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A Video Life-world Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach

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Abstract

This article discusses the [development and] use of a video *lifeworld* schema to explore alternative orientations to the shared health consultation. It is anticipated that this schema can be used by practitioners and consumers alike to understand the dynamics of videoed health consultations, the role of the participants within it and the potential to consciously alter the outcome by altering behaviour during the process of interaction. The empirical study examines health consultation participation and develops an interpretative method of analysis that includes image elicitation (via videos), phenomenology (to identify the components of the analytic framework), text and narrative (to depict the stories of interactions) and a reflexive mode (to develop the conceptual framework for analysis).. The analytic framework is derived from *a lifeworld* conception of human mutual shared interaction which is presented here as a novel approach to understanding patient-centred care. The video materials used in this study were derived from consultations in a Walk-in Centre (WiC) in East London. The conceptual framework produced through the process of video analysis is comprised of different combinations of movement, knowledge and emotional conversations that are used to classify objective or engaged WiC health care interactions. The videod interactions organise along an active or passive, facilitative or directive typical situation continuum illustrating different kinds of textual approaches to practice that are in tension or harmony. The schema demonstrates how practitioners and consumers interact to produce these outcomes and indicates the potential for both consumers and practitioners to be educated to develop practice dynamics that support patient-centred care and impact on health outcomes.

Keywords

, Visual Sociology; Social Phenomenology, , Phenomenology, Self-Care, Social Constructionism, Subjective Experience

Introduction

The nature of the primary care health consultation is changing with increasing emphasis being placed on more patient-centred and less practitioner-directed interactions (Lewin et al., 2006). However, while the effectiveness of patient-centred interactions is increasingly recognised it is not always easy to facilitate this approach in practice. Patients sometimes find it difficult to take an active role in the consultation process as consumers (Stevenson, 2007) and it isn't always appropriate that they should. In addition, practitioners who have limited time to see patients still tend to direct the process rather than orient their practice to a shared approach (Bensing et al., 2006).

In the study reported here, social phenomenology was used to derive an analytic framework which underpins the empirical study discussed in this article and video is used to represent lifeworld (Schutz, 1964, Schutz et al., 1967). This analytic approach is used to discover overlapping and blended visual communication as depicted in the videos through image elicitation, phenomenological analysis ,, narrative and a reflexive mode (Harper, 1988). Each video consultations is analysed as a whole narrative to produce a sense of the video consultation conversation as a whole; physical movement, displays of emotion and knowledge as depicted in the video materials are used to classify video conversations in practice and to determine the interpersonal dynamics that for practitioners may be directive or facilitative, and for service users active or passive.

The analytic components of physical movement, displays of emotion and knowledge supports interpersonal communication skills, such as objectifying, engaging and empathizing (Schutz, 1964, Schutz et al., 1967). The study uses a phenomenological description of emotion, movement and knowledge interactions that comes from the work of Sartre (1969) and outlines the involvement of these three elements in the perceived and the imagined object. This approach has been previously applied to performance video art (Bickerton, 1992). The *video schema* identifies active and passive participant consultations that are typical to the Walk-in-Centre (WiC) environment (Bickerton, 2010). These typical consultations are interactions in tension or in harmony and fall along a continuum. The analysis of videod interactions is used to develop a *schema* to aid understanding of the nature of the shared consultation in order to find ways to facilitate active consultation interaction supporting the patient-led National Health Service (NHS) agenda (Department of Health (DH), 2005) The NHS Plan of 2000 (DH, 2000) places an emphasis on the consumer's voice and thus the use of a *lifeworld* schema for consultation practice offers a more holistic and biopsychosocial health care model, rather than a traditional biomedical model of medicine (Mishler, 1984, Benner, 1993, Greenhalgh, 2002).

Theoretical Framework

The *video lifeworld* described in this article enables health care participants to uncover consultation practice (Schutz, 1964) . The empirical study approach describes,social and phenomenological, textual and narrative, as well as reflexive modes of practice. These various visual communication forms are dependent on how the video is constructed, presented and viewed as visual sociology (Harper,1988) .

The *lifeworld* for Schutz and phenomenologists in general begins from a personal everyday perspective and involves ongoing practical interactions in the world. Schutz understands the lifeworld through the intersubjective (shared) social world of human action and experience. The lifeworld consists of shared socially created interactions together with or constrained by pre-existing social and cultural structures (Ritzer et al., 2003). *Social action* originates in the *lifeworld* of both practitioner and consumer and starts from an everyday perspective involving ongoing practical interactions in the world (Schutz, 1964, Habermas, 1987).

The socio-phenomenological *lifeworld* as defined by Schutz is different from the phenomenological *lifeworld* of Husserl (1980), Heidegger (1962) and Sartre (1969). For them, consciousness is never shared as they adopt a solipsistic understanding based on the philosophical premise that the only certainty is knowledge of ones own mind; one can never know another's mind. In phenomenology, unlike social phenomenology, subjective consciousness is the only consciousness that is known directly so all other knowledge – including the knowledge of other human beings – is bracketed and not taken into account (Spiegelberg et al., 1982). For Schutz, however, consciousness is shared and is always already understood as culturally pre-determined shared embodied space and time, so expectations of other human beings are integrated into consciousness at the shared level.

Using a shared perspective health consultation dynamics are understood to be related to historical and socially determined patterns of behaviour and involves understanding nuances of interactions, presentation of self, and relationship of people to their material environment through visual materials (Harper, 1988). Our everyday world is experienced through personal experience which is coloured by our social environment and cultural history. So our experience is interpreted through our social knowledge and attitudes of everyday life and practices. Out of this everyday social action, typical situations emerge, gained from practical experience of the world (Schutz, 1964). It is these situations that this present study describes as the consultation typical situation. As Schutz has written:"*The fact that the everyday life-world is not a private, but rather an intersubjective and thereby a social reality, has a series of extremely important consequences for the constitution and structure of the subjective stock of knowledge. Because an individual is born into a historical social world, his biographical*

situation is, from the beginning, socially delimited and determined by social givens that find specific expressions" (Schutz et al., 1973, 243). The cultural history of primary care consultations with patients, (rather than the more active health consumer), is dominated by the consultation process associated with the doctor/patient relationship (Layder, 1997). Mishler (1984) identified two main voices in the medical consultation: the *voice of the lifeworld* and the *voice of medicine*. Mishler maintains that these two voices affect health care outcomes, and he also argues that strengthening the voice of the *lifeworld* has the potential to offer more humane and effective care. Mishler also noted that the health consumer's knowledge of their illness in the consultation tended to be disregarded in favour of the more authoritative knowledge of medicine. Other studies have shown that the health interaction outcomes are poor when a doctor blocks or ignores the consumer voice in the *face-to-face* interaction (Collins, 2007). Barry et al (2001) found in their study that patients with long-term conditions had personal illness concerns that needed addressing, but that the doctors tended to only focus on chronic disease strategies (Barry et al., 2001). Scambler found, that increasing active consumer engagement makes for better consultation outcomes and for more humane treatment (Scambler et al., 2001). Cribb (2005) maintains that in order for the NHS Plan for patient-led care (DH, 2000) to work, health consumers need to understand the importance of being an active health care participant. He found that they tend to expect to be passive and expect a directive consultation.

The type of professional health providers treating primary care health consumers are changing and are now likely to include pharmacists, nurses, emergency care practitioners, and nurse practitioners rather than the traditional general medical practitioners (DH, 2007). Since 2000 the Department of Health in the UK has worked toward encouraging autonomous practice amongst nurses, medical scientists and allied health practitioners. In general, practitioners are used to leading consultation practice, but more recently are beginning to expect the consumer to actively participate (Stevenson, 2007). These changing roles are creating discussion around the understanding of caring used by practitioners (Benner, 1993). A systematic review suggests benefits to training health care providers in patient-centred care (Lewin, et al.,2006, Lewin SA, 2002). This video model of analysis of practice is developed with a view to supporting an active reflexive consumer approach to health care and offers the opportunity for personal cultural definitions and categorsiations (Harper, 1988) .

A Royal College of Nursing (RCN) study looking at changing health consumers' worlds through nursing practice recommended that "more attention should be paid to helping practitioner-researchers and health consumers of their services to co-construct health consumer narratives" (Manley et al., 2004, 30). Heath et al commented on this issue that:

> *"Despite a growing body of empirical studies, there are very few papers that discuss the practical and methodological issues that arise in analysing the fine-grained actions and activities of practitioner and patient."* (Heath et al., 2007, 116)

The difficulty of undertaking a fine-grained analysis of the actions and activities of practitioners has long been acknowledged. Benner, in her theory of intuitive knowledge, uses a phenomenological method to describe this process from a nurse's point of view (Benner, 1982). Benner describes the *lifeworld* as intuitive decision-making as a holistic process which is difficult to break down into discrete elements and replicate. In the same way Greenhalgh described a similar process comprising of several elements for general medical practitioners that include an intuitive decision-making method. This method is used unconsciously andthese intuitive decisions are made through rapid, subtle, and contextual input, rather than through simple, cause-and-effect logic. Intuition (*lifeworld)* is described in this article through a *video schema* which focuses not only on the practitioner interaction alone but also includes the patient (consumer). The *video schema* focuses on understanding at the level of shared consciousness and the intuitive process includes both the health consumer and practitioner in the *lifeworld* (Schutz et al., 1964).

This article supports the premise that a greater focus on *social action* that is oriented towards understanding in the NHS health consultation rather than oriented towards the success of the consultation has the potential to increase the capacity for practitioners to deliver and health consumers to participate in patient-centred and patient-led care.

The literature identifies that health consumers are not usually active participants in the consultation interaction (Scambler, 2001, Alonso, 2004) and yet there is growing evidence that the health consumer–practitioner interaction is important for a health consumers' well-being and can affect diagnosis and treatment within a multifaceted context (Scambler, 2003).

Methodology

In the present study the consultation is experienced through video. WiC consultation videos represent *lifeworld* and are analysed using *a video schema*. The *video schema* represents (social action and in these videos all human interactions begin from a shared perspective. Conversations that occur in the videos are described

through emotion, knowledge and movement conversations and raise awareness of the importance of these psychological elements in a consultation (Sartre, 1969). All these elements and how they interact affect the outcome of a consultation. A conversation begins at the shared level of consciousness and consultation participants separate from each other in order to objectify each other in conversation (Schutz, 1964). An objective conversation may continue or develop into an engaged (empathetic) conversation. Each video consultation organises itself into what Schutz describes as a *typical situation* (Schutz, 1964) and these typical situations are discovered through viewing the videos and discovering common themes. These themes are further classified as active or passive, facilitative or directive, in tension or in harmony, textual or narrative. Each consultation is unique although the consultation dynamics tend to fall along a continuum of typical situations. The consultations that took place in the WiC were problem oriented and met the criteria for a textual rather than an engaged fully integrated narrative. elements of the video *lifeworld* schema [Fig 1] below outlines the potentialdifferent typologies of the *video schema* derived from social phenomenology, video narratives and reflexive analysis. .

Elements of the video *lifeworld* schema	
Shared (Intersubjective)	A shared connection is accepted as always already present in the health consumer and practitioner interaction.(Schulz 1964)
Engaged	An engaged conversation is an empathetic interaction where participants are attentive to each other (Video analysis).
Objective	An objective conversation is not engaged (video analysis)
Emotion, knowledge and movement conversations.	A knowledge interaction focuses most on sharing information, a movement interaction is experienced through non-verbal elements such as gestures, and emotional interactions are experienced through feeling elements. (Sartre 1969) A conversation contains all these elements but in this analysis one element is identified to provide an overarching typology of the conversation and this is decided by the viewer of the video (reflexive analysis)
Typical situations Consultation actions cluster together into dynamic typifications	Typical situations emerge through an accumulation of conversations falling along a continuum of one of four typical situations that provide the overall sense of the consultation practice dynamic which maybe active/passive, facilitative/directive in tension or harmony (Sartre 1969) . Again the viewer of the video decides which is the overarching situation depicted in the video.
Typical textual and narrative situations	Textual consultations (Sartre 1969) present a typical situation that can be objective or engaged. Whereas, narrative consultations which are absent in this analysis are fully engaged face-to-face interactions that integrate multiple combinations of perception through linearity, resonances, and/or rhythm and is never objective (Sartre 1969)

The categories given in fig 1 are derived from the theoretical framework for this study described above. They are used to construct schemas (figs 1 and 2) which identify the fine grained intuitive aspects of patient-centred care that are particularly difficult to represent. The schema identifies elements that influence consultation practice and offers a map of the typical situations that might be encountered in a first contact health care consultation. The schema provides a way for both practitioners and health consumers to think about and talk about how the different elements interact to create the outcomes of the consultation. This provides the potential for practitioners and consumers to identify how their behaviour in a consultation interaction could be different creating different outcomes. The schema was derived by applying the theoretical frameworks described above to an analysis of the videos and developing the underlying theoretical concepts into the descriptors given in figs 1 and 2.

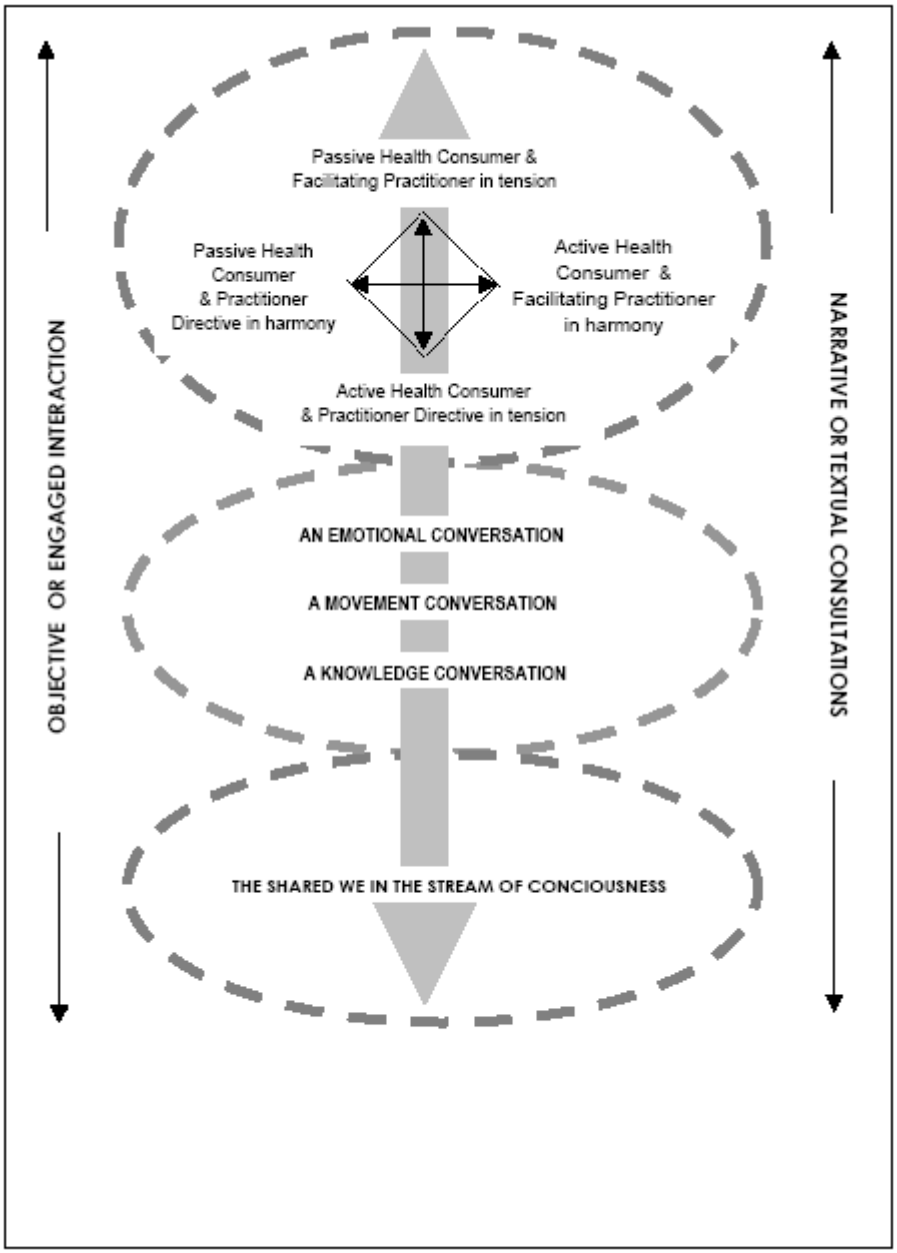
Consultation practice: changing the orientation

The research focus and design as well as the study format and purpose included in the method below can be identified in the integrated framework for social research (Pauwels,2010). The health care videos used for analysis in this study were collected from a Walk-in centre (WiC) adjacent to a busy Accident and Emergency Department in the East End of London. The researcher was a nurse consultant based in the WiC. Health consumers attending the WiC fitting the requirements of the study and practitioners working at the WiC were all invited to participate. The study received ethical approval and all participants signed a consent form. The consultations were videoed from a fixed point of view which included both consultation participants. The consultation rarely included the physical examination unless it did not require privacy and was completed in the interviewing position. The videos were collected over a period of two weeks and because of practical limitations they did not include the intended broad cross section of practitioners and health consumers. A total of 32 videos were collected and of these 28 are included in the analysis. Four are excluded at the request of the participants in line with ethical approval for the study. These collected videos cannot be shared with the public following ethical approval requirements. However, similar health consultation videos are available on the internet (BBC4,2010).

The video consultations used for this study included consultations by general practitioners (GPs), nurse practitioners(NPs) and nurses treating health consumers attending a WiC with minor ailments, many of which could have been treated by a pharmacist with over-the-counter medications and advice (Procter et al., 2008a). The nurses at the WiC were in the main quite new to autonomous practice and were developing autonomous nurse practitioner skills. Health consultations in an A&E are comprised of a large number of urgent primary care presentations as well as emergencies (Coleman P et al., 2001, Salisbury et al., 2003). Many of the health

consumers chose successfully whether they wanted to attend the A&E or WiC (Procter et al., 2008b). Many of the consumers attending the WiC experienced their problem as an emergency even though the health problem could have been addressed through self-care. The *lifeworld* video schema discussed in this article supports self-care and a better understanding of consultation practice.

The following diagram [Fig 2] presents a schematic representation of the *lifeworld* consultation practice discussed in this article.



In this study 28 videos were analysed. Using the schema outlined above all 28 of the consultations were identified as textual consultations rather than narrative. 20 were knowledge conversations; five were emotion, two movement and one mixed. The typical situations presented as 17 active consumers and facilitative practitioners in harmony, five passive consumers with directive practitioners in tension. There were two passive consumers with facilitative practitioners in tension and two passive consumers with directive practitioners in harmony. There were also two dynamic situations that were complex typical situations (Bickerton, 2010).

The reasons for these videos being textual consultations it is suggested could be that the consultations were problem oriented and there was little time to focus on health and wellbeing. A narrative consultation requires time for reflection, so that the participants can integrate the multidimensional experiences that they bring in order to discover a way forward for their health situation. In WiCs in particular it is difficult because the consumers attended on a one off basis, may have a different country of origin, and often speak limited English. Below are three consultations analysed using the *video schema* outlined in this article.

Case 1 –A health consumer attends the WiC feeling unwell with a cold asking for a sickness certificate. The consumer needs the sick note because he was unable to turn up to take one of his final examinations at university. Practitioners working in the WiC environment are not legally able to provide them so the practitioner tries to direct the consumer back to his general practice and is unable to do any more. The consumer has only just registered with the GP. It appears that the consumer has already visited the GP and that the receptionist had not offered him the option of a health sickness certificate. This consultation interaction is an example of the frustration and difficulty that many health consumers, especially those new to the country, have in understanding the NHS health system.

The video shows an emotional conversation that takes place between both consultation participants where they talk, but are unable to share, listen and hear each other. There is no engagement in the conversation and the tone and quality of their voices express frustration. Both participants reframe their questions in attempts to improve communication through an objective conversation, but in the end fail. The practitioner projects her frustration in her erect motionless bodily posture, while the consumer shows his frustration in the way he fidgets, lacks concentration, and continues to reframe the dialogue. The health consumer oscillates between active and passive approaches and the practitioner between directive and facilitative because they are both trying to find a

solution to the problem. Because the practitioner is unable to help and the consumer does not seem to be able to understand this there is tension with no resolution. The result is an active health consumer and a directive practitioner both talking from different perspectives.

Case 2—This consultation also includes a health consumer who is new to the UK but the outcome is quite different. The consumer has had nausea and vomiting and is employed to work with food. He also requires a letter for his employer from a health care provider stating that he is unwell. The health consumer is Spanish and struggles with English so he has brought his roommate along to translate. Both the practitioner and interpreter understand a smattering of Spanish but are not fluent. Throughout the consultation the friend sits quietly except for the occasional interjection to clarify meaning and his comments are not really essential for interpretation. The conversation between the practitioner and consumer evolves quite differently from the previous consultation. The participants are relaxed and actively engage in conversation even though there is confusion on occasion about what the conversations actually mean. This difficulty in understanding generates only a light hearted tension despite misunderstandings. Because of limited understanding communication is often shared through hand and body gestures (movement) rather than words (knowledge) and the movement of the participants at times mirror's each other.

The conversation evolves through an engaged interaction. The participants are in natural dialogue and are in harmony. The consumer says he is a *barrista* at Starbucks and the practitioner thinks the consumer is saying that he is a barrister. The consumer represents his work through schematic gestural movements, miming the movements representing making coffee in a coffee machine. It is only after the practitioner watches the movements repeatedly that he is able to develop associations between the movements, knowledge and signs to complete an association of resemblance so that he understands that the consumer works as a 'barrista' in a Starbucks coffee shop. All the participants, the practitioner, the interpreter and the health consumer connect moving between the shared connection and the objective orientation resulting in an engaged conversation.

The *face-to-face* consultation includes all the different elements of conversations. However, it is a movement conversation which is the most important element in this typical situation. The text is engaged and the social action between a facilitating practitioner and an active health consumer is in harmony.

Case 3 -- A woman is sharing with a practitioner the fact that she is having difficulty swallowing. She tells the practitioner that her throat hurts to the extent that she is concerned she may soon not be able to swallow.

Interestingly she doesn't look too concerned. The practitioner empathises with the consumer as she relates her health history over the past three days. She actively shares her health problem as the practitioner facilitates the conversation. The two participants are engaged sharing knowledge and are interacting in harmony and their consultation dynamic presents an active participant and facilitative practitioner. Following the consumer history the practitioner performs an objective examination. The subjective part of a consultation is dependent on the quality of the consumer and practitioner communication more than the objective assessment when the practitioner performs an examination of the throat, ears and lymph nodes. After the objective examination, the practitioner shares his assessment as a possible quinsy (peritonsillar abscess) and tells the woman it could be serious and that he is referring her immediately to an Ear Nose and Throat (ENT) specialist. As the practitioner speaks, sharing this information, the participant interaction dynamic changes. The video shows the health consumer listening intensely to the practitioner. Her posture is less upright and she appears to be passively accepting what the practitioner shares as he directs a knowledge conversation. There is an anxiety and movement element to the conversation but the knowledge element holds the attention of the participants. The dynamic presents a passive consumer and a directive practitioner in a typical situation that is still in harmony but is diametrically opposed from earlier interactions.

The evolving situation described above in case 3 highlights how a consumer can be both active and passive in one consultation. And in a situation where the health condition requires urgent care the consumer is less likely to actively participate and the practitioner is more likely to take a directive role (Thompson, 2007) so that "The being-in-the-world of the patient seems to change its structure to an attunement of illness as the patient is informed of the disease"(Svenaeus, 1999).

The *video schema* demonstrates ways in which *social action* affects the quality of consultation outcomes and highlights the multiple definitions associated with patient-centred care as here a directive practitioner and passive consumer could be regarded as an appropriate patient-centred approach which 'put the patient and their experience at the heart of quality improvement'(King's Fund, 2009). Clearly any analysis of patient-centred care has to be sensitive to the clinical and contextual environment and this consultation above illustrates a situation where a directive non facilitative practitioner is an appropriate patient centred approach. The consultation dynamic remains in harmony because the service consumer becomes passive in her consultation interaction when the clinical context moves into a more urgent situation and the practioner becomes directive.

This *social action* approach to interpreting consultation practice creates the opportunity for health consumers and practitioners to identify which typical situation is most suited to the requirements of the consultation. For instance in the consultation described in case 3 above the change in dynamic to practitioner directed and consumer passive was arguably entirely appropriate given the results of the examination. The schema provides a framework for practitioners and health professionals to debate issues related to co-constructed text and narrative (Manley et al., 2004). It also highlights the difficulty of undertaking a fine-grained analysis of the actions of both practitioners and consumers because participants come to consultation practice with very different experience and needs. The typical situation described above highlights the importance of a centred approach and shows how a *video schema* has potential as a learning tool to develop a language by which the abstract concepts of patient-centred care and co-constructed text and narrative can be understood and discussed in relation to typical clinical situations. The use of video for reflective practice (RP) in groups such as Action Learning Sets (ALS) and Expert Patient Programmes (EPP) offers the opportunity for practitioners and health consumers to develop competencies and confidence to become familiar with consultation practice.

Discussion

This synthetic socio phenomenology model of practice, described above, provides a new approach to understanding image elicitation and is inclusive of phenomenological intersubjective consciousness, narrative, reflexivity and empirical research. This interpretive approach provides a method of practice that supports a health system that is patient led and patient centred and supports collaborative work. Since 2005, nurses working in WiCs (Salisbury et al., 2002) have been able to qualify to become independent prescribers prescribing from the British National Formulary (BNF) (Lomas, 2009). Similarly, allied health professionals and medical scientists can also become independent prescribers. Such developments underscore the usefulness of RP and ALSs as well as EPPs, which offer a place for reflection on clinical practice. EPPs provide the opportunity for patients with long term conditions to learn in a supportive group environment. However, RP is lacking for the inexperienced health consumers who are the bulk of attendees attending a NHS WiC. Recent research shows that health consumers still tend to rely on friends, the Internet, journals and papers for the majority of their health advice (Schickler, 2004). It is anticipated that by making this *video schema* available to health consumers and practitioners alike there is potential to aid in the development of active participation and improvement in health consultation outcomes. This socio-phenomenological theoretical framework has been

developed as a tool to analyse interaction from a shared *lifeworld* perspective and is equally useful for both health consumers and health practitioners even though their learning associated with the video and video schema may have different objectives. However, even the government is asking health consumers to take the lead in the NHS the health consumer is not expected to learn about how to interact in a consultation.. The schema derived from this research provides a tool which health consumers and practitioners could use to improve their understanding of the dynamics of the health consultation and potentially to facilitate changes in the dynamics to improve outcomes.

The *lifeworld* schema has many close parallels to relation-centred care (RCC). RCC supports psychosocial health education and is founded on four principles: the subjective and personal is important for successful health care relationships; that emotions are an important component of care; that relationships are mutually reciprocal and finally, that relationships are central to all health care (Beach et al., 2005). The *lifeworld* schema like RCC addresses the subjective and personal in health care while identifying emotions as an important element. The video schema includes not only emotions but also places equal importance on knowledge and movement elements in conversations. The lifeworld schema like RCC supports mutual sharing and highlights the importance of genuine relationships. Whereas, RCC focuses on the practitioner in the relationship the lifeworld schema expects the learning tool to be used by both consumer and practitioner alike (Bickerton, 2010). The schema is a useful approach to use in conjunction with RCC because it offers a way to begin to understand RCC through a video schema which illustrates co-constructed relationships in practice.

This lifeworld model provides a visual tool for phenomenological sociology that integrates the four modes of visual sociology (Harper, 1988). It has a different approach from conversation analysis which developed out of phenomenology and ethnomethodology too and is often used to analyse fine grained actions and activities of practitioner and patient (Heath et al., 2007). Heath et al using a conversation analysis model of analysis focus on discrete sequential or syntactical structures in practice. Conversation analysis is not so concerned with the semantics and pragmatic elements of talk but rather with discrete fine grained actions such as how participants open and close their interactions, how they have opportunities to speak, start and change topics, manage disagreements, as well as resolving issues around speaking, hearing, understanding, etc. Conversation analysis analyses transcriptions of audio and occasionally visual materials but sees visual materials such as gaze and

gesture as supplementary to the transcription of spoken interaction rather than an essential part of the process of interpretation (Harper,1988).

This lifeworld model presented in this study on the other hand interprets audiovisual materials as a whole. It interprets consultation participation through a shared intersubjective engaged or objective conversation that might have a tendency towards knowledge, movement or emotion. The consultation interaction as a whole organises into a typical consultation dynamic that is either in harmony or tension and can be interpreted as a text or narrative (Bickerton,2010), This analysis involves less discrete interpretations and is interpreted through broader brush stroke like experiences. The *lifeworld* model does not transcribe the audiovisual materials word for word, gesture for gesture, identifying particular emotions, rather it is concerned with a more generalised interpretation of consultation interaction practice as a whole encounter.

Conclusion

This article discusses a video study that was carried in a walk-in centre in a National Health Service nurse-led walk-in centre in London UK. The empirical study examines health consultation participation and develops a socio-phenomenological method of analysis. This framework adds to the body of work on consultation practice and is different from conversation analysis. The schema describes the shared construction of emotion, movement and knowledge conversations, as well as different participant dynamics that may support a patient-centred interaction. The framework provides a schema that describes a shared *lifeworld* of consultation participation approach. The intention is to replicate these study results with other consultation participants tosee if it is possible for the general public to use this schema successfully. This framework supports a visual sociological analysis of conversation and provides a useful synthetic model that incorporates image elicitation, phenomenology, narrative and a reflexive mode of practice (Harper, 1988).

This schema offers the opportunity to experience consultation practice through personal experience and to gain a better understanding of personal wellbeing and health history. Practitioners, and in particular general practitioners, have considerable experience with videoed consultation practice (Campion et al, 2002). This is a new phenomenon for the consumer. This socio-phenomenological approach offers the possibility for both participants to experience how the communication skills of one participant affects the dynamic of the other, as well as considering the conversation of the consultation as a whole. It points up the importance of addressing emotions as well as movement and knowledge. Focusing on the *lifeworld* offers the potential for the

development of more personalised health care that originates from a place of shared understanding. The framework emphasises the role of consultation participants − consumers as well as practitioners − in a shared *lifeworld* and demonstrates ways in which personal approaches affect the quality of consultation outcomes.

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