions when non-functional dialogue takes place in its own right, and there is no upper level of frame operating.

The above extracts from the consultations show the three occasions when N F D will occur, i.e., when the doctor is carrying out a physical investigation, when the doctor is writing notes or a prescription, and when the patient is getting dressed. If this is one of the few occasions within which patients are offered the opportunity to discuss aspects of their lifestyles, it is not very promising for patients who go to the doctor for a chat,
or for consultations which would benefit from social conversation and elicitation.

Mcgee (86) claimed that the lack of interpersonal care was due to one of the following reasons: a lack of time, it is not needed, patients don't expect it, or doctors have a lack of training. Such explanations are compatible with the findings of this small study. I.e. social conversation occurred when the 'real' data was being collected via nonverbal channels, and therefore did not interfere with the consultation.

Furthermore, the present study adds to the work of Strong (79, 82) and Silverman (84) by showing that although the bureaucratic format excludes social elicitiation in N.H.S. consultations, it is allowed when the major upper level frames are in operation.