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Videos of communication in primary care: a study exploring nurse practitioner and patient consultations in a Walk-in centre

Jane Elizabeth Bickerton

A thesis submitted in partial fulfilment of the requirements
for the degree of Doctor of Philosophy

School of Health Sciences
City University London

Version July 2015

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inform practice In Cox, C. and Hill, M. (Eds.) *Developing Expertise: Professional Issues in Practice and Walk in Centre Nursing*. Wiley & Blackwell.

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Dedication

Dedicated to the memory of Lucy Mary Bickerton, my mother,

a trained nurse and midwife

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Author’s declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at City University London or at any other institution.

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Abstract

The researcher (an experienced advanced nurse practitioner) examined and interpreted twenty videos of consultations between six nurse practitioners and patients aged between 18 and 65 years. A qualitative visual research method (VS) was used drawing on phenomenology, video elicitation, reflexivity, and narrative hermeneutics. The findings demonstrated shared verbal and visual aspects of conversations. The majority of the videos elicited knowledge-based, rather than predominately emotion or movement-based conversations with both parties both empathic and engaged or task focused. The consultation dynamic in most interviews was harmonious rather than in tension, although there were occasions where the nature of the communication varied during the consultation. Furthermore, each NP demonstrated preferences for one of the three different conversation styles (i.e. knowledge, emotion or movement), as well as different ways of responding to patients who were either active or passively involved in an interaction. This theoretically derived video schema was further developed into a video tool (a process and coding guide along with a coding form). The video tool (VT) provided evidence of good video coding inter-rater reliability when compared with the results of the VS.

The study recommends that WiC NPs could use the video schema to reflect on their personal consultation styles as there is potential to develop greater awareness of emotion, movement and knowledge in shared conversations, and a facilitative approach that asks open questions and encourages active shared and flexible approaches to consultation communication. Additionally, research using the video tool could further investigate the psychometric properties of the VT and ultimately the effect of the different styles on patient outcomes such as compliance and satisfaction.

Symbols and Abbreviations

A&E	Accident and Emergency
ANP	Advanced Nurse Practitioner
APRN	Advanced Practice Registered Nurse
CA	Conversation Analysis
CAM	Critical Appraisal Method
Dr	Physician
ED	Emergency Department
ENP	Emergency Nurse Practitioner
ENT	Ear Nose and Throat
EPP	Expert Patient Programme
FWHC	Feminist Women's Health Centre
GP	General Pracititoner
$K = \frac{P(a) - P(e)}{1 - P(e)},$	Kappa equation
MIU	Minor Injuries Unit
NHS	National Health Service
NMC	Nursing Midwifery Council
NP	Nurse Practitioner
PN	Practice Nurse
RCN	Royal College of Nursing
RIAS	Roter Interaction Analysis System
RN	Registered Nurse
SOAP	Subjective, Objective, Assessment and Plan
SDM	Shared Decision Making
SLR	Systematic Literature Review
UCC	Urgent Care Centre
UK	United Kingdom
USA	United States of America
VS	Video Schema
VT	Video Tool
WIC	Walk-in Centre

Chapter 1: The present study overview

1.1. A reflective journey

This study was initiated while the author (JB) was working as a Department of Health primary-care nurse consultant based in a NHS Walk-in centre (WiC) in the East End of London. The remit of the WiC was to see and treat primary-care minor ailments in the community health services, rather than in acute or secondary care hospital-based services (2001b: 26). The nurse consultant role, in this environment was divided into three specific areas: clinical practice, teaching and research, and the objective of this role, was to foster a better understanding of the autonomous nurse practice in a WiC.

The author's interest in healthcare clinical practice began initially as a nursing student at St Bartholomew's Hospital in London in the 1960s, later as a health visitor in the East End of London in the mid 1970s, as a registered nurse at a Feminist Women's Health Centre (FWHC) in the USA and as a licensed Advanced Practitice Registered Nurse (APRN) at Emory University in the USA. In her present role the author is employed as a lecturer at City University London teaching advanced nursing practice and facilitating reflective action learning sets.

Bickerton' s thesis for her research Master's level degree involved an analysis of performance art videos using a phenomenological approach (Bickerton, 1992a). The director of this master's thesis was the late Professor Emeritus Angel Medina (Medina, 1979) a continental phenomenologist from Europe who taught at Georgia State University in the USA and in the course of working with him I interpreted video performance art as structures of consciousness and narrative from a phenomenological perspective. When the author began work on this thesis, her initial intention was to apply the phenomenological framework used in her master's research using Sartre's theory of the imagination, Heidegger and Ricoeur's narrative theory (Heidegger, 1962, Sartre, 1969, Ricoeur and Thompson, 1981) − to investigate phenomenological structures present in video health consultation interactions (Bickerton, 1992b). However, the methodological framework has since shifted from the subjective interpretation to include shared action as exemplified by

the work of Schutz (1964). This theoretically derived video schema was developed into a video tool that provided evidence of good video coding first level inter-rater reliability.

1.2. The present study question and its development

In the course of examining this study literature it became clear, that there was an inadequate understanding of nurse practitioner (NP) communication with patients in a WiC and an insufficient appreciation of the narrative dynamic of video materials. This led to the formulation of the initial study question: What is the nature of patient interactions captured on video of primary-care consultations using qualitative research?

Whereas, at the outset of the study, the participants included GPs, nurses and NPs, this question was later refined to include only videos of consultations between the more experienced NPs. Another area which changed was a shift away from cinemeducation which made use of scripted and hence contrived videos, and which tended to alter the study outcomes (Alexander, Lenahan and Pavlov, 2004). The present study is restricted to only real time unedited video materials of healthcare face-to-face consultations. However, due to ethical restrictions on the use of video recorded material, videos from the WiC are used as the study data, whereas videos from YouTube are used to illustrate how the WiC videos were interpreted. It needs to be noted, that in this thesis the term present study refers solely to the research completed for this submission and carried out by this author.

Thus the revised study question of this thesis is the following: What is the nature of videoed consultations between nurse practitioners and patients aged 18-65 years attending a WiC with a minor ailment? The stages or processes in implementing this study question are itemised below.

- Develop an understanding of communication understood as the exchange of verbal, nonverbal and visual language in face-to-face patient-centred interaction during a nurse-led WiC consultation. The relationship in this consultation is between a patient and NP.

- Review the primary-care narrative literature since 1990 on consultation practice, NP and patient communication, NHS healthcare policy, therapeutic relationships, quality and patient satisfaction with the consultation outcome.
- Conduct a systematic literature review of primary research to examine the nature of patient interactions captured on video of primary-care consultations using qualitative research.
- Develop an understanding of the nature of consultation videos between NPs and patients in a primary-care WiC.
- Outline a qualitative study method using video elicitation, phenomenology, reflexivity and narrative.
- Interpret Youtube videos using a phenomenological video schema to develop and hone the interpretation schema?
- Interpret the WiC videos using the phenomenological video schema.
- Develop and test for inter-rater reliability a structured video tool (VT) developed from the VS.
- Discuss the findings in relation to NP and patient communication, NHS healthcare policy, therapeutic relationships, quality and patient satisfaction with the consultation outcome.

The present study outcomes include limitations, recommendations and implications for clinical practice.

1.3. The role of the nurse practitioner

It was only in the 1990s, that the Royal College of Nursing (2012) agreed a definition of the role of NP and standards for NP education in England. The advanced practitioner role included taking a comprehensive patient history, providing a physical examination, recognising potential diagnoses, and referring patients for relevant investigations so that a final diagnosis could be reached (Royal College of Nursing, 2012). With this data, the advanced nurse practitioner (ANP) was able to treat the patient where necessary with a prescription of medicines in addition to making referrals to appropriate specialists. The clinician was expected to provide a plan of care to meet the patient's health and social care needs involving other healthcare team members as appropriate. The role also included the provision of continuity of

care with follow-up visits. The ANP worked independently as part of a healthcare team to assess and evaluate, with patients, their treatment and care. ANPs provided leadership in advanced nursing practice and ensured, that each patient's treatment and care was based on best practice (Royal College of Nursing, 2012).

Today in the United Kingdom, however, there is still no legislation requiring a NP to have more than first level qualified nurse education (Royal College of Nursing, 2012). Therefore, the only educational guidance is provided by the Royal College of Nursing's (2012) which includes training in healthcare provision to manage urgent and acute episodes, long-term conditions, and health promotion; using a patient-centred approach. Nonetheless, the meaning of patient-centred care is still not well defined (Skelton, 2008). Yet, the ANP is expected to put the patient at the centre of their clinical practice (Royal College of Nursing, 2012).

1.4. Nurse-led WiCs

In 2000, the UK government implemented the development of primary-care nurse-led NHS WiCs, a primary-care first contact urgent care service introduced with the opening of 40 centres in England (Salisbury et al., 2002a). NHS WiCs were designed to meet the ever growing needs of patients with minor illnesses or injuries, which could be treated by a non-medical practitioner. Any person staying in or visiting the United Kingdom could attend a WiC for this treatment without an appointment.

Research demonstrated, that WiCs were used by a variety of people for different reasons, for example Salisbury et al (2002a) established, that the most common reasons for adult attendance at a WiC was sore throats, rashes, coughs, dysuria and emergency contraception. Salisbury et al (2002b) found, that attendees tended to be young adults, not registered with a GP. Hughes (2004) found, that patients needing chronic disease management were more likely than the younger population to be registered with their own general practice and to work closely with the practitioners in the surgery. However, occasionally these patients attended NHS WiCs for a second opinion and, in these situations; the health education aspect of nursing care provided, was of utmost importance (Procter et al., 2009).

1.5. Extending nursing practice in a nurse-led WiC

WiCs aimed to develop the primary-care nursing role (Monitor, 2014). In the nurse-led NHS WiCs, qualified nurses, some of whom had further education in advanced practice, were responsible for diagnosing and treating primary-care minor ailments and minor injuries (Bickerton, Dewan and Allan, 2005). Nurses worked autonomously in WiCs, seeing, treating, and discharging patients and since 2005 have been able to prescribe medication as qualified independent prescribers (Royal College of Nursing, 2012). In these situations the nursing profession required an extension and transformation of the historical nursing role. Nonetheless, Walsh (2001) recognised this NP function as being between nursing and medicine, and found no clear cut demarcation lines.

Fish (1995) differentiated between professional artistry and professional technical skills and competence in healthcare clinical practice. Fish defined professional artistry as ‘a means of taking a holistic view of practice and encompassing skills and invisible aspects of practice which although hidden are far more extensive than its visible elements’. She also maintained, that ‘critical appreciation of these invisible aspects is essential for practice-based research and education of new practitioners’ cited in (Higgs et al., 2013:51).

Gilbert and Hayes (2009) differentiated between two components of communication used by NPs working with older patients these were ‘content’ and ‘relationship’. The ‘content’ component was the literal subjective matter of communication such as information and technical skills and the ‘relationship’ component of communication included the nature of interpersonal interactions.

Bickerton (2010b) (see appendix 15) outlined how NPs were usually taught medical technical skills and subject matter. Whereas, professional artistry or relationship skills were encouraged and developed through personal reflection and clinical supervision on practice, interpersonal relationships and communication skills were founded on earlier nursing training, insight into NP priorities and actions, in addition to a deeper understanding of patient-centred care (Brown, 1999). The focus of the

present study then was on professional communication artistry, rather than professional technical skills.

1.6. A qualitative method

A qualitative approach to data interpretation examines relationships in a particular social context and aims to interpret meanings about a particular situation. This is different from a quantitative approach which aims to measure statistically a cause and effect relationship (Murphy et al., 1998). In evidence-based practice quantitative and qualitative research methods are ranked differently (Bickerton, 2010c) (see appendix 16). Fineout-Overholt, Melnyk and Schultz (2005) ranked systematic reviews and the meta-analysis of randomised controlled trials (RCTs) as the most appropriate quantitative method to an intervention practice; whereas, evidence from a single descriptive or qualitative study is ranked number one as a qualitative research method for describing insight of a patient's experience (Bickerton, 2010c) (see appendix 16). A qualitative approach was used for this study as it interpreted videos of healthcare consultations between NPs and patients in order to understand different kinds of personal and shared communication styles.

1.6.1. Research designs used in clinical practice

The research design describes the study process, which includes what data is collected, who and how the data is collected, where and when the data is collected, as well as how it is analysed (Parahoo, 2014). Positivism and interpretivism are two types of research designs used to study human behaviour. Positivism is a deductive theory associated with a quantitative research method. When a deductive theory is applied to empirical human behaviour data, the data can be statistically measured to provide an objective outcome validated through standardised statistics. On the other hand, interpretivism is used in qualitative research to examine subjective experience and to make sense of its meaning within a study context. Interpretivism then accepts that there can be many different interpretations of the same study data, whereas a positivistic approach measures objectively measurable elements of human behaviour. In the current study data, initially the data was not statistically measured using a theoretically derived VS. The VS was further developed into a VT providing quantative evidence of good first level video coding inter-rater reliability.

Phenomenology and social constructionism are two of three qualitative methodologies discussed by Britten (2011), where phenomenology describes consciousness through human interaction and social constructionism interpreting how phenomena were constructed within a particular context. The third critical approach discussed by Britten and used in healthcare qualitative research examined how power, privilege, and oppression were the products of certain forms of communication. In the present study, it was phenomenology that was applied to autonomous nursing practice in a WiC. The focus of the study was on communication in the consultation as a whole rather than as parts such as the subjective and objective followed by shared decision making or assessment and plan (Elwyn et al., 2003, Bickley, Hoekelman and Bates, 2009).

1.6.2. Phenomenological description and interpretation

Phenomenological studies describe and/or interpret lived experience (Parahoo, 2014). Lived experience in the present study is understood through descriptive intentional structures of consciousness and interpretive textual narrative. Phenomenology views consciousness as always directed towards a particular object and is understood through our structural understanding of an object. The understanding of an object is then the action of video materials (emotion, movement and knowledge structures of consciousness) and their intended relationship between video image or object (Sartre, 1969). Distinct relationships between these different essences is imaginative variation (Parahoo, 2014). Imaginative variation in the present study is the reflexive interpretation of the various combinations of emotion, movement and knowledge elements of consciousness and the interpretation and rewriting of the video narrative as text. These act/object relationships are characterised through the temporal and spatial qualities of the video materials and the video object. Additional to the analysis of time, space and video image, the video narrative is interpreted through the consultation text (Ricoeur, 1984).

Phenomenology was first described by Edmund Husserl in 1901 as a science, that studied unformulated experience prior to an application of any scientific methods (Spiegelberg, 1972). However, generally today phenomenology is classified in qualitative inductive methodologies. It was during the early twentieth century, that

phenomenology developed into a movement which extended Husserl's phenomenology (Spiegelberg, 1982). The movement included the theories of Schutz (1967), Sartre (1969) and Ricoeur (Ricoeur and Thompson, 1981, Ricoeur, 1984). These phenomenological theories provide for a dynamic relational narrative and are interpreted in the present study through the simultaneous interpretation of audio and visual elements that comprise the video.

Traditionally recorded shared lived experience has been analysed using conversation analysis (CA) (Heath, Hindmarsh and Luff, 2010). Nonetheless, Knoblauch (2013) suggests, that Schutz's theory merits consideration in adding to CAs' understanding of transcribed recorded data of healthcare consultations. In the present study then, phenomenology examined the health consultation using a synthetic holistic approach, whereas CA micro-analyses particular bits of conversations in the consultation, particularly those at the beginning and end of sentences. Harvey Sacks (Sacks and Jefferson, 1992) developed CA the 1960s. It is a qualitative method regularly used to analyse patient and practitioner interactions in health consultations (Heritage and Maynard, 2006, Heath, Hindmarsh and Luff, 2010, Royal College of Nursing, 2012, Knoblauch and Schnettler, 2012). It grew out of ethnomethodology, a sociological theory developed by Garfinkel (1967). It also has phenomenological underpinnings (Britten, 2011), but whereas VS examines lived experience within a holistic narrative, CA analyses fragments of holistic intersubjective interactions (Psathas, 1995, Heath and Hindmarsh, 2002, Campion and Langdon, 2004, Collins et al., 2007).

1.6.3. Reflexive and reflective practice

Reflexivity in this study is built from the point of view of the authenticity of the author (Harper, 1988). I reflexively interpret the lived experience of the WiC NP and patient consultation videos using Sartre's theory of the imagination (Sartre,1969). The phenomenological analysis involves kinaesthetic, intellectual, emotional, empathic, and intersubjective awareness as well as socially constructed typical situations elicited through the video narrative recorded in the WiC context (Schutz, 1964, Ricoeur and Thompson, 1981).

Reflective practice has been used for practice development for many years enabling individuals to reflect on, and develop new understandings of their clinical practice (Boud, Keogh and Walker, 1985). Reflective practice, for the purposes of the preesent study, includes areas of reflection such as clinical supervision, mentorship, action learning sets and expert patient programmes. Action learning, as discussed by McGill and Brockbank (2004), provides a reflective model where participants can reflect to gain a better understanding of their healthcare role. This process of personal learning and reflection takes place with the support of a group or set. The set works on real issues from clinical practice and members support each other to develop an action plan through a collaborative process of learning. Balint (1957, 2000), the British object relation theorist used a variation of this reflective model in that he supported therapeutic learning working with groups of doctors reflecting on actual clinical encounters and the therapeutic role of the doctor in their interaction with the patient in the health consultation encounter.

1.6.4. Video data analysis

These videos were further analysed by JC (one of my supervisors) using a structured video tool (VT), see chapter seven. Investigator triangulation was completed (Polit and Beck, 2012) using the VT which included a coding guide, process guide and coding form that the I developed (see chapter seven). These coded elements were the different conversations, typical situations and text identified in the video schema (VS).

Polit and Beck (2012) outline how this triangulation provides an opportunity to check the consistency of coding used in the study. In general there was good agreement between JB and JC with 94 out of 100 consultation elements in the interpreted 20 videos independently agreed. A kappa coefficient was calculated to establish the inter-rater reliability between the two consensus ratings (Hallgren, 2012), see chapter seven. There were however, six coding item differences across five videos found between me and JC. These differences were first reviewed by JC who found she had made an error in coding two of the videos (three elements). Additionally, through discussion with JB, all the remaining three coding differences were resolved (please see figure 7.4) and consensus was achieved between the reviewers for all

20 interpreted WiC consultations. The VT was adapted to reflect these coding differences and consensus (see in appendix 9 VT v1 and the final version figure 7.1, 7.2 and 7.3). The yellow highlights in appendix 9 have been added to the final version of the VT.

1.7. Summary of chapters

Chapter 1 provides an overview of my relationship with the material in this thesis over many years and defines the basic terms and structures used in this thesis. Note, that relevant terms are defined in the glossary in Appendix 1.

Chapter 2 provides a review of narrative literature on healthcare consultation practice and research methods used to study the area of interest.

Chapter 3 provides a systematic review and an in-depth critique and synthesis of qualitative research in which video was used to analyse primary-care patient and practitioner interactions in consultations. This chapter determines a specific gap in this literature leading to a refined study question, aim, and objectives, that can be found at the end of the literature chapter included in this submission.

Chapter 4 provides a novel method used for the study including sampling and recruitment; data collection and analysis; ethical considerations and rigor. It demonstrated how the research was undertaken and how the VS was applied to practice and used to examine the dynamic interaction between primary-care practitioners and patients, and will be included in this final thesis.

Chapter 5 includes the application of the VS to YouTube videos of consultation interactions. I found videos on the internet, that demonstrated the various units of meaning, the themes, and narrative texts found in the WiC videos of primary-care consultations. This was completed because for ethical reasons the WiC videos could not be used to illustrate the VS in practice.

Chapter 6 includes the interpretation and findings of the data using the VS. In this chapter, I applied the VS to 20 video WiC consultations of patient and NP interactions. The chapter presents the findings of the interpretation which included

shared action, emotion, knowledge and movement objective and engaged conversations; dynamic interactions in tension and harmony, and tasked oriented texts. Subtle communicative differences were interpreted.

Chapter 7 shared the development of a semi-structured VT that was checked for rigour. VS interpretations are triangulated using the VT coding with the establishment of good first level inter-reliability confirming the potential utility of VS. The coding and process guide, and coding form, are included in the chapter.

Chapter 8 provides a discussion chapter where the study findings were discussed in relation to existing literature, policy, and theory, revisiting existing literature outlined in chapters two and three. It also reviews the findings of the study in terms of the NP and WiCs, and the use of video as an audiovisual research tool with consideration to study limitations and strengths. The chapter discusses the further development of the VS as a semi structured video tool(VT). The chapter discusses the potential implications and relevance of findings to the understanding of the practitioner and patient clinical encounter.

Chapter 9 summarises the study outcomes and made recommendations for future research. The study focused on two main issues: the primary-care nurse-led WiC consultation and the use of a video schema to develop understanding of professional artistry between the practitioner and patient. A video tool was developed using the elements of the theoretically derived VS and provided evidence of good video coding and the potential for good inter-rater reliability. Finally, this chapter makes recommendations for clinical practice and education, management, policy and research.

Chapter 2: A survey of narrative literature on healthcare consultations

2.1. Introduction

The purpose of this chapter is to provide a clear understanding of issues related to healthcare consultations between health professionals and patients in clinical practice and in particular the literature related to the way nurses extend their practice in a primary-care nurse-led WiC. The aim of the narrative literature review is to outline the changing role of the primary-care NP in the NHS and to develop a question for the systematic literature review in chapter three.

2.2. Background literature

The background literature provided the context for the study. It provided an overview of healthcare services in addition to an overview of the different kind of healthcare communication that took place in various settings between patients and practitioners. Communication in health care in general has changed since the introduction of the NHS in 1948, as have the providers.

The literature search included research on patient satisfaction and recent changes in the healthcare service that have influenced health professional roles. One particular area was the role of the advanced practitioner and the patient in primary- care clinical practice.

Communication is a key factor in healthcare clinical practice and is complex, but is generally understood as an exchange of information, that can involve different forms and processes such as writing, talking, or using visual or gestural signs (Berry, 2007). DeVito (1988) defined communication as the sending and receiving of messages between two or more people with the opportunity for a conversation within a particular context. Moreover, therapeutic roles and relationships have continued to evolve as NHS health policy seeks to provide a more patient-led and patient-centred service.

Health and illness includes a broad range of schools of thought that address health and illness such as sociology, medical sociology, economics, psychology, ethnography, political and gender theories (Ritzer and Goodman, 2003).

These approaches to the healthcare consultation are explained and are subsumed under broader issues relating to modernity, medicine, and health addressed by Scambler Higgs (1998). These issues include dichotomies such as modernity/postmodernity, modernism/postmodernism, and modern/postmodern sociology and highlight the changes that have occurred in world views since the development of the enlightenment concept of modernity in the 18th century. Spiritual beliefs were a powerful controller of our worldly day-to-day practice in the 18th century. In the modern world individual choice and responsibility have tended to replace spiritual beliefs as the essential core values (Stumph, 1982). Postmodern theories differ from these modern theories focusing on inconsistencies in health care rather than essential similarities (Scambler and Higgs, 1998). Modern theories have a coherent core and methodology, whereas postmodern theories reject essential connectedness deconstructing health and illness through relationships such as power, gender and economics.

2.3. Walk-in centres

Nurse-led WiCs were introduced in the United Kingdom in 2000 to broaden access and to diversify types of provision that were more flexible (Chapman et al., 2004).The nurse-led centre provided health promotion and treatment for minor ailments and sometimes injuries. A recent integrative literature review of nurse-led WiCs mostly in England argued, that nursing education provision needed to meet the requirement of WiCs and, that WiC services needed to meet the needs of the primary-care population and be equitable (Desborough, Forrest and Parker, 2012). This review found WiC services could be organised into five themes: ‘users of WiCs, quality of care provided at WiCs, impact on other healthcare providers, perceptions of WiCs and satisfaction with WiCs’. Since the instigation of nurse-led WiCs, the health promotion aspect of care had become less relevant, and many WiCs have changed to GP-led urgent care centres (UCCs) managed through emergency departments (Primary Care Foundation, 2012).

2.3.1. Urgent care and afterhours services

When WiCs were originally set up, health promotion was an important aspect of the care given by the nursing staff. More recently WiCs have been concerned with seeing and treating and reducing accident and emergency attendance (Bickerton et al., 2012) (see appendix 14). Desborough, Forrest, and Parker (2012) found a paucity of data on the nature of consultations at WiCs and data on GP referral activity. The authors' pointed out, that there was a need for clearer evidence for WiCs, that nursing education should include more advance practice nursing skills, and discussion on how the healthcare provision of WiCs might be better integrated with community services.

Since the start of 2010, 50 WiCs across England have been closed with approximately a third subsumed by UCCs based in emergency department (Monitor, 2014). Furthermore, commissioners are considering closing further centres or making changes to services or locations. Already the original concept of the nurse-led NHS WiC has changed to include services such as GP-led health centres, equitable access centre, open access centre, 8 to 8 centre, same day centre, health centre, medical centre, primary-care centre and WiC services (Monitor, 2014).

A recent review of UCCs named 'seeing and treating' as more appropriate care than 'triage and wait' (Primary Care Foundation, 2012). The review highlighted the importance of reassurance to patients where appropriate, but made no mention of health promotion or prevention. The report saw triage as only appropriate if a patient moved quickly to a full consultation. They named three models of UCCs that were co-located with accident and emergency (A&E), remote from a hospital with full diagnostic capabilities, and similar to a WiC. The review of the literature included 42 published papers, which highlighted a lack of evidence, that UCCs reduced accident and emergency (A&E) attendance, and in some cases seemed to increase the total A&E burden.

2.4. Healthcare services

The structure of health care in England was divided between hospital and community services, and this policy led to a lack of integration of services between the two. A&E

was traditionally used for emergency care, yet, there was a lack of consensus about the core activity of A&E (British Association for Accident and Emergency Medicine, 1998). For example with the expansion of the role of the pharmacist, the introduction of UCCs, WiCs and the introduction of general practice services into emergency departments, an expanded primary-care role increasingly blurred the distinction between primary care and acute emergency medicine (Procter et al., 2009). This particular problem was discussed in the *National Evaluation of Walk-in Centres* by Salisbury et al (2002a) and again more recently with the new healthcare policy which encouraged UCCs to be integrated into emergency departments (EDs), along with various forms of WiCs, general practice, physiotherapy, pharmacy and mental healthcare services. Thus, the future role of WiCs is unclear.

Sandhu et al (2009) found, that ENPs and GPs focused more on health promotion and counselling than A & E physicians who focused more on the health condition treatment during consultations. The result was that there was less satisfaction with the emergency doctors even though there were no significant differences in consultation length. The ENPs were most satisfied with the consultation when they actively worked on patient sharing information through building a relationship and collaborating, with the patient. Nonetheless, researchers recommended, that future studies investigate consultation interaction dynamics.

The nurse consultant role was introduced in 2000 by the Department of Health, and supported the development of autonomous non-medical practice in both primary care and acute care. A more recent review of the literature suggested, that the research on these roles was still not robust and their impact on patient and professional outcomes needed further research (Kennedy, 2011).

Coulter and Ellins (2006) discerned that the nature of the doctor relationship with other healthcare professionals was changing as non-medical healthcare professionals developed advanced practice skills to see and treat patients. Laurant et al (2005) in their Cochrane review of the literature found, that the substitution of doctors by appropriately trained nurses maintained good outcomes for patients. However, the cost savings from the difference in salary were offset by NPs seeing fewer patients within an equivalent period. What Rashid (2010) pointed out in her

integrative literature review was, that nurses needed better training and support and, that patient's views needed to be better represented.

2.4.1. Primary and secondary services

Primary care focused the consultation interaction as much on the person as on the disease, whereas in secondary care the focus is primarily on disease management (Britten, 2011). Therefore, the nature of the health consultation, particularly in primary care, has to take into account the importance of long-term conditions and the health and general wellbeing of patients. In doing this there is a move away from the first contact problem oriented consultation to coordination of continuous care (Wilson and Childs, 2002). The type and length of consultation becoming less important than the integration of care across professionals such as the GP and the practice nurse (Kadam, 2012).

Technical nursing skills and professional artistry, both are essential for good nursing practice, but this literature search concentrated on perspectives, that characterised the field of communication health studies. Ong et al (1995) established three different purposes for personal communication in health care, which included the interpersonal relationship, the exchange of information and the treatment decision making context. Thus, communication is considered as an intervention and part of the therapeutic relationship (Warnecke, 2014). Such interventions (subjective and personal approaches) involve the art of relationships in communication such as how people engaged, felt or acted towards each other (Bach and Grant, 2009). In a systematic review of communication and nurse-patient interaction Salmon and Young (2011) discussed communication in nursing educational theory and clinical practice as inherently creative and were mainly developed in explicitly creative disciplines.

Communication was included as part of a structured approach to health care, that was essential to put the patient and their concerns at the centre of any healthcare intervention (Department of Health, 2010b). The Department of Health guidance document, titled the Essence of Care, provided 12 patient-centred benchmarks of quality care for clinical governance relevant for patients and carers and practitioners. Communication, the exchange of verbal, nonverbal and visual was one such

benchmark and interpersonal skills understood as relationships in practical everyday face-to-face interaction, that were essential to support a person-centred outcome in health care. The Department of Health (2010b) included the following criteria in this discussion of communication as a benchmark:

- Communicating safely and effectively,
- Building therapeutic relationships, considering individual differences, capabilities and needs;
- Being able to engage in, maintain, and disengage from therapeutic relationships;
- Using a range of communication skills and technologies including verbal, nonverbal, and written communication.
- The nurse was expected to recognise the need for an interpreter when addressing communication in diversity, promote well-being and personal safety and identify ways to communicate and promote healthy behaviour.
- Nurses were also expected to maintain accurate, clear, and completed written or electronic records whilst respecting and protecting confidential information.

Both the Essence of Care document (Department of Health, 2010b) and the Health and Social Care Act (Department of Health, 2012) supported patient choice and patient (called person in the first document) centred care. These new government policies built on the NHS plan (Department of Health, 2000) were all essential elements of the ‘Essence of Care’ policy (Department of Health, 2010b), which introduced a patient-led approach, patient-centred care, proactive health care, wellbeing and self-care.

Street et al (2009) found, that improved health outcomes were intrinsically linked to communication and, that the actively involved patient (i.e. the patient who was engaged in their care) was more likely to be emotionally supported with access to care together with involvement in shared decision making. However, there was little research that pointed to what behaviours supported patient participation or what particular preferences patients had for participative interaction (Stevenson, 2007). Stevenson also suggested patients expected professionals to set the tone for the consultation, thus making each consultation unique and requiring an individualised

approach. Nonetheless, Seale (2006) found that primary-care nurses offered more holistic care and hence more information than GPs leading to higher levels of satisfaction, whereas GPs focused more on information gathering and diagnostic skill. Seale suggested both GPs and nurses could benefit from illustrated examples of each other's approaches.

2.4.2. Our health, our care, our say

The Department of Health (2006) in the paper Our Health, Our Care, Our Say, set out a new direction for hospital and community services. The government policy was strongly in favour of a patient-centred NHS and this emphasis was again highlighted in the proposals set out in the Health and Social Care Act (Department of Health, 2012). One of the means of achieving this goal was the establishment of Healthwatch, an independent body whose remit was the supervision of the performance of local health providers. New GP consortia were created in England, which were responsible both for commissioning health care in their local area and for holding the majority of the NHS budget. All hospitals freed from central government direct control were able to earn money by treating more patients privately. Patients today are expected to take a lead in their health care, an essential element as research has established as much as 80 percent of the diagnosis in a consultation is based the patient history (Epstein, 2003). Ader (2003) pointed out the positive orientation of the patient to the diagnosis as an additional factor in the social and psychological wellbeing of the patient. Yet little is known about NPs knowledge and diagnosis-centred communications in practice.

2.4.3. A patient-centred NHS

In 2002 Hazel Blears, the then Minister for Public Health, recognised the importance of self-care in a patient-centred NHS, especially for long-term conditions. Many patients with long-term illnesses, who were expert in their own conditions, did not want to spend any more time than necessary visiting their GPs and going to hospital (Department of Health, 2002). The government believed that, with better health information, patients could be empowered to manage care and only use skilled health practitioners when they needed help. Despite this policy, there is little evidence about the effectiveness of health information giving in routine practice,

although studies such as Sandhu et al.(2009) suggested that patient satisfaction and giving information are positively associated with relationship building.

2.4.4. Expert patient programme

The Government (Department of Health, 2001a) started an expert patient programme (EPP) in 2001 to support patients in managing their own care, and to encourage participation in decision making. The programme actively supported support groups run by patients who were expert in a particular area of illness and disease (Department of Health, 2001a). In the expert patient support groups, participants shared their experiences of the illness and disease process and were able to gain a better understanding of wellbeing measures to improve outcomes (Lorig et al., 1999). The EPP supported patients with long-term conditions to maintain an appropriate level of health and wellbeing within their disease management. This is reflected in Duggan (2006) who notes patient contexts, medical education, and close relationships highlight future directions for theory building, health literacy, health outcomes, family communication, developmental issues, and a life span perspective are important directions for the future of health care.

2.4.5. Advanced level nursing: a position statement

In 2010 the Department of Health issued a position statement on advanced practice and on nursing with the of bringing about support for nationally agreed standards (The Council for Healthcare Regulatory Excellence (CHRE), 2009). At the time the Nursing and Midwifery Council (NMC) required no more than a first level registration nursing qualification for ANPs, unlike other countries such as the USA, Canada and Australia (Royal College of Nursing, 2012, International Council of Nursing, 2012). The Scottish Government (2008) supported the development of advanced nursing practice with the provision of a toolkit. Furthermore the Royal College of Nursing (2012) developed competencies and skills for advanced practice, but nonetheless the Nursing Midwifery Council and the Government had failed to provide a protected title for advanced nursing practice. Thus, the recognition and preparation for advanced nursing roles varies within the UK and internationally.

The Royal College of Nursing (RCN) competencies defined advanced NPs as highly experienced and educated nurses, who diagnosed, treated and discharged patients and made necessary referrals to specialists. In order to meet these high standards of care the Department of Health for England in 2012 supported local governance of ANPs under the following four themes:

- Clinical face-to-face practice,
- Leadership and collaborative practice,
- Improving quality and developing practice,
- Developing self and others.

However, the role still lacked support in many areas. For example, Rebecca Rosen and Lesley Mountford at the Kings Fund London (2002) wrote a paper outlining the challenges in developing and supporting extended nursing roles in the NHS WiCs and suggested lessons could be learned from general practice. These lessons included a variety educational programmes developed to support advanced nursing practice (Royal College of Nursing, 2012). Part of my role, as a nurse consultant based in primary care was to extend nursing practice through teaching advanced practice skills in a university and providing opportunities for the nurses themselves to reflect on their own educational needs (Bickerton, 2010b) (see appendix 14). Therefore, the nurse practitioner workforce in the UK is likely to have widely variable levels of knowledge and experience as there is no predetermined, universal level of competency to be achieved before a nurse undertakes such a role. In particular little is known about their communication skills. In the present study novice nurse practitioners are registered nurses, proficient nurse practitioners have been working in the NP role at the WiC for at least 6 months and the ANPs had completed a recognised advanced practice training qualification (Bickerton, 2010b).

2.4.6. Non-medical prescribing in England

In 2002, the Department of Health extended the role of nurses, pharmacists and allied health professionals as supplementary prescribers or non-medical prescribers (Department of Health, 2002); and in 2005 non-medical independent prescribers (NIPs) began to see, treat and prescribe medications to patients without having to

follow a specific patient care plan (Tonna et al., 2007). A review of the literature on supplementary prescribing by nurses and pharmacists from 1997 to 2007 found, that nurses and pharmacists were positive about the opportunity to prescribe and complete episodes of care as autonomous practitioners providing patients the opportunity to be seen and treated by only one practitioner.

2.4.7. The Health and Social Care Act of 2012

The Health and Social Care Act of 2012, is the Act of Parliament which was brought into law by the coalition government of the Conservative and the Liberal Democrats and involved a major reorganisation of the NHS. The Act provided a strategy to place more information and choice in the hand of patients, and reformed clinical leadership so that health services could be organised for patients' best interest. The Act provided for a greater integration of services in health and social care, on the premise that these services should operate less in silos and offer more joined up services. It was hoped placing the patient as the lead and at the centre of the healthcare process would improve outputs and support patient engagement with their own care. The Act (Department of Health, 2012) set up a structure to integrate not only emergency and community care, but also social care with the intention of improving communication and the general health and wellbeing of the population as a whole. Thus, there is a growing rhetoric of the importance of communication in health care.

2.5. Patients and professionals in clinical consultations

The term 'health consultation' has been defined differently over time, but it is nonetheless, a central concept in primary care and relates to the therapeutic relationship and interaction between a healthcare provider and patient (Pendleton et al., 1984). Many factors have contributed to changes in consultation styles, content, and length of time (Scambler, 2003). Furthermore, it was only recently that NPs were able to see, treat and discharge patients (Department of Health, 2000), thus little is known about NP consultations. In the WiC, nurses were given as long as they wanted for their consultation; whereas elsewhere, the NPs might be expected to average twelve minute consultations (Howie et al., 1999). However, Howie et al found that extending the length of the consultation of GPs did not seem to improve

patient satisfaction rather they found it more realistic to improve the way time was spent within the consultation itself. Thus, the quality of a consultation was more important than the length of the interaction and the implications of this for the ANP consultation length, is unknown.

Mishler (1984) and Marinker (1998) found that the patient and practitioner demonstrated two contrasting sets of health foci in clinical consultation practice: the practitioner paid attention to the disease process and the patient to the illness symptoms. Since current healthcare policy supports a patient-centred approach for all health care, it is important for the patient and the practitioner to have a broader perspective of their role in the consultation process to enable effective communication (Collins, 2007). Nonetheless, due to engrained perceptions about doctor-patient relationships, patients tend to lack the necessary understanding and strategies to engage actively in their care and do not always feel supported by practitioners to do so (Stevenson, 2007).

All clinical consultations are expected to be patient centred (Stewart, 2003). Patient-centred communication requires the practitioner to pay attention with the patient's view and this may vary in different settings and is sometimes counterintuitive when the patient seeks an authoritative rather than facilitative communication (Stewart, 2001). Freeman, Car, and Hill (2004) suggest that giving patients a recording of their consultation in primary-care settings could change patients perceptions of their consultation and improve shared decision making. In summary, there is little evidence that patients are able to actively engage in healthcare professional consultation (Stevenson, 2007).

2.5.1. Patient and healthcare settings

It has been demonstrated that different health settings have variations in patient involvement and engagement with patient-centred care. For example, Thompson et al (2007) highlighted a patient with an acute illness wanted less active involvement in their treatment decision making and put more trust in the practitioner's decision making. However, a patient with a chronic illness was more likely to demand increased involvement in care decision making. In a further example Thompson (2007b) described the patient presenting with a myocardial infarction in an

emergency situation in A & E, as wanting to be less involved in their care and more trusting of the health professional than a patient experiencing a long-term condition, such as hypertension, treated in a primary-care setting. In chronic conditions, the patient was more inclined to be proactive and engaged in their health and wellbeing, and more actively involved in their health and wellbeing with positive effects on their personal long-term healthcare outcomes. Nonetheless, Frank, Asp, and Dahlberg (2009) described the phenomenological lived experience of nine patients in emergency care and found there were three areas of patient concern, which were: being acknowledged; struggling to become involved; and having a clear space. Thus, some acute patients also may wish for more involvement in care decision making processes.

2.5.2. Practitioner and healthcare settings

The healthcare setting can also determine the practitioner approach to patient communication. The emergency nurse practitioner (ENP) is expected to provide a more problem-focused approach to their consultation, whereas the primary-care WiC NP is expected to provide a more holistic and comprehensive approach that includes health promotion (Salisbury and Munro, 2003a, Salisbury and Munro, 2003b).

Triaging or streaming patients in A&E or a WiC requires practitioners to sort patients into groups depending on the urgency of the patient's condition (Procter et al., 2009). Therefore, in an A&E situation streaming patients with emergency problems results in separating them from patients with less severe healthcare problems, where relevant treatment might include nursing care, social services, pharmacy, and or physiotherapy. In this situation the clinician makes a quick assessment of the patient based on patient information. In the WiC, patients were seen and treated in the centre, or referred on to the acute sector, or to a primary-care service (Bickerton et al., 2011) (see appendix 13).

The nurse-led WiC tended to emphasise the consultation health promotion and a treatment role; whereas a GP-led WiC was more focused on the 'see and treat' approach (Salisbury and Munro, 2003b, Salisbury and Munro, 2003a). In the beginning nurse-led WiCs were developed to provide more patient choice (Salisbury et al., 2002b), but more recently the service has been used to help reduce waiting

lists in primary-care services and attendances in A & E (Procter et al, 2009). Since 2010 at least 50 of these nurse-led NHS WiCs have closed (Enright, 2013). Therefore, it is unclear how much patient-choice is enacted in current WiC consultations as the ethos of care has changed to more acute models of care.

Jackimowicz, Sterling and Duddle (2012) completed a qualitative literature review on patients' subjective experience of nurse-led clinics and found four important factors that influenced the patients experience in particular. These were:

- The establishment of a therapeutic relationship,
- Effective communication,
- Person or patient-centred care,
- A high level of clinical knowledge.

The lay person often believed the illness was their own fault and these beliefs were difficult to disentangle from the professional model and made a clear communication style difficult in the clinical encounter (Layder, 1997). However, in order for the Health and Social Act (Department of Health, 2012) to be applicable in practice, a patient's comprehension of health and illness required further analysis.

Martin and DiMatteo (2013) suggest that even though communication is thought to be 'low-tech' it may be the most essential tool for delivering effective health care. This position is shared by Warnecke (2014) who highlights that even with recent technological advances it is caring and empathy that are the doctor's best therapeutic tool for healing. There is very little literature comparing the consultation styles between different health professionals and one such article recognised nurses for listening skills and the doctor for diagnostic skills (Collins et al., 2007). Whilst a literature review of the pharmacist seeing and prescribing treatment in the United Kingdom sugggested that the new role of pharmacist as independent prescriber was likely to change the nature of pharmacy practice (Tonna et al., 2007), and consultations in particular. This indicates that not only may the nature of consultations vary between practitioners, but that practitioner's consultations change over time.

There is evidence to suggest that the role and consultations that primary-care professionals undertake is changing. The Department of Health (2010a) included pharmacists, practice nurses, community therapists (such as physiotherapists and occupational therapists), community, optometrists, dentists and midwives as part of 'first point of contact' in primary-care services. As such all these advanced practitioners have the potential now to see, treat, and discharge without referring on to a medical practitioner. This potentially increases the amount of effective history taking, diagnostic, therapeutic intervention and information sharing required by all these practitioners.

In examining the consultation interaction from the patient perspective, Stevenson (2007: 65) suggested that 'patients were generally positive about consultations in which opportunities for participation were available and negative about consultations in which opportunities for participation appeared to be blocked'. Patients also appreciated what Kemp et al (2008) describe as the 'Tell back approach' to information sharing and understanding, where the practitioner reported back to the patient what the practitioner understood the patient to be saying as they reported the symptoms of their health complaint. The importance of the patient's concerns was ascertained by Anden, Andersson and Rudrbeck (2005) with understanding as the most basic concern of patients to meet satisfaction with the consultation experience. There are many factors therefore, that contribute to effective communication between the practitioner and patient in the healthcare setting. Therefore there is a need to consider the whole consultation and how the many 'factors' interrelate to each other during the communication process between practitioner and patient.

2.5.3. Healthcare interactions

There is growing evidence that the healthcare interaction is important in terms of a patient's well-being and can affect diagnosis and treatment within a multifaceted context dynamic (Fischer and Ereaut, 2012).These interactions can be analysed from a wide variety of perspectives including, class, gender, power (Ritzer and Goodman, 2003), culture and imperialism (Said, 1993), all of which impact on outcomes. Any given study of healthcare interactions has to choose which perspective or focus to use to develop understanding of the impact on outcomes. In

the present study the focus is on developing a practice framework that will enable participants in healthcare consultations to better interpret the process of shared communication and interaction enabling participants to begin to develop awareness and understand how this can be achieved in practice.

Mishler identified two main voices in the consultation interaction: the voice of the lifeworld and the voice of medicine (Mishler, 1984). These two voices, their characteristics, and the consultation participants could affect consultation outcomes with the result that strengthening the voice of the lifeworld would offer a humane and effective method of care. Mishler commented that the voice of the lifeworld of the patient tended to be treated as non-medically relevant. Other studies have shown that when a doctor blocks or ignores the lifeworld or the face-to-face interaction of the patient through the voice of medicine, the health interaction outcomes are poor (Barry et al., 2001) and that increasing use of the lifeworld makes for better consultation outcomes and for more humane treatment (Scambler and Britten, 2001). Barry et al (2001) also found that patients with long term conditions had quality of life issues that needed addressing. Physicians, on the other hand, focused on the long term condition as a medical issue rather than a lifeworld issue (Collins et al., 2007). The NHS Plan (Department of Health, 2000) gives the patient the lead in their health care; and in the present study the patient has a real presence and the findings offer ways for a more active lifeworld contribution.

2.6. Communication in healthcare consultations

Face-to-face communication involves both verbal and nonverbal interaction (Heath, 1984). Examples of types of nonverbal communication include visual facial, and body expressions, listening, silence, and eye contact even though there is relatively little research concerned with how gestures are used with talk and within interaction to reveal emotional and personal experience (Heath, Jones and Lebaran, 1986).

Verbal communication skills include different approaches to face-to-face talking such as questioning, confronting, challenging, summarising and explaining. Furthermore, Bevington (2014) included verbal, knowledge, feelings, bodily and sensory under

general forms of communication. Yet visual sensory and knowledge forms of communication have been little researched in primary-care nursing.

Caris-Verhallen et al (1997) described nursing communication as generally understood to be the exchange of information with understanding. In a systematic review of communication and nurse-patient interaction, Fleischer et al (2009) found that the terms ‘communication’ and ‘interaction’ are used synonymously in both empirical findings and theoretical knowledge. This review considered mostly qualitative research that was completed in hospitals and nursing homes rather than primary-care practice. Few papers were found that related to primary-care community settings or shared processes and intersubjective experiences of relationships. Fleischer et al (2009) found that many of their review studies used study designs and methods from disciplines such as sociology and psychology rather than nursing derived theory.

Benner (1982) introduced the concept that clinical experience informed practice and in particular, novice nurses could become expert nurses over time as they developed skills and understanding of patient care through theory, clinical practice and experiential communicative artistry. Bury, Janes and Dowling (2005) argued that the patient knew more about their chronic illness than the GP and so became more knowledgeable about their health and were less accepting of medical authority. Stevenson, Cox and Britten (2004) found in their systematic review of 134 studies of two way communication between patients and health practitioners about medicine reported mixed findings. These findings varied according to whether patients felt that they could share their beliefs around medicines with the doctor during a consultation or not, and the study recommended further development of interventions that facilitate concordance in practice. Epstein(2003) found that the patient’s history influenced the diagnosis up to 80 percent more than the clinician’s physical objective assessment competencies, thereby emphasising the importance of good communication during a consultation and ensuring all practitioners are adequately trained.

Communication interventions were found to improve understanding between health professionals and women in maternity care (Rowe et al., 2002), thus communication

is amenable to change. Halcomb et al (2007) identified in their literature review that the two most important factors that affected patient satisfaction were ‘confidence and credibility’ and ‘interpersonal and communication’ skills. Furthermore, a study carried out by Kessler, Kutka and Badillo (2012) in A&E, linked a patient-centred approach to a face-to-face consultation (i.e. use of contact, communication, core question, collaboration, and closing the loop) with improved patient outcomes.

2.6.1. Nurse practitioner consultations

There is little known about NP consultations, the systematic review completed by Fleischer et al (2009) only included four studies about ANP communication. Additionally Gilbert and Hayes (2009) found there was limited research and knowledge on the characteristics of patient and ANP communication. Due to the lack of evidence for advanced practice nursing, much of the ANPs’ styles of consultation, of necessity, have been based on the work of GPs (Smith, 2004). Moreover, Hill and Sawatsky (2011) recognised that the NP role was stressful for the new novice NP. Most NP programmes provided excellent didactic information and clinical exposure, but additional guidance and support was needed for the expert NP role.

NP clinical supervision uses the models discussed below to provide flexibility to the communication approaches in clinical supervision. However, it should be noted that biomedical approaches in clinical supervision are rare. The biomedical approaches are an essential part of NP communication but it is important to understand this approach within the whole context of communication and care. The subsections below outline different approaches to healthcare consultation practice focussing on different aspects of care. The knowledge then gives practitioners the opportunity to be more flexible and dynamic in their clinical interactions. The expectation then is that the more experienced and knowledgeable practitioner has the potential to move between different models of care depending on the patient presentation.

2.6.2. Primary-care practitioner consultations

Britten (2010) commented that primary-care communication was organised around values that included patient-centred, comprehensive and holistic methods of practice, yet none of these values have been comprehensively defined. Britten

argued that further development of these concepts requires a synthesis of qualitative studies to build up a cumulative evidence base (Britten, 2011). Freeman et al (2002) identified the importance of giving the patient time and space at the beginning of the consultation to tell their story. They emphasised the importance of the practitioner sitting quietly to listen until the patient's view was told. However, communication still tends to be understood in terms of professional concerns and any research into the shared lived experience of patient and practitioner tends to be analysed as discrete elements using conversation analysis (Atkinson and Heritage, 1984). More recently, discussion of health and illness has come to comprise a broader range of theory that includes medical sociology, sociology, economics, psychology, ethnography, political and gender theories (Ritzer, 2000, Ritzer and Goodman, 2003). Yet, much primary-care communication research has tended to focus on the medical model (Roter and Frankel, 1992), which limits generalising these findings to nursing.

In the1950s, health care was biomedically focused (Parsons, 1952). Parsons was considered by many to be the father of medical sociology who developed a grand theory of action integrating social sciences into an overarching theoretical medical model of care (Parsons, 1937). This theory saw human action in health care as voluntary, intentional, and symbolic which fitted a biomedical model of medicine. This model also took into account psychoanalytic aspects of illness and with this marked the beginning of a broader view of traditional biomedical medicine (Parsons, 1952). However, this theory was not patient-centred as the practitioner directed the health care without discussion with the patient. The patient was passive and the doctor was the only active participant.

Parsons (1952) compared the relationship to that of parent and child. His paternalistic model determined the sick role as deviant from a healthy social role. This ideal theory highlighted a typical pattern of social phenomena and the patient role was organised into areas that included rights and obligations. Parsons revisited this model later in 1975, he then re-evaluated the physician patient relationship, and found that even though the relationship still remained unequal, it was no longer deviant from normal healthy societal behaviour (Parsons, 1975). What Parsons achieved was to examine clinical consultation from a medical sociological

perspective which added a new dimension to medical science. Nonetheless, his approach was very much focused on the medical point of view, rather than the patient who played a rather passive role in their healthcare recovery; thus his model is not congruent with current patient-centred models of healthcare delivery (Department of Health, 2010b).

2.6.2.1. Biomedical model

Parson's model followed the traditional philosophical view of the separation of mind and body (Stumph, 1982). The limitations of this biomedical model of care hindered diagnosis and treatment of psychiatric problems. It was only in 1977 that Engels brought attention to the limitations of making diagnoses of particular illnesses and diseases based on biochemical imbalances alone (Engel, 1977). Engel recognised the importance of the psychological aspects of the disease process as equally important to the biological aspects of disease. In this approach there was no separation of mental health from physical wellbeing.

Since 1972, the medical profession, and in particular the Royal College of General Practitioners (RCGP), have encouraged doctors to extend their clinical practice beyond a purely organic biomedical approach to include the patient's social environment and psychological wellbeing in disease process and management (Royal College of General Practitioners, 2013). The medical profession and general practice in particular have been integral in moving the quality of the consultation from the biomedical model to a far more patient-centred model, with the result that primary health care today uses a biopsychosocial approach to communication (Engel, 1978). Health care now tends to consider a holistic patient's psychological and social health and wellbeing in clinical practice including the biological aspects. Therefore, there is a need to consider a holistic method to investigate contemporary consultations.

2.6.2.2. Biopsychosocial model

The biopsychosocial approach offered a way to link the biomedical and the social and psychological aspects of the health consultation (Frankel, Quill and McDaniel, 2003). While the biomedical approach tended to be based on scientifically provable

data, a biopsychosocial approach to health was more holistic than the biomedical approach to health. In the biopsychosocial approach the patient was not treated in solely a biomedical way or ‘simply as a mechanical body separated from the mind, but as a person inhabiting a social environment and having psycho-social, even spiritual needs’(Sharma, 1992:111). The biopsychosocial model of care broadened the biomedical approach and was for Epstein et al (2003:57) ’sharing power and enhancing autonomy, being honest, caring, collaborating with the patient, communicating empathy, involving family and social networks, attending to the spiritual dimension, considering the effect of the health system’. This broader view of health and wellbeing meant that allied healthcare professional skills were needed to discuss the patient’s lifestyle and public health as the environment began to play a much more important role in health care.

2.6.2.3. Psychosocial model

Epstein, Perkin and De Bono (2003) found that as much as 80 percent of medical consultations concerned the patient’s history, which influenced the diagnosis made and significantly influenced the clinician’s physical objective assessment competencies. For this reason alone, a large proportion of the clinical consultation was focused on communication skills, and many of the skills used in psychotherapy and counselling were used in primary care, but were used less in the acute setting.

Manley et al (2005) in their research studying changing patient’s worlds through nursing practice expertise provided a patient-centred and holistic model of psychosocial nursing care. Psychological approaches to health care were included in the biopsychosocial approach and, when seen in isolation, focused on the patient’s memories and the patient psychological experience of the world (Gilbert, 2004). Gilbert recognised that a more rounded and holistic approach to health care was achieved by paying attention to a patient’s psychological and social wellbeing and provided an opportunity for patients to be more involved in their healthcare outcomes.

2.6.2.4. Person-centred model

In the 1950s Carl Rogers developed a person-centred model of communication. Rogers was a psychologist and therapist, and provided a foundation for the biopsychosocial and patient-centred care used today. He believed that the client ultimately knew the solution to their own problems (Rogers, 1980). Rogers viewed people as healthy and motivated to live in a healthy way; especially when helped to actualise themselves as autonomous and responsible individuals (Rogers, Kirschenbaum and Henderson, 2002). In order to provide an effective therapeutic environment the practitioner empathised with the client and felt a positive regard for the client.

More recently studies have shown how a patient's active involvement in their health consultation supported successful results from a personal healthcare plan (Elwyn et al., 2003). However, the definition of patient-centred care is not clear. Whereas, the Kings Fund (2009) and the Department of Health (2011) put the patient at the centre of care, Skelton (2008) describes patient-centred care as poorly defined and he is not sure if it actually exists.

2.6.2.5. Relation-centred care model

In long-term conditions the concept of patient-centred care is often extended to include environmental aspects of patient care, and extends the consultation interaction between two people to include relationships in the community. The Resoling and Pew-Fetzer Institute emphasised the importance of emotion in mutually supportive relation-centred health care which thereby is extended to include subjective and personal active participation (Tresolini and Pew-Fetzer Task Force, 1994). Beach and Inui (2006) described this relation-centred interaction as central to the chronic healthcare management. Additionally, Elwyn (2005) discussed how the paternal physician role had changed into multiple roles that included 'problem solver', 'symptom interpreter', 'information navigator', and 'facilitator of decision making'.

2.6.2.6. Shared decision making model

Elwyn et al (2003) differentiated shared decision making (SDM) from patient-centred and relation-centred care communications. SDM takes place in the second part of the consultation encounter when treatment and the plan of action are discussed. In this situation, both participants share information, take steps to build a consensus about treatment, and reach agreement on the treatment (Charles, Gafni and Whelan, 1999). This approach supports the development of patient knowledge and a more patient led and contractual practitioner-patient relationship. Gross (2002) defined SDM through a concordant approach that involved listening, hearing and supporting patients to understand and agree in partnership with the practitioner about their health status and treatment.

Layder (1997) found that patient ideas and beliefs were difficult to disentangle from the pathological model of health care. However, a patient-led service required comprehension of health and illness models, in addition to issues of wellbeing and self-care, which Schickler (2001) found that patients understood from many different perspectives. On the other hand, Britten et al (2000) stressed the adverse consequences of the lack of patient participation arising from the patient having insufficient knowledge and skills to full participate in the process and emphasised educational programmes to improve patient involvement. The Expert Patient Programmes (EPPs) are examples of such programmes the government has developed to help patients understand their role in self-care (Department of Health, 2001a).

Supporting Britten et al (2000), Collins et al (2007) argued that the patient did not necessarily have the competencies to be involved in SDM, even though this strategic sharing of responsibility and power was included in patient-centred care. SDM, when compared with various practitioner models, illustrates various levels of strategic patient power which are dependent on the kind of consultation interaction used by the practitioner (Thompson, 2007a).Thus, in analysing patient-professional communications it is important to consider the skills and knowledge sets that both patient and professional draw on during the consultation.

2.6.2.7. Health solution focused model

Towle et al (1999) pointed out particular elements of SDM that aided solution-focused communication. These included a partnership between consultation participants where the practitioner aids the patient through information sharing in an appropriate format and the practitioner has an understanding of the kind of involvement needed for decision making, such as responding to patient's concerns.

Towle suggested that with this kind of partnership the patient then knows and understands the various disease management choices, including research evidence in relation to patient's needs values and lifestyle so that they have the skills to mutually agree an appropriate action. Furthermore, the practitioner can then establish competencies that support clinical engagement. These include discovering the kind of preferred consultation relationship; such as being able to develop a partnership with the practitioner; sharing health problems, feelings, beliefs, and expectations with the practitioner in a systematic way. They also included communication with the practitioner at an appropriate time in the consultation, the ability to evaluate information and negotiate decisions, resolve conflict, and finally, agreement on action plans.

2.6.2.8. Inductive model

Fraser (1992) developed what is called the inductive consultation process and it is the model normally taught to medical students for both acute and primary care. This comprehensive and systemic approach was the health consultation approach used in the WiC, but was referred to as 'SOAP' documentation (Bickley, Hoekelman and Bates, 2009). The approach followed subjective patient history (S), the objective physical history (O), the assessment (A), differential diagnoses and assessment; and the consultation plan (P) of treatment for the presenting problem. The inductive consultation was originally supported by clinical decision software algorithms that raised red flags where further review was required (Hanlon, 2005).

The inductive consultation process or 'SOAP' provided a comprehensive model of learning for the NP incorporated loosely into a patient-centred approach (Stewart and Gilbert, 2005). In addition, NPs often incorporated their patient-centred

communication skills from their previous nursing experience (Machin and Pearson, 2014). I was interested in these skills and their influence on invisible structures of the consultation dynamic (Fischer and Ereaut, 2012).

2.6.2.9. Patient-led model

Perakyla and Ruusuvuori (2007) highlighted five components that supported patient participation including:

- Contributing to the direction of action,
- Influencing the definition of the consultation's agenda,
- Sharing in the reasoning process,
- Emotional reciprocity,
- An influence on the decision making process.

Cribb (2005) recognised these approaches as supporting patient empowerment, and furthermore, Stevenson (2007) found that patients liked to have opportunities to participate in a consultation conversation. However, the UK was seemingly behind other European countries in engaging patients in their healthcare system, as the UK continued to take a more paternalistic stance in relation to information about medication, SDM, patients' access to records, preventive advice, and self-management of chronic disease (Coulter, 2006). A systematic review by Stevenson, Cox and Britten (2004) found little research that examined fundamental patient compliance, issues for concordance, for example whether patient and practitioners SDM in practice and suggested the development of interventions in that was supported SDM.

In their study of patients' agendas in general practice Barry et al (2000) found that patient's needs were rarely voiced and therefore could not be addressed in the consultation. Barry et al (2000) suggested that new consultation strategies were required to foster each patient's articulation of their needs. The study further provided evidence of limited communication in reality between the practitioner and patient and thereby the limited opportunities for concordance.

In summary, over the past 40 years primary-care health communication has moved from the traditional biomedical model of health care discussed by Parsons to a holistic model of care that includes both a psychosocial and biomedicine focus (Williams, Annandale and Tritter, 1998). Furthermore, a review of ANPs by Charlton et al (2008) discerned the inclusion of biopsychosocial styles of communication resulted in improved patient satisfaction, an increased adherence to treatment plans and improved patient health. Butalid et al (2012) in their review of patients views between 1998 and 2001 on doctor and patient interaction found that listening, giving support, and showing respect to the patient were equally important throughout the consultation to achieve patient satisfaction.

2.6.3. Examples of patient-centred interaction in consultations

Practitioners integrate relational expertise with consultation communication. Examples of these approaches used for teaching patient and practitioner interaction in primary-care practice are outlined below (Bevington, 2014).

Heron (1976) pinpointed six categories of different types of therapeutic human relationship approaches that could be broadly classified as either directive or facilitative. The three subtypes of directive approaches were prescriptive, informative, and confronting.

- The prescriptive approach describes a critical or directive practitioner giving advice or information.
- The informative approach the practitioner gives or interprets information and instructed the patient with new knowledge.
- The confrontation practitioner that challenges behaviour and provided direct feedback within a caring context.
- The three subtypes of facilitative approaches includes
- the cathartic approach that enables the client to release emotions through weeping, laughter, trembling or anger;
- the catalytic approach encourages the client to discover and explore latent thoughts and feelings; and finally,

The supportive approach offers comfort and approval, affirming the client's self-worth. Thus while NHS patient-centred policy (Department of Health, 2005a) affirms that both practitioner-centred and patient communication is essential in clinical communication practice. The Heron (1976) model then, presents different approaches that practitioners can use for communication in practice.

2.6.3.1. Stewart: Patient-centred interaction

There are many definitions of patient-centred interaction and Freeman, Car and Hill (2004) recalled that it is only recently that patients have begun to want to understand their personal health and wellbeing in more depth and to be involved, whereas previously this had been left to the medical practitioner. Bevington (2014) incorporated Heron's interventions into the patient-centred interaction model. Bevington argued that patient-centred approaches took more time and were more stressful on the practitioner because of the patient involvement and their wanting to understand the SDM treatment process. However, using patient-centred decision making the patient was more likely to follow the treatment plan since the interaction facilitated the patient to explore their concern and needs through a biopsychosocial approach. In the Bevington (2014) model, the practitioner's agenda focused on using open questions to ascertain the patient understands of the illness, their expectations and how concern affected the patient. The interaction included the catalytic, cathartic and supportive approach.

In contrast the practitioner-centred approach asked directive and closed questions, and focussed on determining the patient diagnosis rather than facilitating the patient agenda leading to a shared decision outcome. These different approaches of interpersonal interaction have the potential to occur in any of the inductive and SOAP communication strategies. Heron's facilitative approaches are expected to be used more readily in a patient-centred interaction, but the prescriptive, informative, and confronting approaches are included also in the patient-centred approach. Information sharing has an important place in advice and reassurance, a prescriptive approach may be needed to make sure a patient understands their healthcare options, and finally a confronting approach may work with smokers and alcoholics if they are ready to listen to advice and change their behaviours (Bandura, 1977).

Stewart and Gilbert (2005) also adapted Heron's patient-centred clinical method which includes:

- Exploring both disease and the patients' illness experience,
- Understanding the whole person,
- Finding common ground,
- Incorporating prevention and health promotion,
- Enhancing the patient and doctor relationship,
- Being realistic.

Using this patient-centred interaction approach, involved understanding the patient's unique illness experience, exploring their Ideas, concerns, expectations, feelings, thought, and the effects of the illness on the patient. At the same time the practitioner considered the disease process such as the patient's subjective symptoms, the physical examination, and assessed objective signs integrating them alongside underlying pathology and possible differential diagnoses. Finally, through SDM, understanding of the illness and the disease were integrated into a treatment plan. Stewart and Gilbert provide a holistic patient-centred communicative approach that can be readily incorporated with the 'SOAP' and Fraser's inductive process into NP clinical practice (Fraser, 1992, Cox, 2005, Stewart and Gilbert, 2005).

2.6.3.2. Byrne and Long: Doctors talking to patients

Byrne and Long (1976) developed six biopsychosocial strategies that involved practitioners talking to patients to encourage a patient-centred and more patient inclusive approach. These strategies facilitated doctors to think about the relationship they had with their patients, encouraged the doctor to discover the reason for the patient's attendance, and to think about the inclusion of the patient in the discussion of treatment. Byrne and Long (1976) found that verbal behaviours used when doctors were talking to their patients ranged from closed information gathering to nondirective counselling. Furthermore, they found that the consultation approach depended on whether the doctor was more interested in developing his own line of thought or that of the patient's.

The model of practice recognised the practitioner-led approach to clinical practice and did not readily meet the government's policy of putting the patient in the lead of all healthcare practice (Department of Health, 2004). Thereby Byrne and Long (1976) provided the opportunity for practitioners to provide a range of communication skills that can be used in the NP consultation i.e. It reminds practitioners of facilitative and non-directive information giving and the importance of directive closed information gathering during the subjective history taking where the majority of the information for diagnostic reasoning is collected (Bickley, Hoekelman and Bates, 2009).

2.6.3.3. Neighbour: The inner consultation

In his model of healthcare interaction Neighbour (1987) recognised the importance of the inner consultation for nurturing patient rapport. His techniques included summarising what was shared by the patient about their health problem so that the practitioner could then adapt their understanding if the revised summary did not reflect what the patient meant. A joint agreement was set for the plan of action, enabling the patient to take ownership and responsibility for the management of their problem.

Furthermore, Neighbour (1987) highlighted the importance of safety netting in the consultation, so that there was a clear plan for follow up and referral. He also recognised the importance of the doctor taking care of him/herself, so that they were psychologically well prepared to be attentive to the next patient. The practitioner needs to be able to listen carefully to the patient and communication in a facilitative manner so that a patient-led conversation translates into a patient centred and shared decision making process. Neighbour's inner consultation recognised the importance of including the patient in the consultation interaction, and the importance of reflective practice for the practitioner to maintain psychological wellbeing.

2.6.3.4. Cohen Cole: Three function consultation

Cohen-Cole (1991) developed a health consultation model which included gathering data by asking different kinds of questions such as open-ended, facilitation, the patient's expectations and the impact of illness on a patient's quality of life. In the

process of gathering data, the practitioner was expected to develop a rapport and respond to the patient's emotions supporting a respectful partnership. Furthermore, the model expected the practitioner to educate and motivate the patient about their illness and negotiate a treatment plan that can be maintained. In addition, Lyn (1987) used this three function model to teach information gathering, emotion handling and behaviour management to clinicians working in an ED. Practitioners gained a better and enriched knowledge of emotion, knowledge, and action conversations. This approach recognises the importance of care with emotional handling in combination with information and behaviour for the clinician in the clinical ED encounter.

2.7. Holistic and patient-centred healthcare practice

A biopsychosocial holistic approach to health and illness provides the opportunity to develop a positive holistic definition of health rather than a negative medical one (Stacey and Homans, 1978). It concerns wellbeing and health-related quality of life that are part of a wide variety of health promotion activities. Contemporary theories of illness and health draw from a broad range of schools of thought including sociology, medical sociology, economics, psychology, ethnography, political and gender theories and their approaches to the health care consultation (Ritzer 2003).

Berger and Luckmann (1979) describe face-to-face relations and differentiate between close and more abstract relations. These relations are by necessity flexible and the various patterns evolve and are ever changing although they revolve round typical situations**,** similarly to Schutz, that are reciprocal and present in all encounters. The patient-practitioner is one such interaction and it is this typical situation that is, today, expected to be patient-centred**,** having evolved from the passive patient interaction described in the twentieth century by Parsons (1975).

Berger and Luckmann (1979) developed a theory through a dialectical process drawing on the work of Nietzsche and Marx grounded in social existence and the realisation of social institutions. Human activity develops habitual patterns of institutionalised human activity. These institutionalised activities for the next generation are social constructions already in existence and this generation embodies these social constructions into their everyday lives. In the third phase of

the social construction of reality, socialised individuals, children and adults become distant from the everydayness of these original activities and learn about them through objectified social constructions developed through a historical perspective. Rather than taking this historical theoretical approach to knowledge that is too distant, Berger and Luckmann and Schutz enable us to come to know what is real in everyday conversations and interactions. The authors allow the possibility of addressing the various postmodern themes such as gender relations, the issue of power in the relationship between patient and practitioner, as well as the larger social, cultural, and economic issues that exist in human activity and impinge on human nature.

2.7.1. Holism in healthcare communication and clinical practice

Lewin et al (2001, 2009) defined 'holism' as including the whole person (the social, psychological and physical) and in at least half of the studies included in this review either video or audio recording was used for part of the research method. Stewart and Gilbert (2005) described patient-centred care as a 'whole-person' practice, where the practitioner was open to all of the dimensions of the patient's problems. Thereby the practitioner engages with the patient emotionally, cognitively, and intuitively to create new shared insights together with the patient.

Todres, Galvin, and Dahlberg (2007) interpreted holism through phenomenology. Whereby holism was the melding of many different personal horizons that were temporally and spatially interrelated: 'The "balance of health" refers to the way a human being finds its place in the world as a meaning pattern being-in the-world. Health was thus not a question of a passive state, but rather of an active process-a balancing' (Svenaeus, 1999:159). This understanding of holism is related to our conscious understanding of healthy living and includes the biopsychosocial understanding of holism discussed in the next paragraph. Phenomenological hermeneutics understands biopsychosocial health and wellbeing through our own personal history and our shared cultural history. Each of our knowledge of the NHS is based on shared knowledge, but interprets our health and care uniquely. The NHS domains discussed in the next paragraph are understood from a different perspective.

Current NHS policy includes ‘holistic’ care, but is understood differently in various healthcare services. So for example, with reference to palliative care, the Department of Health (2006) defined the term ‘holism’ through five domains that were background information and assessment preferences, physical needs, social and occupational needs, psychological wellbeing and spiritual wellbeing. Whereas the ANP model of care used the term ‘holism’ in a different social context referring to nurse interventions that attend to the patient/client’s everyday life using health education and health promotion to maintain and improve wellbeing (Royal College of Nursing, 2012).

In a review of patients’ experience with nurse-led clinics Jackimowicz, Stirling, and Duddle (2012) found that patients expected NPs to have the relevant technical skills and competencies to diagnose and treat. However, for the patient to change their behaviours and commit to improved self-care management, they needed an open and trusting relationship with the nurse. Jackimowicz, Stirling, and Duddle (2012) recommended that nursing should focus on the patient as a whole person, rather than on illness and disease.

A holistic approach to the patient self-care continuum (Department of Health, 2005a) includes health promotion, lifestyle and prevention. The continuum moves from assisted health care to shared and facilitative management for acute conditions, to directive compulsory management for certain psychiatric care conditions, and to directive management for trauma. The NP then is likely to use different skills dependent on the type of health setting where they are working. In the present study the practitioners are most likely to require assisted health care and shared facilitative management of acute conditions. The patients attended mainly for reassurance, advice and treatment.

2.7.2. Evidence of shared communication patterns

Bury, Janes, and Dowling (2005) argued that there were a number of factors that enabled a more shared approach to health care, including patient access to health information through the internet, chat room discussions, and media coverage, and the increasing use of alternative medicine. Nonetheless, Bensing and Verhaak (2006) found that communication patterns between patients GPs tend to be

practitioner directed, rather than shared consultations (Bensing and Verhaak, 2006). Barry (2002) completed a study of doctor patient communication and named four different factors that interacted to construct different versions of reality. These factors were setting, participants, time, and forms of data recording. Collins (2005) found that doctors tended to emphasise the importance of biomedical interventions, whereas nurse's interactions tended to depend initially on how they perceived patient behaviours, and were often influenced by service user's contributions and explanations. This applied to both nurses and NPs.

Barratt (2005) studied NPs in a WiC encounter and found that NPs adapted their consultation styles to respond to the styles of patient self-presentation with the aim of maximising patient satisfaction and adapted their consultation styles to help resolve tensions. Barratt collected his data through direct observations of consultations, post consultation semi-structured interviews with NPs, and the use of a field journal. His study recognised five different styles of consultation based on patient self-presentation in a WiC. The consultation styles were: patients seeking treatment, patients presenting clinical histories, patients checking the severity of their illnesses, and patients changing from seeking treatment to confirm their presentation, and finally patients who anticipated their need for treatment. Thus, Currie et al (2011) suggested that there needed to be much more research about patient-centred consultations in primary-care nursing.

Nonetheless, Appleton (1993) argued for the focus of nursing to be on caring. She used a phenomenological method to describe knowledge as the essential core of this caring and that mutual understanding of caring had the potential to add to the primary-care interaction. Hardy et al (2010) provided evidence of interconnected components that constituted expert nursing practice and included types of knowledge of which one was holistic practice knowledge. Their research model articulated professional artistry in nursing. They recommended that 'more attention should be paid to helping practitioners and patients of their services to co-construct narratives' (Manley et al., 2005:30). Stacey (1988) described this 'holistic' approach as an opportunity to develop a positive rather than a negative definition of health. All the above evidence suggests that the nature of the patient practitioner relationship is

becoming more patient-centred with SDM although the speed of change is slow (Freeman, Car and Hill, 2004). Thus, more research is needed in this area.

2.7.3. Evidence regarding cultural competence

Cultural competences such as gender relationships, resources, status and ultimate meanings are important for understanding clinical practice. Kleinman (1998) suggested that heterogeneity and complexity define most social and cultural situations and the form and practice of local cultural knowledge is not always shared. Shifts and misunderstandings in meaning have the potential to transform the clinical encounter and are especially problematic for engagement with minority patients as they see their role in the clinical encounter as less equitable than the predominant population(Katz and Alegría, 2009, Alexander, Hearld and Mittler, 2014).

Furthermore, Govender and Penn-Kekana (2007) found that gender, by itself, or along with other inequality factors, influences interactions between healthcare providers and patients. They highlighted the importance of incorporating gender into practitioner training and patient health literacy programmes to raise awareness and empower patient in their interactions with providers. Hall and Roter (2002) in a meta-analytic review found that patients talk differently to male and female physicians and that shared action statements were significantly more frequent with a female than male clinician in general medical visits. However, this was not the case with gynaecological visits. Additionally, Horman et al (1987) found that male providers tended to be identified as physicians, whereas female providers tended to be identified as nurse practitioners.

Even more interesting were the findings of Matteliano and Street (2012). In their study NPs were found to be distinct in their approaches to cultural competences in patient interactions. NPs established culturally sensitive partnerships, encouraged self-advocacy, addressed contextual considerations, and adjusted practices to meet the needs of the patient emphasising a holistic approach. Furthermore, doctors working in women's health care practice look at and talk with their patients more than other doctors, and give more medical information and advice. Although GPs have approximately the same affective behaviour, they are less verbally attentive and warm (van den Brink-Muinen, Bensing and Kerssens, 1998). Additionally, persistent

gendered assumptions can cause tension between clinician and patient, with resulting poor clinical experiences and out-comes (Owiti et al., 2014).

There is very little literature comparing the consultation styles between different health professionals. One such article recognised nurses for listening skills and the doctor for diagnostic skills (Collins et al., 2007). Other studies show gender patterns of practice differed in some subspecialties from those evident in primary care (Roter and Hall, 2004). There is also an association between race concordance and higher patient ratings but these authors suggest that the results may be due to other attitudes that mediate the patient-practitioner relationship such as increasing ethnic diversity (Cooper et al., 2003). There is a similar situation for issues raised around gender inequalities and social class with increasing recognition that there needs to be sensitivity to potential similarities in gender and social class as well as to their differences (Williams, Annandale and Tritter, 1998). In particular, gender differences in the perception of physician's empathy cannot be attributed to stereotype bias (Nicolai and Demmel, 2007). Campbell-Heider et al (2005) found that knowledge of group differences did not guide individual communications between the patient and practitioner and further results that showed little link between cultural competence and evidence based practice (Owiti et al., 2014). Furthermore, Dyche (2007) describes how the reciprocal nature of discourse is as important as the clinician's ability to interpret patient cues and adapt communication to individual patients.

In primary care, Henry, Forman and Fetters (2011) found limited recognition of nonverbal behaviours and suggested that video elicitation has the ability to offer a more complete understanding of the different kinds of information in the clinical interaction. Such information is needed as there is currently little evidence about the characteristics of nurse practitioner communication **(**Gilbert and Hayes**,** 2009), visual, sensory and knowledge communication (Bevington, 2014) and nonverbal communication (Heath, Jones and Lebaran, 1986). Furthermore, Stevenson (2014) found there was relatively little research concerned with how gestures are used with talk and yet suggested that gestural visual and nonverbal communication were especially useful in situations where there was no shared language. Additionally,

Quigley et al (2013) recommended research on patients' perceptions of specific verbal and nonverbal behaviours by the clinician.

Overall there is a basic lack in this literature of nurse practitioners and their consultation styles (Smith, 2004). However, Jackimowicz, Stirling. and Duddle (2012) in her qualitative literature review of nurse-led clinics highlighted that patients subjective experience was most influenced by establishing a therapeutic relationship, effective communication, person or patient-centred care, and a high level of clinical knowledge. Furthermore, Britten et al (2000) stressed the adverse consequences arising from the patient with insufficient knowledge and skills to fully participate in the clinical process. However, a study of doctor-patient communication differences between countries found the most important qualities for the patient were characteristics such as gender, age, having psychosocial problems, and familiarity between the doctor and the patient (van den Brink-Muinen et al., 2003). Furthermore, Dyche (2007) describes how the reciprocal nature of discourse is as important as the clinician's ability to interpret patient cues and adapt communication to individual patients.

Rogers (1956) recognised that in order to provide an effective therapeutic environment the practitioner needed to empathise and have a positive regard for the client. More than fifty years later Warnecke (2014) highlights that even with recent technological advances it is still caring and empathy that are the doctor's best therapeutic tool, and Martin and DiMatteo (2013) found communication**,** although low-tech, was still the most essential tool for delivering effective health care. The most appropriate communication skills are where the clinician takes the patient seriously, listens, empathises, and pays attention to the patient as person (Arborelius and Bremberg, 1992b). The length of the visit and eye contact between clinician and patient were also positively related to the patient's assessment of the clinician's empathy (Montague et al., 2013).

2.7.4. Evidence regarding patient-centred models

Stewart and Gilbert (2005:444) described patient centeredness as 'a widely used, but poorly understood, concept in medical practice', and suggested that qualitative studies might be the best way to interpret and share these qualities of care. There

have been many studies examining the GP patient-centred consultation using different definitions.

Stewart (1995) and Mead and Bower (2002) completed two reviews focusing on patient-centred approaches to care. Both reviews included medical studies rather than a cross section of healthcare professionals. The aim of the reviews was to find a consensus view between different patient-centred approaches. Stewart (1995) named components including: exploring both disease and the patient's illness experience; understanding the whole person; finding common ground; incorporating prevention and health promotion, and enhancing the patient doctor relationship. Stewart included lived experience and a qualitative component to their consensus view of patient-centred interaction, whereas Mead and Bower's (2002) research review focused on the biopsychosocial perspective, recognised the therapeutic relationship, the patient as person and the doctor as person, and sharing power and responsibility as themes in the literature in their review of patient-centred consultations Thus, despite the different perspective both reviews highlight the importance of the patient as a person, the patient-practitioner relationship, and the importance of facilitative processes during the consultation.

Despite this consensus it is likely that not everyone has the skills and knowledge to ensure patient-centred care. Peter Campion et al (2002:692) demonstrated only a limited ability for registrars of the Royal College of General Practitioners (RCGP) to achieve patient-centred outcomes, which he defined as 'the ability to elicit patients' ideas, concerns, and expectations'. Roter and Hall (2004) found that female physicians in primary care were more patient-centred, actively engaged, psychosocially and emotionally focused. The patients of female physicians spoke more, disclosed more biomedical and psychosocial information, and made more positive statements than those of male physicians. The visits were also two minutes or ten percent longer on average.

Lewin et al (2001) carried out, and updated by Dwamena et al (2012), a systematic review of quantitative, mixed methods and qualitative literature on randomised control trials (RCTs) and the use of interventions to improve patient-centred interaction. Lewin et al reviewed objectively measurable interventions and included

studies that encouraged shared clinical practice. They found that training in patient centredness for healthcare providers improved communication. However, in the 17 studies that met the inclusion criteria for their review, there was little consensus on the definition of patient-centredness and whether practitioner skills training in consultation practice education improved healthcare outcomes. Of these 17 studies, only two included nurses and none included pharmacists, midwives, dieticians, or physiotherapists. However, the more recent review (Dwamena et al., 2012) added twenty nine new studies of which six studies included trained nurses and/or NPs practising in community or hospital outpatient settings; and four studies included both primary care physicians and nurses.

2.8. Audio and visual video data

Visual and nonverbal communication is more accessible and can be analysed more deeply than audio recorded or observed consultations (Kuusela et al., 2013). Video may be used to examine different communication approaches (Coleman, 2000). Coleman found that using video recording was unlikely to influence the behaviour of either GPs or patients, but it could influence a person's decision to take part in the study. Similarly, Themessl-Huber et al (2008) found videoing consultations in their structured literature review showed little evidence that it changed patient or practitioner behaviour.

David Pendleton, a social psychologist, was a pioneer in using video to provide evidence of consultation practice for analysis, and was instrumental in constructing a new consultation model with GPs that emphasised patient-centred communication (Pendleton et al., 2003). GP training still uses videos of consultations for reflection and learning. Consultation videos of general practice clinical encounters were also used by GP registrars to demonstrate competences as part of their masters programme examination. Video and the videoing process then has become an essential part of primary-care clinical practice, both for learning and demonstrating best practice reflection.

2.8.1. Video as a tool for interpretation and analysis

Visual content still tends to supplement the written and spoken language, rather than having equal relevance for data analysed in a study. Thus for example, conversation analysis (CA) uses video as a tool to capture healthcare interactions, although the visual elements usually supplement the oral recordings, which were transcribed into written language before the data was analysed (Collins, 2007, Heath, Hindmarsh and Luff, 2010, Stevenson, 2014). Both the Roter Interaction Analysis System (RIAS) and CA coded verbal text and on occasion visual elements and discerned discrete measurements that were statistically measureable. Barry et al (1999) suggested that all these studies specified discrete qualitative elements and were limited in their ability to recognise the unvoiced agendas. Olsson, Sandman and Jansson (1996) used phenomenology to assess the subtleties of communication, as did Perakyla (2002) using a content analysis method.

Both CA and RIAS determine discrete interaction measurements analysing audio recorded data, supplemented with analysis of visual recordings. Heath, Hindmarsh and Luff (2010) used CA as the method of choice in their book Video in Qualitative Research, but the focus was on audio analysis using the visual images to reveal elusive phenomena (such as gestures). They suggested transcribing the audio along with repeated reviewing of three to six fragments of video, as well as sharing and discussion to focus on detailed analysis. This approach enabled the viewers to return to a section of the video, and to discuss fragments with colleagues for shared interpretation.

Videoed consultations were used to stimulate discussion and comments (Bensing, Roter and Hulsman, 2003). In fact video has been used in various ways in research methods. A Cochrane review that examined internationally recognised reviews of primary research in human health care of patient-centred interventions linked 17 studies of which nine used video as part of their intervention and one study used both audio and video (Lewin et al., 2009). These studies highlighted different uses of video.

Many different uses of video can be identified in the literature, for example: Howe (1996), Langewitz et al (1998) and Smith et al (1998) used videoing of actual

consultation interactions of the participant in simulated or in real patient clinical situations. These videos were used to support learning and education.

Clark et al (1998) and Thom, Bloch and Segal (1999) used educational videos as an intervention technique to share information and support learning. The educational videos were scripted and edited professionally; whereas; the participant consultation videos would have been recorded from a fixed point of view. None of these video studies discussed by Lewin et al (2009) or the more recently updated review Dwamena et al (2012) that included video methods as an intervention to better understand patient and practitioner communication Such as sharing a video with health information to assess if the added knowledge improves patient understanding of their health situation.

2.8.2. Video as a teaching tool

Videos recorded from a fixed point of view have the potential to provide a chronological audiovisual document of an event as it takes place (Heath, Hindmarsh and Luff, 2010). The video narrative can be played repeatedly and can be viewed, reviewed and analysed by several authors studying the same materials. Videos are used as trigger tapes for discussion that raise particular communication issues in relation to the different healthcare issues raised in the film clip (Ber and Alroy, 2001), and used in addition to illustrate and labelling particular structural approaches and issues that are raised through role play (Lumlertgul et al., 2009). Another use for videos is for education about particular chronic diseases from the patient or the practitioner perspective.

Film and video clips are useful in other areas too, such as sharing health information on the internet, or sharing examples of illness and disease processes in EPPs. Videos are also used as an intervention tool in research related to healthcare communication. An example in qualitative research is CA that only uses recorded materials transcribing audio and video in order to analyse intersubjective social order in healthcare interactions (Psathas, 1995).

Alexander, Hall and Pettis (1994) used audiovisual materials, including films and video clips for teaching and examining consultation practice. Alexander, Hall and

Pettis (1994) provide examples of situations in which film clips are used as teaching tools and called these ‘cinemeducation’. Alexander, Hall and Pettis provided a compendium of video clips derived from popular films that could be used to teach healthcare practitioners how to deal with typical situations. Tailored trigger questions were used to raise the viewers’ awareness, diagnostic impressions, therapeutic and treatment considerations, and associations with professional personal life.

Alexander (2002) provided examples of how these videos were successful in teaching practice. Henry and Fetters (2012) confirmed that these contrived film video clips that Alexander used were for a different purpose than videos recording real patient and practitioner consultations. Contrived images were able to manipulate the interpretation of images through operations such as lighting, editing and directing. Video recording in real time in a fixed position meant that there was less likelihood of contrived and constructed images that might alter the interpretation outcomes. Video used in research is for data gathering and is different than video used for education. In education the video is tightly directed and edited to maintain the viewers’ attention and to impart information and knowledge.

2.8.3. Video as a patient teaching tool in the NHS

Video clips on health education can be found on public and practitioner websites. NHS choices (2011) provides many video clips of patients relating stories of their illnesses, specific information on illnesses and disease processes such as diabetes, high blood pressure, migraine headaches and peptic ulcer disease and these are sometimes played in health service waiting rooms. Educational videos are also recognised as important for patients with psychological difficulties such as stress or depression (Chapman and Sonnenberg (2000). Chapman and Sonnenberg found such patients often state they lack health information and highlighted that health information made them feel calmer and safer.

2.8.4. Ethical issues using audio or video recording

Themessl-Huber et al (2008) discussed the advantages and disadvantages of using audio and video recording in research practice and deduced that authors needed to report their ethical and recruitment processes in greater depth for future meta

analyses. All participants should be told there was little evidence that recording consultations negatively affects their content or the decisions made in the clinical consultation.

2.9. Satisfaction with the consultation

Salisbury, Wallace and Montgomery (2010) completed a secondary analysis of patient satisfaction surveys and determined that these surveys were not useful in discriminating levels of satisfaction between practices, doctors, or different types of patients, though they were increasingly used as an indicator of doctor and practice performance. Desborough, Forrest and Parker (2012), in a systematic review of qualitative and quantitative studies of nurse-led WiCs, discerned that patients appreciated nurses listening and communication skills, and were generally more satisfied than with GP care. In primary-care visits at a managed care organisation (MCO) patients were as equally satisfied with midlevel practitioners as they were with physicians (Roblin et al., 2004). However, in adult medicine, patients were more satisfied with diabetes visits provided by physicians than by NPs and physicians assistants. However, Laurant et al (2005) in their Cochrane Review found that well-qualified nurses were achieving higher levels of patient satisfaction and similar healthcare outcomes as doctors when substituting nurses for doctors. Thus, while there is a lot of emphasis on gathering satisfaction data, it is unclear if there is a valid way of comparing performance between different professional practitioners. There is conflicting data about patient's satisfaction with medical versus nursing care.

2.9.1. Consultation times

Ogden et al (2004) suggested that the length of consultation and how the time was spent affected patient satisfaction. In particular, they suggested that a doctor who listened and tried to understand the patient's concerns was more likely to satisfy and meet the emotional needs of the patient, and achieve improved concordance with outcomes. However, a Cochrane review by Wilson and Childs (2002) found no statistical evidence that the length of the consultation affected the consultation outcome, even though there was evidence that longer consultations addressed client psychosocial issues (Deveugele et al., 2002, Zantinge et al., 2005).

2.9.2. Non-medical practitioners and out-of-hours medical practitioners

Redsall et al (2006) looked at first contact care provided by both nurses and doctors in primary care. They suggested that patients reported higher satisfaction with nurses than doctors noting that patients had less understanding of the new NP role. Nigel Crisp at the Department of Health (2005b) recognised the importance of all NHS organisations reviewing their delivery of services and asking their patients if their emotional and physical needs were being met. Crisp asked that patients be listened too as an equal, and be treated with' honesty, respect and dignity'. Crisp believed patients should feel confident, in control, and able to make choices about their treatment in a comfortable, caring, and safe environment. In order to do this the patient needs to be seen in an environment where they are comfortable to lead, are comfortable to actively engage with the healthcare professionals about their concerns and take an active part in the SDM and with concordant health treatment outcomes.

Since 2005, pharmacists have provided complete episodes of care as independent prescribers. Although it was suggested that patients were likely to accept pharmacist prescribing, a review of the literature found no available research that this was the case (Tonna et al., 2007). However, a more recent survey of pharmacists suggested that only a few pharmacists have been willing to take on these new prescribing roles (McIntosh et al., 2012).

Bowitz (2003) completed a systematic review of the effect of different models of afterhours primary-care services on clinical outcome, medical workload, and patient and GP satisfaction. The systemic review only considered GP afterhours' services and found that telephone triage and advice services seemed to reduce immediate medical workload and had the potential to reduce costs. However, patients were less satisfied with telephone consultations than face-to-face consultations.

2.10. Impact on other healthcare providers

Between 2000 and 2010, 230 WiCs opened in England (Monitor, 2014). These WiCs were very popular and exceeded expected levels of attendance. However, health providers have debated their use suggesting they created unnecessary demand for

self-limiting minor ailments, were expensive, and that the money spent on WiCs could be better spent elsewhere.

There have been three main waves of NHS WiCs in England. The first wave in 2000 involved the opening of upward of 72 nurse-led WiCs, including centres adjacent to A&Es (Monitor, 2014). These nurse-led centres were followed by the opening of six GP-led WiCs aimed at commuters that have been closed within five years. An initiative by the then Minister of Health Darzi opened a further 135 GP-led WiCs that included complex health conditions such as palliative care, whereas the remaining 50 nurse-led centres were more likely to provide health promotion and advice and information (Monitor, 2014).

In their literature review on international nurse-led WiCs, Desborough, Forrest and Parker (2012) found that other health providers viewed WiCs as improving access to primary care. However, Pope et al (2005) advised that the funding would be better diverted to existing services. The WiC clinical consultation impacted on the quality of care, and other services where a patient sought advice of a health professional to help solve a health complaint (Carter and Berlin, 2003). Rosen & Mountford (2002) recounted that clinicians (mostly nurses) in a WiC were challenged by the diversity of patient complaints, in establishing differential diagnoses, and treatment planning.

Nurse-led WiC patient-centred interaction was organised around and documented under a structured process ‘SOAP’(Cox, 2005). This is a consultation and documentation approach that is used by practitioners and students seeing, treating and documenting patient encounters (Fraser, 1992).This comprehensive and systematic approach discussed earlier in the chapter provides a useful format to organise the results of the technical tests completed in the clinical encounter which is facilitated through the clinician’s communication skills and professional artistry.

2.11. Summary

This chapter has outlined healthcare issues related to consultations between health professionals and patients in clinical practice. These issues included discussions of the different kinds of clinical settings in the NHS and the quality of communication in the consultation. The literature surveyed the use of video for research, teaching and

as a learning tool, patient satisfaction and the impact of WiCs on other healthcare providers.

This chapter established that in the consultation it is important for the practitioner to establish an accurate patient history to support the appropriate diagnosis, and for the patient to engage with the encounter to ensure positive outcomes, satisfaction and concordance. Many factors are known to influence patient participation in the consultation and these include the skills of the practitioner, patient expectations, location and type of patient need. To date much research has investigated the components of good communication, but few studies have considered the whole communication flow between patient and practitioner. Existing and available qualitative literature has used video as an intervention and documentation to better understand practitioner and patient interactions.

This narrative review also established that there was limited information on NP consultations within WiCs in particular. With the outcomes of this narrative review in mind, the following systematic literature review question was defined: What is the nature of adult patient interactions captured on video of primary-care consultations using qualitative research?

Chapter 3: Systematic review of the literature

3.1. Introduction

This chapter provides a systematic review of primary research literature regarding video recorded consultations between healthcare professionals and patients in primary care. The systematic review used a clearly stated set of objectives and an explicit, reproducible method to find studies that met the study eligibility criteria. Firstly, a search was undertaken that included research published in English since 1990, unless earlier relevant literature was found through snowballing, hand searching, and reference list searching. This systematic search was first performed in June 2012, which included studies that used mixed methods. In March 2013, the systematic review was repeated with expanded search terms. The final results included eight primary research qualitative studies that used video to understand interactions between patient and practitioners in primary-care consultations. A critical appraisal was completed of publications that met the inclusion criteria using Greenhalgh and Taylor (1997) to assess study quality. As all eight included studies were deemed to be of sufficient quality to include, data was extracted from these studies and synthesised using a thematic approach (Thomas and Harden, 2007). Four descriptive themes were synthesised from the data and are discussed in chapter three. They are complexity in communication, forms of communication, interpersonal interaction themes, and satisfaction with the consultation outcome. In addition there was one analytic theme professional artistry.

3.2. Background and rationale for the systematic literature review

A systematic literature review was completed with the aim of understanding the nature of patient interactions captured on video of primary-care consultations using qualitative research.

While Chapter two outlined policy, theoretical, and research perspectives of healthcare consultations, there was limited evidence for the holistic content of primary-care consultations and in particular for NP clinical communication. The purpose of the present chapter is to search for systematically and review any available primary research literature on clinical interaction which employed video and

qualitative methods of interpretation and/or analysis. In particular, this review is concerned with the combined audio and visual components of consultations recorded on video and how this is used to understand and explore consultation interactions in primary care. The literature search strategy identified eight peer-reviewed published articles through online databases which included primary-care video recorded practitioner and patient consultations. Findings from the reviewed papers were synthesised and the gap in the literature identified through this process was used to support the formulation of the research question for the present study.

3.2.1. Systematic review question

The systematic review question (What is the nature of adult patient interactions captured on video of primary-care consultations using qualitative research?) had four components, namely: population, issue, outcome and study design (PIOS) (see figure 3.1):

Population: Any word that captures adult patients e.g. with acute or long-term conditions

AND

Issue: Any word that captures consultation combined with any word that captures professionals involved with the consultation - i.e. with a primary-care professional

AND

Outcome: Any word that captures video recording

AND

Study type: Any word that captures 'nature' i.e. qualitative research type studies outputs.

3.3. Methods

3.3.1. Inclusion and exclusion criteria

3.3.1.1. The main inclusion criteria

The following inclusion criteria were used in the systematic review:

The articles should be published in the English language.

The publications should be related to primary care e.g. primary urgent care centre, acute care, Walk-in centre, community, domiciliary, Drop in, primary Care in accident and emergency.

The primary research should be qualitative e.g. phenomenology, grounded theory, thematic analysis, ethnography, content analysis, conversation analysis, discursive analysis, ethnomethodology, visual analysis or hermeneutics.

The primary research should use video for analysis or elicitation to support interpretation, understanding and or thematic analysis.

The primary research should focus on communication in the consultation e.g. interaction, conversations, social action, shared communication, dynamics and themes between practitioners and primary-care patients who may be called clients or users.

3.3.1.2. Exclusion criteria

The following exclusion criteria were used in the systematic review and were removed by hand from the articles returned from searches:

• Quantitative intervention or comparative studies

• Mental health issues, drug addiction, mental and physical disabilities, palliative care, cancer care, secondary health care and hospital care that were not primary care focused.

• Paediatrics or young adults under 18 years old.

• Students and education.

• Cultural or racial issues, interpreter or gender differences addressed in the title or abstract of the paper.

• Computer or telemedicine that was not a face-to-face consultation in the same physical space.

• Quantitative systematic literature reviews or literature reviews or opinion papers or letter to editors.

• An outcome which was not focused on the whole clinical consultation interaction from beginning to end, but only an aspect of it.

Simulated film and video and documentary material used for information sharing, instruction, video as print materials, as a decision aid intervention rather than for interpretation and understanding.

3.3.2. Information sources

In 2012, I worked with the University librarian to search databases to complete a pilot search. The databases searched were EBSCOhost (CINAHL full text, E-Journals, Medline with full text, Psychology and behaviour, PsycINFO, SocINDEX with full text), OVID-on-line (Amed, Embase, Global health, Journals from OVID) Web of Science, SCOPUS, Google scholar, and the British Library. These databases allowed coverage of medical (including nursing and psychology), social science and general science databases as was appropriate to the research question. A range of additional sources of information was also consulted, which included academic web search engines, websites of key organisations, hand searching of books on community nursing including the NP and practice nurse. Hand searching was completed at the Royal Society of Medicine library, the City University London library at West Smithfield, and Northampton Square, the Kings Fund library, the RCN library and the British Library. Sources were examined for research papers, editorial papers, and relevant policy documents and government directives. It was anticipated that the majority of the material would be sourced via electronic databases, even

though a considerable number of books was sourced at the British Library. The main purpose for this search was to collect papers in nursing, health and medical journals, in addition to some sociology and psychology journals which were likely to be the most current sources of information (i.e. articles published since 1990). Papers were picked out using bibliographical references searched in Google Scholar. Relevant books associated with the healthcare interaction in different academic disciplines were found in the British Library electronic integrated catalogue, grey literature and theses.

The search criteria included the terms related to the PIOS and are presented in the following table. The search terms were chosen because they were expected to capture all relevant key words. Thus for example the term ‘practitioner’ was used and included GP, family practitioner, NP, clinical practitioner, etc. (see appendix 2).

Population: adults with acute or chronic physical conditions	***Issue: Primary-care consultations***	***Outcome: Nature of video***	***Study type qualitative primary research***
(Adult OR Over 17 years AND Patient/s OR User/s OR Client/s OR Consumer/s OR woman Or Person Or People OR women Or men Or man Or adult Or interviewee	(Consultat* OR Communicat* OR Interact* OR Social action OR talk OR Discussion OR Encounter AND GP OR General practitioner* OR Doctor OR Physician OR Internist OR Clinician OR Practitioner OR Social worker OR Counsellor OR Pharmacist OR Dietician OR Physiotherapist OR Midwife OR nurse OR Health visitor OR Community Matron AND General Practice OR Primary care OR Urgent care OR Walk-in centre OR Community OR	Video* OR Audio OR visual OR Taped/tape	Hand search Qualitative OR Mixed method OR Phenomenology OR Grounded theory OR Thematic analysis OR Ethnograph* OR Content analysis OR Conversation Analysis OR Discursive analysis OR Ethnomethodology OR Visual OR Hermeneutic* NOT RIAS

Population: adults with acute or chronic physical conditions	*Issue: Primary-care consultations*	*Outcome: Nature of video*	*Study type qualitative primary research*
	Domiciliary OR Drop in OR Primary Care OR Accident & emergency Or ED Or emergency department		

Figure 3.1: Table of search terms

3.3.3. Search results

On the 14th and 16th April 2013 these databases were systematically again searched for primary research articles published since 1990, incorporating the search terms shown in figure 3.1. There was a final rerun of the search in May 2014, but no new articles were identified through this search.

In Ovid MEDLINE with full text, a total of 4231 research articles were screened on line in the database to remove easily distinguished quantitative, literature reviews and paediatric studies. This left 522 records which were downloaded to an Endnote X5 library.

In EBSCO the total number of records discovered through database searching in all the different databases totalled 4790 and a total of 220 downloaded to an EndnoteX5 library with the removal of easily identifiable exclusion criteria. There were 587 records found in Psychology and behaviour (23 downloaded to Endnote); 594 records sourced through SOCindex and 23 (downloaded to Endnote X5); 1367 records were located in CINAHL with (67 downloaded to Endnote X5), and 2,242 records were found in PsycINFO with (107 downloaded to Endnote X5).

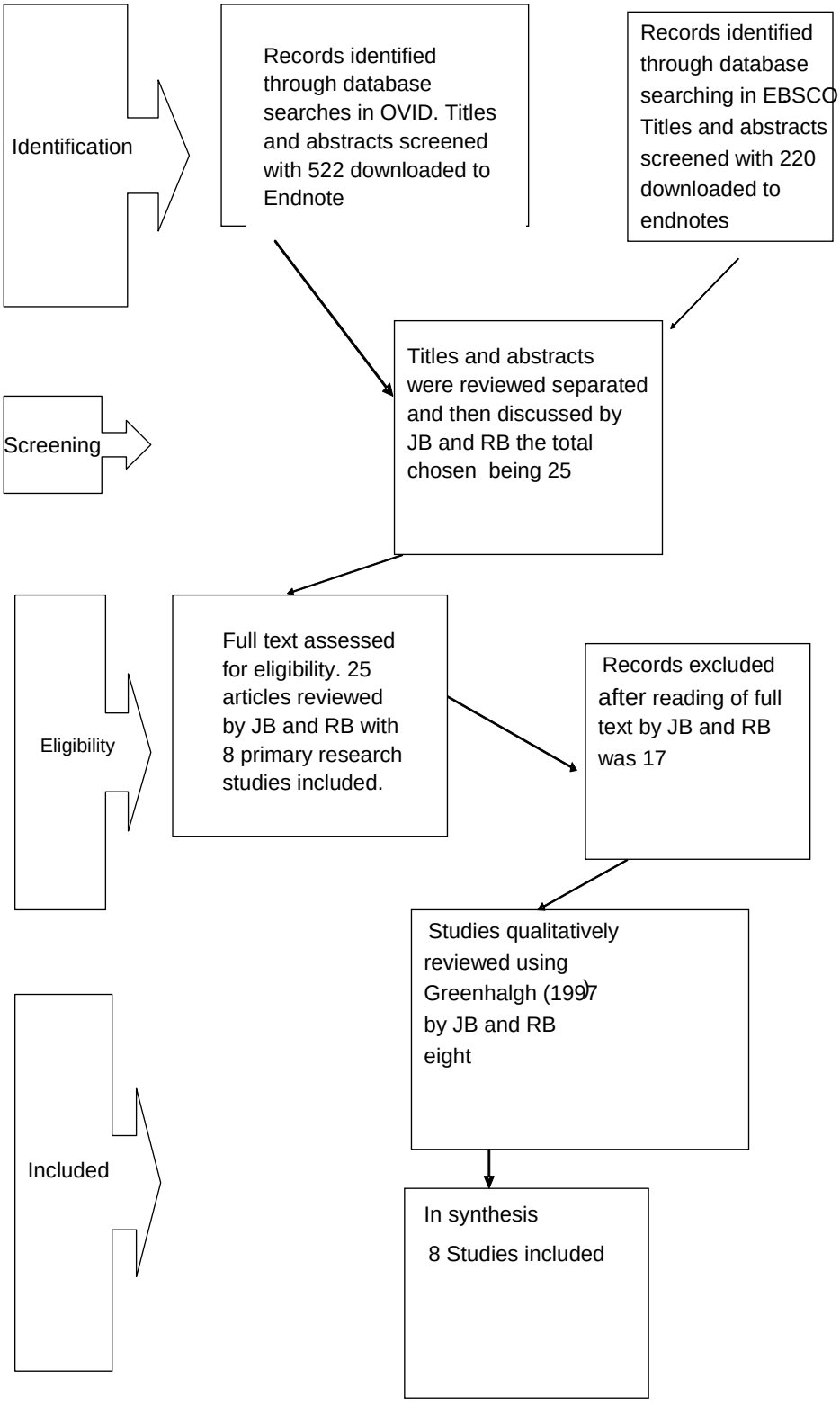

Figure 3.2: Flow diagram of systematic literature review

OVID and EBSCO databases were downloaded separately to Endnote X5. EBSCO databases were combined and duplicates were removed. The title and abstracts of

EBSCO and OVID were then separately reviewed using the inclusion and exclusion criteria; and a decision reached using the inclusion and exclusion criteria with an agreement of 25 articles.

The full text articles of all these 25 articles were downloaded and reviewed by the main supervisor and I I finding thatout of the 25 articles, eight primary research studies met the systematic review criteria (see below in figure 3.3).

Literature Title	***Authors***	***Publication***	***Date***
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	Arborelius, E and Timpka,	Scandinavian Journal of Primary Health Care	1991
What does a human relationship with the doctor mean?	Arborelius, E. and Bremberg, S.	Scandinavian Journal of Primary Health Care	***1992***
Patients comment on video-recorded consultations--the "good" GP and the "bad".	Arborelius, E., Timpka, T. and Nyce, J. M.	Scandinavian Journal of Social Medicine	1992
Pharmacists' evaluation of key communication skills in practice.	Hargie, O. D., Morrow, N. C. and Woodman, C	Patient Education & Counselling	2000
Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations.	Olsson, P. and Jansson, L.	Scandinavian journal of Caring Sciences	2001
Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	Ariss, Steven M.	Social Science & Medicine	2009
A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Bickerton, J., Procter, S., Johnson, B. and Medina, A.	Human Studies	2010
'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	Henry, Stephen G., Forman, Jane H and Fetters, Michael D.	Journal of Evaluation in Clinical Practice	2011

Figure 3.3: Table of research studies included in the literature ordered chronologically

3.3.4. Assessing risk of bias in individual studies and synthesis of results

The eight systematic literature review articles were further examined using criteria developed by Greenhalgh and Taylor (1997) (critical appraisal method or CAM). See figure 3.4 of the table below for an example of the CAM questions as applied to one of the 8 included studies (Henry, Forman and Fetters, 2011).

Criteria	*Relevant article*
Question 1 Is the paper described an important clinical problem addressed via a clearly formulated question?	Do doctors and patients identify information likely to be tacit clues or judgements based on tacit clues during health maintenance examinations?
Question 2 Was a qualitative approach appropriate?	Qualitative analysis of video elicitation interview transcripts
Question 3 How were (a) the setting and (b) the subjects selected?	72 video elicitation interviews of 18 doctors & 36 patients from 6 primary care urban,/suburban /rural/university-affiliated /private /internal medicine & family doctor practices in south-eastern Michigan
Question 4 What was the investigator's perspective and had this been taken into account?	Using reflexivity a coding scheme for tacit clues (i.e. nonverbal behaviours) and judgements based on tacit clues (i.e. gestalt judgements. Participants had difficulty or could not articulate underlying reasoning). 33 categories from text used to code transcripts by primary author & reviewed by second author. Codes modified & four new codes added. Disagreements reconciled & adjudicated by third author when necessary.
Question 5 What methods did the investigator use for collecting data and are these described in enough detail?	A modified snowball sampling technique was used to identify practices in Michigan in the USA interested in participating. Doctor eligibility criteria were being a community-based general internist or family doctor; willingness to allow one's patients to be recruited; and willingness to be interviewed and be video-recorded during consultation practice and for spontaneous comments to be audiotaped following video elicitation.
Question 6 What methods did the investigator use to analyse the data and what quality control measures were implemented?	The primary unit of analysis for this study was the transcripts from participants' audiotape elicitation interviews. These were coded using already published codes and additional codes were added. Interviews from doctors and patients were evaluated separately. The study was IRB approved. Interviews from doctors and patients were evaluated separately using a template analysis approach
Question 7 Are the results credible and if so, are they clinically important	Participants' comments fell into two broad categories: statements relating to the doctor–patient relationship, and statements relating to judgements informing medical decision making. They were credible
Question 8 What conclusions were drawn and are they justified by the results?	Doctors have different levels of nonverbal sensitivity (measured by their ability to recognise people's emotions from video clips). Doctors sometimes had difficulty articulating how they judged whether a patient was depressed, and patients sometimes had difficulty explaining why they felt comfortable with their doctors. Neither doctors nor patients always fully appreciate how or why they make certain judgements in the examination room, and doctors vary substantially in how often they recognise the role of tacit clues during clinical interactions Some doctors and patients have more insight into the role of tacit clues than others. These methods can inform interventions
Question 9 Are the findings of the study transferable to other clinical settings?	Video elicitation can improve both medical decision making and the doctor–patient relationship by providing a more complete understanding of the kinds of information – tacit and explicit, accurate and misleading – on which doctors and patients depend during clinical interactions

Figure 3.4: Table of examples of critical appraisal as applied to Henry, Forman, and Fetters.

The two tables below summarise the quality review of all eight studies using the criteria established by Greenhalgh and Taylor (1997). See questions and data in figure 3.5. for a table of summary of studies with extracted data question 1 through 5 and 3.6 for a table of summary of studies with extracted data question 6 through 9.below.

Greenhalgh and Taylor 1997 Criteria → Article ↓	***1***	***2***	***3***	***4***	***5***
Arborelius. and Timpka, 1991	Yes Short-comings in the patient-doctor relationship.	Yes	Primary care Sweden 46 pts/videos 12 GPs 4 HCs	Yes The relevance of asymmetry in the consultation relation-ship	video-recorded consultations reviewed by participants alone who audio recorded comments Yes
Arborelius and Bremberg, 1992b	Yes Patients are often not satisfied with the doctor's behaviour	Yes	Primary care Sweden 46 patients & 12 GPs at 4 HCs	Yes A Doctor's behaviour determines the patient's satisfaction with the consultation	Yes Videoed consultations were reviewed by participants later on different occasions. Comments They stopped the tape as often as wanted. There were audiotaped.
Arborelius, Timpka, and Nyce,1992	Yes Patients positive and negative experiences	Yes	Primary care Sweden 46 pts. /videos/ 12 GPs 4 HC at s	Yes Investigators reflexively comment on interaction.	Yes Video elicitation patient comments transcribed and analysed
Ariss, S. M, 2009	Yes Limitations were opportunity for patient participation & discussion of problems, treatments, & management of illness.	Yes	Primary care USA 23 frequent attendees and 10 GPs	Yes Reflexivity	Yes 13 Videos randomly chosen and transcribed
Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010	Yes Social action focused on outcomes understanding rather than in consultation communication	Yes	Primary care UK walk-in centre 28 patients /nurses ,NPs &GPs	Yes Reflexivity Shared and participatory reflection	Yes Videoed consultations of walk-in centre practitioner and consumers conversations typical situations and dynamics interpreted directly through visual and audio content
Hargie, O. D., Morrow, N. C. and Woodman, C, 2000	Yes What constituted effective communicative performance by community pharmacists	Yes	Primary care UK 15 Pharmacies 15 and 20 consultations per pharmacist	Yes Reflexivity	Yes Videos obtained of pharmacy consultations
Henry, Stephen G., Forman, Jane H and Fetters, Michael D.,2011	Yes Information & judgements based on tacit clues during health maintenance examinations	Yes	Primary care in south-eastern Michigan in the USA. Data included 72 video elicitation interviews (18 doctors and 2 patients per doctor.	Yes Reflexivity	Yes Video consultations and video elicitation interviews of, patients and doctors identified tacit clues and judgements

Greenhalgh and Taylor 1997 Criteria → Article ↓	***1***	***2***	***3***	***4***	***5***
			Doctors recruited from six different practices A modified snowball sampling technique used to identify practices interested in participating.		
Olsson, P and Jansson, L.,2001	Yes Ways of relating between midwives' & parents' in ante- and postnatal midwifery consultations	Yes	Primary care Sweden Midwifery 5 postnatal parents and 5 midwives at different centres and a total of 58 video consultations	Yes Investigators experienced caregivers, mothers and academicians, one of them with several years as a practising as an antenatal midwife.	Yes Videos Descriptions and interpretations of transcribed text along with viewing original video

Figure. 3.5: Table of summary of studies with extracted data question 1 through 5.

Greenhalgh and Taylor 1997 Criteria → Article ↓	6	7	8	9
Arborelius. and Timpka, 1991	Inductive analysis of comments into patterns, themes, and categories of analysis, followed by similarities & differences between comments	Yes Patients oriented towards relation-ships, doctors more oriented towards medical tasks.	Association of power between the parties implying mutual dependency different roles and asymmetry in the relationship. Influence of video-recording mostly marginal patients and doctors.	Yes
Arborelius and Bremberg, 1992b	Sequential analysis of transcribed audio tape. 227 spontaneous comments from patients. 21 (14 tapes) involved Dr relationship. Microanalysis usually 1 min prior to verbal and nonverbal emotional and/or intellectual messages	Yes Concrete meaning of human relationship deals with simple and obvious things: listens, empathises, and pays attentions to the patient as person.	The patient wants a real relationship not only as a patient, the doctor to take symptoms seriously, both verbally and nonverbally. It does not seem to be a question of time but rather a question of awareness of these needs.	Yes
Arborelius, Timpka, and Nyce,1992	Explorative approach based on grounded theory themes and qualitative abstractions to construct classifications of positive and negative comments	Yes Relationship with GP influenced course & choice of intervention	Acceptance of Interventions often linked to whether a GP treats the patient with respect or not	Yes
Ariss, S. M, 2009	Conversation Analysis used to analyse 13 videos	Yes Asymmetrical roles between GPs /patients collaboratively achieved during course of consultation interaction	Evidence describing barriers and opportunities for achieving patient-centred ideals could be used to change the way healthcare interactions are conducted.	Yes
Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010	Socio Phenomenology used to understand communication in Walk-in centre videos	Yes Videos interpretations knowledge based interactions between active consumers and facilitative practitioners,	Patients attending Walk-in centres are seeking information from GPs NPs & nurses and the majority of practitioners and consumers interact in harmony.	Yes
Hargie, O. D., Morrow, N. C. and Woodman, C, 2000	Videos analysed individually by the pharmacist concerned; and then groups of 3 pharmacists shared expertise & evaluations	Yes 11 core skills and 45 related sub-categories provide a cartographic representation of skills employed by	Building rapport most important skill and within this confidentiality component. Challenge to link in a measurable way skilled communicative	Yes

Greenhalgh and Taylor 1997 Criteria → Article ↓	6	7	8	9
		community pharmacists.	performance to actual health outcomes	
Henry, Stephen G., Forman, Jane H and Fetters, Michael D.,2011	Qualitative analysis of video elicitation interview transcripts identifying tacit clues: Environment, proxemics, physical characteristics, gesture/body language, touch, facial expression, gaze/eye contact, vocal cues. Examples included lighting, physical setting , distance between people, body orientation height, clothing, attractiveness, pointing, shrugging shoulders, leaning forward, hand on someone's shoulder, touching oneself, smile ,expression of surprise, mutual gaze, looking at person rather than looking at floor, voice tone, speech, sigh etc.	Yes Doctors had different levels of nonverbal sensitivity to emotions and tacit clues in video clips and patients had difficulty explaining what made them feel comfortable	Future research should further elucidate the role of tacit clues in medical judgements and doctor–patient relationships.	Yes
Olsson, P and Jansson, L.,2001	Video transcription of audio and qualitative content analysis to – identify patterns of relating	Yes A variety of content themes and ways of relating were examined. Demonstrating a basic pattern of relating interposed with other patterns.	Midwives need to reflect on ways of relating as these influences how expectant/new parents deal with information given and satisfaction with care.	Yes

Figure. 3.6: Table of summary of studies with extracted data question 6 through 9.

3.3.5. Qualitative evidence extraction

The extraction of qualitative evidence in the present study followed the guidance provided by the Cochrane Collaboration Qualitative Methods Group (Noyes and Lewin, 2011). A thematic analysis and synthesis using the model of Thomas and Harden was performed (Thomas and Harden, 2007). As there were only eight primary research articles, the process of analysing the data was completed by hand without using NVivo. During the thematic analysis process (Thomas and Harden,

2007), the primary studies were read and re-read by the second supervisor (JC) and I (JB) to establish familiarity with the literature outcomes. This was a three-level process including line-by-line coding, development of descriptive themes, followed by the development of analytic themes (Morton et al., 2010).

3.4. Summary of systematic literature review

All eight primary research articles were published between 1991 and 2011 and were all deemed of sufficient quality to review following use of the Greenhalgh and Taylor (1997) qualitative critical appraisal tool. Out of the eight primary research papers included in this review, three were completed in England (Hargie, Morrow and Woodman, 2000, Ariss, 2009, Bickerton et al., 2010b), (see appendix 10). Four of the articles included data from studies completed in Sweden (Arborelius and Timpka, 1991, Arborelius and Bremberg, 1992a, Arborelius and Bremberg, 1992b, Olsson and Jansson, 2001), and one article was undertaken in the USA (Henry, Forman and Fetters, 2011).

3.4.1. The use of video and the method of analysis

All the studies used various different qualitative methods of analysis that involved video data. Olsson and Jansson (2001) transcribed and applied content analysis to video recordings taped in the consultation room. A fixed view video-camera was placed in the consultation room prior to the entrance of the study participants. The camera was visible to all participants and the first author waited outside to be able to assist if the midwife wanted the position of the camera adjusted.

Arborelius and Timpka (1991) applied an inductive analysis to videotapes of primary-care consultations. The study participants were videotaped during their consultation; and later, the videos were shown to the doctors and patients on separate occasions. The study participants reviewed the tapes, and spontaneously commented on them. Using a qualitative inductive process, these comments were organised by the researchers into emerging patterns, themes, and categories. Arborelius and Bremberg (1992b) used a sequential analysis of these same videotapes, transcribed the audio of the video, and later reviewed and noted relevant nonverbal and visual aspects of the video. Arborelius, Timpka, and Nyce (1992) analysed the same

material using an explorative approach based on grounded theory themes and qualitative abstractions of the video to construct classifications of positive and negative comments made by patient participants. These three studies used the same videotaped data and a process of inductive analysis to develop the study outcomes.

Similarly, Henry, Forman and Fetters (2011) also reviewed videotapes of primary-care consultations, with study participants, to elicit comments from the doctors and patients as they separately commented on the tape. These video elicited comments were then analysed and coded using a coding guide of nonverbal behaviours from a major textbook (Knapp and Hall, 2009). Henry, Forman and Fetters (2011) also used video elicitation which provided an opportunity to improve understanding of the consultation process, and argued that video elicitation had the ability to offer a more complete understanding of the different kinds of information in the clinical interaction. The data included tacit and explicit knowledge, as well as accurate and misleading information. For Bickerton et al (2010b) (see appendix 10) interpretations of clinical interactions using a VS provided the opportunity to consider both audio and visual data, which has the potential to enhance understanding of the consultation interaction. Since the VS allows a repeated review of a consultation, it also offers the opportunity to be used as a learning tool for reflection, not only for practitioners, but also for patients.

As Ariss (2009) pointed out, both practitioners and patients depended on patient-centred approaches, shared participation SDM and shared understandings. These have been designed to change and improve healthcare interactions and are dependent on the study design to limit bias in the study outcomes. Ariss (2009) applied CA to particular transcribed video segments of naturally occurring interaction, applying Sacks and Jefferson (1992) who used a transcription system focussed on representing the sequential organisation of talk. Bickerton et al (2010b) (see appendix 10), rather than using a transcription of the videos of consultations, interpreted the study using visual sociology to understand social action in clinical communication.

Finally, Hargie, Morrow and Woodman (2000) used the video data for pharmacists to reflect on the quality of their practice. The pharmacist participants used a constitutive ethnographic pattern of building skills through personal analysis, group sharing, and finally, pooling their expertise and knowledge to rank the skills and competencies as important or essential for best practice qualitative interaction between pharmacists and patients. They examined the quality of practice as a whole, rather than measuring particular skills important to professional practice. The measurement of clinical skill competencies was important, but that was not the focus of the systematic literature review (SLR). The results of their study provided a ranking order of the essential communication skills that led to a quality consultation interaction for pharmacists and patients.

3.4.2. Patients and professionals in clinical consultations

Bickerton et al (2010b) (see appendix 10) was the only study that included more than one professional group in their database. The study included the interpretation of GPs, NPs and nurse interactions between patients in WiC consultations. Five articles studied the doctor and patient interaction (Arborelius and Timpka, 1991, Arborelius, Timpka and Nyce, 1992, Arborelius and Bremberg, 1992b, Ariss, 2009, Henry, Forman and Fetters, 2011) and three of these articles came from the same research database (Arborelius and Timpka, 1991, Arborelius and Bremberg, 1992b, Arborelius, Timpka and Nyce, 1992). There were three qualitative studies that included non-medical autonomous practitioners: Olsson and Jansson (2001) examined the midwife and parent interaction in a primary-care midwifery clinic, Hargie et al (2000) interpreted the pharmacist and patient interactions in community pharmacies and Bickerton et al (2010b) (see appendix 10) examined NP and GP interactions in a WiC.

All the primary research studies had both video and qualitative as part of their research method. The number of study patient participants varied from five to 46 and the number of clinician participants from five to 18. Nonetheless, all the studies used video-recorded consultations as the primary data in different ways. Henry, Forman, and Fetters (2011) used video elicitation to gather the thoughts and feelings of the practitioner and patient interaction. As the video of the consultation was replayed,

the participants were encouraged to share their own personal understandings of their recorded consultation. Bickerton et al (2010b) (see appendix 10) used video elicitation and a video schema to interpret directly both the visual and audio elements of the video materials. Arborelius and Timpka (1991) noted that the videoing process caused little disturbance and when it did it tended to be at the beginning of the video and was mostly marginal both for the patients and for the doctors. The quality of the consultation was understood through interpretation of the midwives' styles.

3.4.3. The codes, descriptive and analytic themes of the eight studies

In total, 19 coding terms were identified. These were expert professional judgements, professional controls conversation, making patient feel valued, interpreting patient nonverbal cues, patient focused, poor information sharing, patient involvement, expert patient, patient controls conversation, things patients like, things patients don't like, asymmetry in discordant or concordant interactions, non-engagement or engagement, doctor and patient perspectives, difficult communications, nonverbal communication, complex communication, shared conversations, and art of consultations.

Following several re-readings of the primary research systematic literature and studying the line-by-line coding, four descriptive themes were isolated which were 'complexity in communication', forms of communication, interpersonal interaction', and 'building satisfaction'. One analytic theme emerged, which was 'the analytic theme was 'professional artistry'. These themes are briefly summarised and discussed in this chapter.

Complexity in communication involved communication and interpretations, for example where the patient could be easily understood by the doctor, or the doctor found difficulty in assessing whether the patient understood the information. Communication in these studies included verbal and visual clues, for example interpreting body language, interpreting appearance, positioning, and use of physical appearance. These interactions mostly involved micro-communication, such as the social interaction relationship between the practitioner and patient in the consultation

narrative. An example would be tacit visual and verbal clues (Henry, Forman and Fetters, 2011).

The different forms of communication involved codes such as accord, disagreement, non-engagement, professional centred, patient involvement, and negotiating turn taking. There was a natural asymmetry in the clinical encounter due to the difference between doctor's and patient's perspectives, the importance of good information giving, patient centredness, and patient concerns about not getting what they need.

Interpersonal interaction was related to discordant and concordant relationships. An example of a concordant relationship between practitioner and patient was where the patient felt listened to and heard, and the practitioner was able to articulate clearly the treatment and give the necessary advice and reassurance.

Building satisfaction with the consultation tended to occur when codes such as equal knowledge, equal conversations, trying to meet the patient's needs, negotiating appropriate management in partnership, turn taking and reassurance.

The analytic theme was professional artistry and followed the definition used by Fish (1995), which differentiates artistry from professional technical skills. The artistry skills involved being able to have a holistic view of clinical practice involving not only verbal communication skills, but more importantly invisible aspects of practice that were critical for enhancing technical knowledge and informing best clinical practice. The codes relating to professional artistry involved the art of communication used for meeting patients' needs and negotiating appropriate management. An example is:

> 'I'll use my body a lot, I mean, I'm pretty focused about it' and 'you're also going to see ability to steer the conversation. I mean you can do it non-verbally'. These comments suggested that this doctor had given the role of non-verbal behaviour in doctor– patient interactions considerable thought' (Henry, Forman and Fetters, 2011:937).

3.4.3.1. Complexity of communication in healthcare consultations theme

The first theme identified was the complexity of communication in healthcare consultations. For example Ariss (2009) identified how GPs managed conflict by a variety of mechanisms including: not making comments on patient's comments.

> ‘The following example demonstrates how GPs might resist patients’ talk by withholding responses….. the patient precedes a statement regarding the type of treatment which works best for her (i.e. ‘‘bed rest’’, line 3) with a sequence marking what is to follow as a potential source of conflict (‘‘I KNOW NOWADAYS th[ey do TELL YOU NO]T to’’, line 1). Notice also that this turn has raised volume (in capitals) and successfully resists the GP’s overlapping attempt to’ (Ariss, 2009:913)

All eight articles in this systematic literature review examined themes and patterns of communication as a whole throughout a primary-care consultation. The studies analysed clinical interaction and its effects of the whole consultation on different aspects of the process. The studies investigated a wide range of verbal and nonverbal, intellectual (and on occasions) emotional interactions as well as the dynamics realised between the patient and practitioner. For example Arborelius and Timpka (1991) examined the reciprocal understanding between the practitioner and the patient and how it was influenced by shared knowledge, the ability to communicate concerns, and to what extent the consultation participants were comfortable with each other’s social interaction. Two examples from Arborelius, Timpka and Nyce (1992:215) are:

> “I was anxious that I would not get everything I wanted to have” “Forced by time ... will I get what I need right now, here, so I can end and continue with other things I have to do the rest of this day?”

> ‘You can ask him about everything, he doesn’t behave in a superior way and he doesn’t laugh at a simple question’.

3.4.3.2. Different forms of communication theme

The second theme identified was the different forms of communication included all eight studies. The reviewed studies identified different types of communications with different types of patients. Sometimes this was to pace the consultation to the patient’s needs.

> ‘’…. see how I slow down the pace of the patient. You . . . find yourself doing that as you read the patient. You have to pace the dialogue to the patient. It’s nice to see that I don’t look rushed in the room. Although in my mind, I’m whirling. Okay, so I sit down, I try to relax and look relaxed. This [video] is interesting, because I’m, I’m even though she’s talking I’m not looking at her, I’m, I’m semi-listening to her. Which is good feedback for me because I should

> probably kind of probably look at her face more . . . she knows that I'm paying attention' (Henry, Forman and Fetters, 2011:937).

Arborelius, Timpka and Nyce (1992) asked patients to distinguish between a good and bad GP. A good relation with a doctor is experienced when the doctor listens in an involved manner to what the patient says, treats the patient as an equal, is trustworthy and is a provider of care and not just medical services. On the contrary the bad GP acts in an uninterested or distanced manner and the patient is worried about not getting what they want, or feel humiliation due to the GP's superiority.

> "I really felt I was taken care of"
>
> "He decided for me what to do-lovely" (Arborelius, Timpka and Nyce, 1992)

Henry, Forman and Fetters (2011) discussed consultation interactions falling along a continuum that moved from analytic and deliberate content to intuitive and tacit content. Tacit clues are data that clinical participants use to reach judgements, but are not directly noticed during the consultation interaction. These tacit behaviours were often difficult for the consultation participants to discern precisely, due to the reasoning behind them. Henry, Forman and Fetters, (2011:936) provide a few examples of commonly mentioned tacit clues through gesture or body language, physical appearance, and vocal cues:

> 'You know, and sitting down and having them explaining it, and not explain in doctor terms, but in my terms. . . . Something I can understand.'
>
> '[the patient] in a biker shirt you know with his boots and his, and his beard and that look that – that he's ah, he's a skeptic . . . he's here reluctant – I gotta prove myself to him, every point I make has to have some basis, and something he can understand.'
>
> 'She's also the kind of [patient] that if um you um try to cut her short she'll make it harder for ya, so you kinda let her talk a little bit. . . . if I cut her short she'll kinda raise her voice and keep talking kind of thing.'

Olsson and Jansson (2001) recognised different patterns of nonverbal and verbal communication and identified five different patterns sets of behaviour between the midwives and their antenatal and postnatal participants. There were three basic patterns and two less used patterns where the basic features were either communicating actively or listening passively paying or not paying attention and the

midwives were either actively facilitating or instructing or lecturing. The only tension in any of the consultations was when the parents were listening absentminded. Overall, the midwife's communication style was directing the consultation content. Bickerton et al (2010b) (see appendix 10) interpreted different kinds of shared conversations between consultation participants which were named as emotion, knowledge or movement and if they were an engaged or empathic conversation.

Ariss (2009) noted that doctors used the most convenient and practical communication methods when time was short in the consultation. As doctors, they appeared to be open to negotiation, but at the same time limited the patient's discussion of symptoms. Arborelius and Timpka (1991) found that doctors focused on task-oriented issues, while patients tended to focus on the relationship with the doctor. In fact, one third of all patient comments were about the relationship, whereas the doctors only commented on the relationship six percent of the time, and were much more likely to comment on task-oriented issues. Some of the comments from the patients had no correspondence to the doctors' comments. For example the doctors commented on the difficulties in writing/glancing at papers during the consultation, whereas no patient commented on being disturbed by this problem (Arborelius and Timpka, 1991).

3.4.3.3. Interpersonal interaction theme

The third theme identified was the interpersonal interaction dynamics that took place in all eight studies. Several studies identified an overall asymmetrical relationship between practitioners and patients (Arborelius and Timpka, 1991, Ariss, 2009). Arborelius and Timpka (1991) noted that asymmetry in the clinical interaction was related to the doctor's medical knowledge and the power connected to this knowledge; Ariss (2009) also found asymmetries related to the boundaries of the patient's knowledge and how sharing was sequenced during the consultation. In Arborelius and Timpka (1991), this asymmetry was illustrated in some of the patient's comments on the doctor's behaviour where they accepted that the doctor was the only person who could diagnose, prescribe, but nonetheless, patients commented that they might not be listened too or get their preferred treatment and therefore felt powerless.

> ". . . the patient is easy to get on with, she gives clear and adequate information". The contrast can be: "... a tricky patient, difficult to relate to, difficult to understand what he, in fact, meant" (Arborelius and Timpka, 1991:73).

The asymmetrical relationship was also found in the midwives with their antenatal and postnatal parents. The research found that midwives developed particular patterns and themes as individuals and as professionals in their consultation patterns. The research found five patterns, which included three basic patterns where the midwives were directive in two of their consultations and the parents were passive (Olsson and Jansson, 2001). These findings were different from the study where GPs, nurses, and NPs in conversation with patients were more likely to be facilitative and the consumers active in their communicative dynamic practice (Bickerton et al, 2010) (see appendix 10).

Ariss (2009) found that different orientations to knowledge in health topics meant that certain topics became closed without discussion or concordance in the consultation. In consequence, doctors and patients may not be explicitly aware of this pattern behaviour and the tacit clues which indicate the phenomena is occurring, and yet there appeared to be no previous research studying the relevance of emotions and knowledge judgements functioning as tacit clues, and hence it is unlikely that the Doctors had training in how to better manage the communication process (Henry, Forman and Fetters, 2011). Arborelius and Bremberg (1992b) noted that there was an association between the doctor's behaviour and patient's compliance. If the patient understood the doctor in a positive way, then the communication was effective, i.e. the doctor was paying attention to them and their concerns, which in turn promoted the patient's cooperation.

> 'I know the first place that she'll stop [if she has real emotional trouble] will be [my office] and that's probably a more appropriate time to try to do something with her depression . . . and you go well that's pretty smug, . . . get off your high horse Dr ___, how do you know all this stuff? Well because I know. I mean, it's here. … like, you've seen her lots of times. I can't describe every detail as to why I know that, but I've been down the road long enough to know . . .' '(Henry, Forman and Fetters, 2011:937).

Bickerton et al (2010b) (see appendix 10) suggested that where a patient took a passive approach to the consultation dynamic, the practitioner was at odds as to how

to provide facilitative interaction practice, because it led to tension in the interaction. This then provides another example of the asymmetrical relationship. Similarly midwives adopted five patterns of communication, of which there were three basic patterns which were named “the ‘respectful gardener and her developing plants’, ‘the propagandist teacher and her ignorant pupils', and` the steering inspector and their representatives of the population” to direct parents who became passive during the birthing process (Olsson and Jansson, 2001).

3.4.3.4. Building satisfaction with the consultation

The fourth sub theme identified was satisfaction with the consultation outcome and although there were two studies that explicitly mentioned satisfaction as part of their findings (Arborelius and Timpka, 1991, Arborelius, Timpka and Nyce, 1992). Other articles in this systematic review suggested that satisfaction with the consultation interaction was dependent on communication, and as (Henry, Forman and Fetters, 2011) suggested was supported by a range of nonverbal and verbal cues.

> ‘And I didn’t feel like she was like looking at – I never saw her look at her watch. . . . I never that [sic] she was thinking oh this has gotta be done, I gotta go to the next patient. I was – No I was real happy with her. ‘Cause sometimes you can see the doctors like getting impatient or whatever’(Henry, Forman and Fetters, 2011:936).

Hargie, Morrow and Woodman (2000: 68) established that effective communication was closely connected to patient satisfaction and provide as an example reassurance and rapport building:

> ‘‘This medicine is extremely effective and I would expect the inflammation to clear up within the week’’.
>
> ‘‘I understand your worries, but their own needs, and this in turn demands a more really you are OK’’.
>
> ‘‘ I think you’d be better taking the adult Meltus because it just thins the phlegm and then you cough it up yourself . . . ’’. ‘‘Have you tried an inhalation at all? Sometimes it can help . . . ’’.

Arborelius and Timpka (1991) examined what made an interaction approach more or less satisfactory. The results showed that the patient and doctor were interested and satisfied with different aspects of the consultation. Patients commented on the effect

of the relationship itself, whether it was positive or negative, whereas doctors tended to share a patient's ability to provide adequate information about their health concern.

The patient's experience of a satisfying human relationship with the doctor corresponded to specific behaviour such as explorative, listening, and/or emotional responses from the doctor. When reciprocal eye contact was present, the patient's comments seemed to express a satisfaction with something more than the doctor's mere listening to his medical symptoms. A probable interpretation was that the doctor had understood and responded to the patient, e.g. by active and empathic listening (Arborelius and Bremberg, 1992b). On the other hand, when the patient felt dissatisfied with the relationship with the doctor, there was specific behaviour such as the absence of these kinds of responses.

> "The patient's comment: 'He is unbelievable at listening, you know, and specially that he really takes his time. I feel, how I can say it, he just takes his time. That's so wonderful. In one way I almost feel relief, when I go out from there. The fact that there is a person who really has listened to me. At home I often think I have said the same thing umpteen times during the same day. I really feel myself nagging"' (Arborelius and Bremberg, 1992b:163).

The patients commented more about relationship with the doctor and expressed a need to be seen and accepted by the doctor as a person rather than a patient. These needs were both realistic and practicable in most kinds of consultations. It did not seem to be a question of time, but rather a question of awareness of these needs. Such needs were described in the relationship between the infant and the mother in psychodynamic theories, especially the object-relations theory (Arborelius and Bremberg, 1992b). Therefore, for example, when a doctor listened carefully and took the symptoms seriously and, provided emotional responses, there was the potential to support the patient's self-esteem, self-respect, and self-confidence. However, the patient's self-image could be damaged when the practitioner belittled the problems, or did not have eye contact, or answer emotional messages.

Henry, Forman and Fetters (2011) noted that both patients and practitioners made judgements based on tacit clues during video elicitation interviews, when they were reviewing their clinical consultation with an author. Henry, Forman and Fetters found

that, although both doctors and patients made judgements in the consultation based on tacit clues, some were better than others at consciously interpreting these clues. They found that nonverbal behaviour was the most common category of tacit clue mentioned by both patients and doctors. It should be noted that there were relatively few references to tacit clues overall, but within those references patients and doctors discussed the judgments that were made differently. It was discovered that participants had different levels of sensitivity to nonverbal emotional communication.

3.4.3.5. Professional artistry theme

The analytical and overarching theme from this systematic review is that of 'professional artistry' where by the health professional was able to attune to different clients. This theme was found in six studies (Arborelius, Timpka and Nyce, 1992, Hargie, Morrow and Woodman, 2000, Olsson and Jansson, 2001, Bickerton et al., 2010b, Henry, Forman and Fetters, 2011).

> ''I think I kinda sensed, ya, I mean he's kinda a quiet guy and I don't know, maybe I just interpret that as he's listening and wants more information', or 'I probably cue on some things I'm not even conscious of' (Henry, Forman and Fetters, 2011:936).

The results of this review determined that the primary-care interaction was complex having micro and macro-communication components which altered moment to moment as professional and patient related to each other. However only Henry, Forman and Fetters (2011), Ariss (2009), and Bickerton et al (2010b) focused more on the micro rather than the macro components of communication. The interaction of professional and patient is not fully understood nor fully researched within the literature. Moreover, Hargie, Morrow and Woodman (2000) emphasised the importance of the context of the healthcare situation itself and that this inevitably affected the behaviour of the participants and needed to be considered along with the face-to-face interaction itself.

It could be argued also that the research method itself affects the context of the healthcare situation, that there was a long way to go before practitioners and patients could begin to understand fully the meaning of clinical interaction. The interaction process was not only complex within a particular healthcare discipline, but

also across primary care. All the studies in this literature included medical and non-medical practitioners working in primary- care services seeing and treating patients as autonomous practitioners. Midwives, pharmacists, NPs, and GPs work in collaboration in primary care and many of the communication skills researched in the studies are applicable across professions. In fact Bickerton et al (2010b) (see appendix 11) did not differentiate between GPs, nurses and NPs as professionals seeing and treating patients in a WiC, and argued that the VS had the potential to be used across health professionals seeing and treating patients as autonomous practitioners in the primary-care context.

3.5. Summary of findings

Eight primary research studies were found from the systematic search which applied the relevant criteria from the question: what is the nature of patient interactions captured on video of primary-care consultations using qualitative research? The review included international primary healthcare services from the UK, the USA, and Scandinavia: two took place in the USA, three in UK and three in Scandinavia and included data from medical and non-medical practitioner consultation practice.

Only one study combined data from GPs, nurses and NPs. The other seven studies focused either on primary-care medical practitioners or on non-medical practitioners. In the non-medical practitioner studies there was one study focused on pharmacists, one study that focused on midwives and the present study, which included GPs, nurses, and NPs with the result that little is known about the skills sets that different professional bring under similar situations with patients. It was not clear how these factors might have influenced the study outcomes, but the literature search does show that there are proportionally more studies examining medical practitioners (5) in primary care than there are non-medical professionals (3) in this SLR that found a total of eight relevant primary research articles.

Although the studies all used video to collect the original consultation data, audio data was most frequently used to interpret the micro-verbal and nonverbal aspects of communication. Where the visual element was included in the other data analyses it was almost always supplementing the audio content, unless the video was used for

video elicitation and the comments were audiotaped. This occurred for various reasons. Either the video was used for video elicitation and the comments were audiotaped, or conversation analysis was used so the transcription focused on the audio conversations in the video, or the audio was transcribed and notes taken on the visual materials of the video. Only one study directly interpreted the video giving equal value to both the visual and the audio elements of the video materials.

3.6. Research implications of the review

A variety of different analytical methods were used in the eight reviewed studies: content analysis (Olsson and Jansson, 2001), inductive analysis (Arborelius and Timpka, 1991) and qualitative analysis of video elicitation interview transcripts (Henry, Forman and Fetters, 2011). Ariss (2009) used CA to describe and compare discrete patterns of communication at the beginning and end of each conversation sequence. Socio phenomenological analysis was used to interpret WiC typical situations in consultations (Bickerton et al., 2010b) (see appendix 10) and constitutive ethnography was the method the pharmacists used to cooperatively locate essential communication skills.

Thus, video appears to offer the potential to capture the quality of not only transcribed audio recordings during a consultation, but also an opportunity to examine the visual elements of a consultation. Of the eight studies using video to collect consultations in primary care, six studies used video elicitation where the comments were audiotaped, or interpreted directly into themes or patterns. The two other studies applied conversation analysis and or content analysis.

The five descriptive and analytic themes identified in this SLR in chapter three supported much of the narrative literature discussed in chapter two. Chapter two found only limited studies completed on the primary-care nursing consultation and Fleischer et al (2009) identified that most nursing research on communication was completed in hospitals and nursing homes rather than primary-care practice. Additionally, Desborough, Forrest, and Parker noted that because WiCs were relatively new there were only a limited number of completed studies, and even less research examining the nature of consultations at WiCs.

Complex communication in advanced nursing practice in primary care tends to be based on the work of GPs because of the lack of community nursing research (Smith, 2004). Additionally Gilbert and Hayes (2009) found there was little research or knowledge on the characteristics of patient and ANP communication specifically in the WiC. Where research was completed, Fleischer et al (2009) found that forms of communication and interpersonal nursing skills tended to be understood synonymously in empirical findings and theoretical knowledge.

Laurant et al (2005) in their Cochrane Review identified that well-qualified ANPs were achieving higher levels of patient satisfaction and similar healthcare outcomes to doctors when substituting nurses for doctors, and Halcomb et al (2007) recognised patient satisfaction was most dependent on the professional's 'confidence and credibility' as well as 'interpersonal and communication skills'. However, Laurant et al (2005) emphasised there was no valid way of comparing performance between different professional practitioners.

Benner (1982) introduced the concept of professional artistry in nursing using phenomenology. Benner found that clinical experience informed practice and in particular, novice nurses became expert nurses over time as they developed skills and understanding of patient care through theory, clinical practice and experiential communicative artistry. Appleton (1993), similarly to Benner, applied a phenomenological method, and described how a mutual understanding of caring had the potential to add to the primary-care interaction. In agreement, Manley et al (2005) recommended that more attention be paid to helping practitioners and patients to understand better how to co-construct narratives.

3.7. Gaps and recommendations for further research

As a result of this systematic review, several gaps in knowledge in this area of primary-care video healthcare interaction have become evident which need further investigation. There were proportionately far more studies that included the medical practitioner rather than the non-medical practitioner. There were no studies focusing only on the NP and patient consultation in the WiC situation. Although the studies examined complex interactions, there was less consideration given to the emotional

component of conversations than to intellectual content or information, whether given verbal or nonverbal. Healthcare interactions tended to be interpreted through audio transcription with the visual content supplementing the audio through direct video observation with note taking, unless conversation was captured through video elicitation. This lack of appreciation of the visual aspects of video is a potential barrier for fully understanding the professional artistry of consultations. The literature supported that both patients and practitioners should be engaged in the consultation to support better patient outcomes. The following revised study question has been established as result of this review: What is the nature of video recorded consultations between NPs and patients aged 18-65 years attending a walk-in centre with a minor ailment?

Chapter 4: Overview of the methodology and method used in this thesis

4.1. Qualitative methods in the systematic literature review

The qualitative methods in the systematic literature review, outlined in the chapter three, included both video elicitation interviews and direct personal reflection of video elicitation (Bickerton et al, 2010b). For example, Ariss (2009) audiotaped the participant's comments of their videoed consultation which were later transcribed and analysed. In other studies both the participants and authors analysed and interpreted the video directly, making notes on the nonverbal or visual aspects of the video, or made video elicited comments which were audiotaped and later transcribed (Arborelius and Bremberg, 1992b). These methods were varied even though they all began with the collection of primary-care video consultation data.

Henry and Fetters (2012) suggested that audiotaped commentary of video elicited consultations between patients and practitioners gave researchers an opportunity to integrate the thoughts, beliefs, and emotions of the study participants into the content of the video content. Henry and Fetters (2012) also supported the gathering of data on specific events or moments in the consultation interactions. This method was different from a conversation analysis (CA) method that distinguished relevant discrete moments and events in transcriptions from recordings (Atkinson and Heritage, 1984). CA tends to use recorded data as either transcribed audio data alone or transcribed audio and visual data. Video elicitation used by Henry and Fetters (2012), applied a labour intensive and expensive method that combined standard interviews with video recordings in order to fully understand and improve primary-care interactions consultation practice as data was collected and analysed through an ongoing research generating theory process. Bickerton et al (2010b) (see appendix 10) used video for the elicitation of the reflexive narrative understanding of the author and not for video elicitation interviews. The video materials were interpreted directly in a socio-phenomenological approach interpreting the video materials involved understanding the video as a dynamic face-to -face conversation, text and narrative, rather than, using a transcription of the recorded data(as would be used in CA). CA would make discrete measurements of face-to-face conversations,

whereas the patterns analysed by Schutz were more difficult to verify and validate (Knoblauch, 2013). However, the VS used in the present study, allowed the video to be replayed directly interpreting the video materials and story as a whole in realtime, rather than first transcribing and then analysing the video material using Jefferson's notation (Sacks and Jefferson, 1989). The present study VS integrated the work of four phenomenological twentieth century philosophers and thus provided a qualitative reliable and repeatable scientific method (Denzin, 1970) This VS is applied using the experience of the reviewer. I am an ANP and have previous experience of interpreting video narrative using phenomenology (Bickerton, 1992a).

4.2. Overview of this chapter

This chapter provides an overview of the methodology and methods used in this thesis, in particular a discussion of the use of audiovisual data in the method, and phenomenology as the methodology. The chapter discusses the use of a convenience sampling method to select study participants (Parahoo, 2014). Finally the chapter deals with the choice of study samples, the use of video elicitation, the ethical approval process, the importance of rigour for the study findings and an overview of the VS which was used to interpret the videos of WiC consultations.

The present study method was based on visual sociology and included a qualitative method of interpretation based on a theoretically derived VS, phenomenology, image elicitation, and reflexive narrative interpretation (Harper, 1988). The terms are loosely defined by Harper (1988) and are further explained below. Nonetheless in Harper (2012) the phenomenological methodology was closely linked to ethnomethodological and ethnographic methodologies, rather than a communicative and strategic framework used in the present study (Habermas 1987a). Video and photographs can be used not only to document events, but also to elicit data (Harper, 2012). Video in the present study is used to elicit the unique qualities of audiovisual materials reflexively organised into a dynamic narrative. This differs from Heath, Hindmarsh and Luff (2010) who analyse the unique qualities of video as discrete elements of a document. They transcribe the audio materials of particular moments in the video document supplementing the transcription with relevant visual notations.

Visual methods, used to interpret healthcare interactions, are a recent development and are seen as a valuable addition to written and spoken language (Harrison, 2002). Harrison's review of the use of the visual image in sociological literature distinguished between different components of visual data in documentation, illustration, and art forms created using a range of products such as pen or paint, video and film. In the present study visual sociology was applied to everyday videos of primary-care WiC consultation narrative. The video medium was found to be versatile and readily available for use by both amateurs and professionals. In particular, video was seen as an excellent tool for amateurs to record natural events from a fixed point, as it was used to record the WiC consultations.

4.3. Quality in clinical consultation communication

Research data on the nature and quality of the health consultation communication has been collected in many different ways. Data has been most frequently gathered through surveys, questionnaires, interviews or focus groups, which were completed before or/and following the face-to-face consultation using postal or telephone interviews. However, it was rare to include the visual elements with the verbal directly within the video analysis communication (Bickerton et al., 2011). In order to do this, audio and visual data from the consultations were recorded and replayed, or directly observed in practice. Harrison (2002) discussed how health disciplines and health-related research have begun to include the visual world of consultation as a unique topic of sociological study. Knoblauch and Schnettler (2012) recommended reflexive video analysis because it facilitates intersubjective hermeneutical understanding.

Barry et al synthesised four factors influencing patient-doctor communication and pointed out that the perception of the consultation differed markedly according to whether the source was an audiotaped consultation, the transcript of the consultation, or differing accounts offered by doctor and patient. Barry et al also pointed out that the research team of five members' sometimes confounded accounts of the same data (Barry et al., 1999). Thus, Barry et al (1999) concluded that this detailed interpretation of a consultation was time intensive and required skilled experienced authors. The present study author suggests that only using a real

time audiovisual method of interpretation offers the possibility of a less costly method and less contentious research outcomes.

4.4. The present study methodology: phenomenology

Classic phenomenological analysis describes the subjective everyday lived experience as always intentionally directed toward an object or something (Spiegelberg, 1972). These subjective perceptions of lived experience are structurally organised but are not measurable. They are in Husserl's view the universal and invariant structures of the lifeworld. Lifeworld is the world of immediate lived experience where the horizons of temporality, spatiality, intersubjectivity, embodiment and mood dimensions are interconnected in consciousness. In this WiC video present study, these subjective experiences were elicited through audio and visual materials in video. The audiovisual materials characterised the structurally organised lived experience of the lifeworld as video image or object. The present study methodology, following Spiegelberg (1982) extended Husserl's theory to include Sartre, Schutz and Ricoeur's, guiding themes that led to the further development of phenomenology in the twentieth century.

4.4.1. The phenomenological movement

Phenomenology has many different schools with similarities and differences (Dowling, 2007). Spiegelberg (1982) published a history of the phenomenological movement and established a number of guiding themes that ran through twentieth-century phenomenology and dispelled the assumption that there was an organised school of phenomenology. The movement was divided into two schools: German and French. The phenomenologist Edmund Husserl (1859-1938) began the German movement, and was later followed by Max Scheler (1874-1928), Alfred Schutz (1899-1955) and Martin Heidegger (1887- 1976). The later French phenomenologists included Jean-Paul Sartre (1905-1980), Maurice Merleau-Ponty (1908-1961), and Paul Ricoeur (1913-2005). The phenomenology of Husserl, which provided the grounding for this visual sociology method is summarised in figure 4.1 below. This phenomenological approach was further developed or adapted by philosophers Sartre, Schutz, and Ricoeur.

Phenomenology (adapted from Spiegelberg, 1982)	Phenomenology
Edmund Husserl (1859-1938).	Husserl described reflexive experience from a first person point of view. Knowledge was built on personal patterns of experience where knowledge was not transparent, the essence or thing in itself was arrived at through phenomenological bracketing or epoché and was understood through the essential structural qualities of the phenomenological experience. Bracketing or reduction is the process of recovering original awareness (perception) of describing only the structural qualities of personal intentional acts and objects known through lived experience. This reflexive act/object relationship existed in the stream of consciousness or lifeworld and involved temporal and spatial awareness that included kinaesthetic, intellectual, emotional, empathic and intersubjective awareness. Phenomenology was concerned with the structure of experiences described through perception, thought, memory, imagination, emotion, desire, bodily awareness, embodied action and social activity such as language.
Sartre explained the distinction between perceptual and imaginative consciousness through Husserl's concept of intentionality	It viewed the structure of experience as intentionally directed toward objects and was an act/object relationship. This perceptual consciousness relationship was different from the things they represented: there was a thing in itself and the imaginative representation of the thing.
Schutz and phenomenology	Social action originated in the intersubjective consciousness of social action and knowledge of the everyday lifeworld. These intentional relationships were always experienced directly and transparently without drawing on existing theories and belief. Experience was interpreted through a stock of knowledge at hand, the natural attitude of everyday life and practices of common sense reasoning in a particular culture.
Ricoeur and phenomenology	Hermeneutics combined phenomenological description and interpretative hermeneutics expanding the study of reflexive textual interpretation to include reflective narrative theory.

Figure 4.1: Table of phenomenological attributes

4.4.2. Phenomenology

The phenomenological movement thus manifested itself in different approaches and included different styles. However, in the methodology used in this thesis all the phenomenological approaches were connected initially through the concept of the lifeworld or lived experience though their styles developed different aspects of phenomenology (Husserl, 1980). The different approaches that include Schutz (1964), Sartre (1969) and Ricoeur (1984) are discussed in the development of the VSl below.

Sartre (1969) developed a psychology of the imagination where personal lived experience was organised through temporal and spatial reflexivity, kinaesthetic, intellectual, emotional, empathic, and intersubjective awareness. Understanding was built on personal patterns of experience. These patterns of experience were only

built through understanding that was grounded in personal knowledge. Transparent knowledge was arrived at through bracketing all knowledge, which was not based on this knowable lived experience.

Sartre (1969) described how knowledge, emotion, and movement organised in varying ways. Sartre's interpretation recognised emotion as an essential structure alongside movement and knowledge. Our understanding was structured by these psychological elements interacting with each other. However, this interpretation was never more or less than the lived experience of the person perceiving the situation. This lived experience existed prior to objective and scientific data and is realised in this current study through the video image.

4.4.3. Phenomenology and sociology

Whereas, Sartre described the intentional structures of individual lived experience, Schutz (1964) was interested in the intentional social or shared structures of lived experience. Ethnomethodology discussed below was also considered by Psathas (1968) as a phenomenological approach to social science and Garfinkel acknowledged the influence of phenomenology (Eberle, 2012). Garfinkel (1967) was concerned more with appearances, whereas Schutz focussed on transparency. For Schutz (1964) lived experience was constructed in the stream of consciousness and assumed a mutually shared understanding and was the basis of all human interaction. Social phenomenology supported a mutually shared connection at the beginning of any social action. Schutz focussed on establishing formal structures of lived experience in everyday social situations as well as a pragmatic understanding of everyday typical situations that were based on practical experience and an understanding of a historical social world. This understanding was relative to particular situations in social history and provided individual experience with an order of meaning and a particular way to experience the world. This knowledge was based on practical experience of the world (Schutz, 1967). Schutz included in his pragmatic world, a stock of knowledge at hand, a natural attitude of everyday life and practices of common sense reasoning.

The stock of knowledge at hand was socially acquired knowledge such as our general knowledge of the NHS, or as the national understanding of illness, disease,

health, and wellbeing. A natural attitude of everyday life held that laymen and sociologists alike have similar understandings of health care which would endorse the NHS plan that the public should have the ability to take the lead in their health care (Department of Health, 2000). The third practice of common sense reasoning supported the existence of facts taken for granted and alongside unique experiences. Thus, in a health consultation, personal health experiences were viewed from a perspective of both a generalised approach to the consultation where the practitioner learned about the patient's health concerns, their history, and made a physical assessment that led to a possible diagnosis and plan of action and treatment. Each health consultation was unique as each participant brought a unique history. There was no way of knowing all these multiple realities and it was the professional artistry of the practitioner that mostly facilitated a shared understanding of the subtle communication and relationships.

This generalised order of the consultation was located in human signs such as language and knowledge, emotion and expression, patterned bodily movements derived from Schutz's analysis of face–to-face interactions, and in the present study these are interpreted as emotions, knowledge and movement conversations (Sartre, 1969, Bickerton, 1992b)

4.4.4. Phenomenology: the hermeneutic narrative

Ricoeur and Thompson (1981) were also concerned with lived experience and how action was interpreted and explained. Ricoeur interpreted the objective, social action and personal lived experience. For Ricoeur knowledge was understood through action, text, and narrative. These different kinds of lived experience were dependent on three different kinds of phenomenological or temporal spatial relations. Phenomenological time was not chronological but expanded and contracted dependent on interpretation and reflection. Prefigured time was based within a historical context and our biographical history. Ricoeur outlined two further kinds of interpretation named configuration and refiguration. Configuration was most likely to occur in problem focused or task oriented reflexive consultations where the conversation was directed to solving a health problem and providing a solution or treatment. Refiguration supported reflective interpretation where the participants

engaged in multiple shared connections through lived experience that bring together different conversations and levels of meaning to the understanding of health and wellbeing. Hermeneutic or interpretive phenomenology differentiated between the reflexive configured or problem focused reality and the reflective and reconfiguration of reality. This refigured experience only occurred through reflective fully engaged interactions.

In summary these three different phenomenological hermeneutic methodologies of reflexive and reflective practice supported the integration of shared and personal lived experience and provided an approach to organising communication (see fig 4.3). Of these three different phenomenological approaches it is Schutz to date who lacks a presence in nursing research as Paley (1997) noted and Dowling (2007) illustrated when she reviewed the different phenomenological methodologies used in nursing research. While Dowling (2007) recognised many different schools of phenomenology nonetheless, neither Schutz or Scheler were included although they were important figures in the German phenomenological movement (Spiegelberg, 1982).

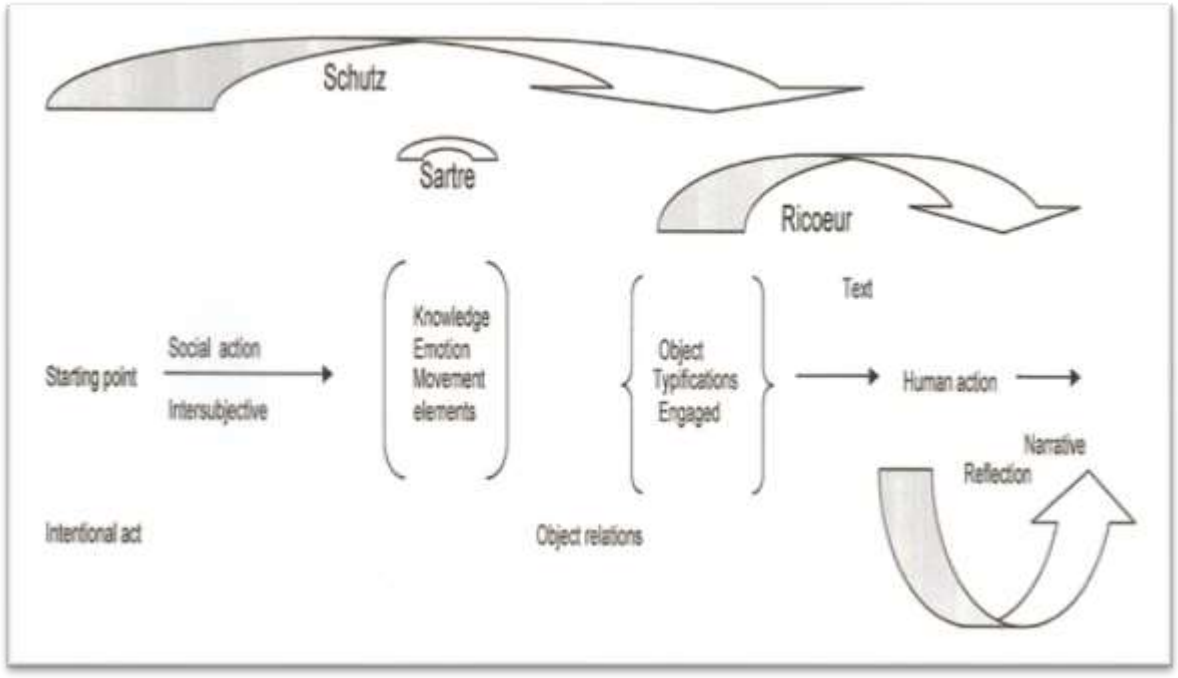

Figure 4.2: The phenomenological methodology of the present study

4.4.5. Data collection method: semi- structured observation

During observation a researcher systematically notes and records events or activities that they are viewing (Marshall and Rossman, 1995). In unstructured observation researchers place few restrictions on the data collected (Polit and Beck, 2012). Spradley (1980) uses a progressive unstructured to more structured approach where observers undertake experiencing everything using all senses before focussing on elements of their observations. I too, through a process of progressive focussing progressively focused my interpretation from an overarching impression to phenomenological structures as I watched and re-watched the videos (see figure 4.3). During the first stage of the VS process I observed the full range of activities that occurred during each WiC consultation (physical activity, posture, non-verbal and verbal interactions), I noted down everything and anything of interest that I saw. I then watched the videos over and over again, making notes and reflecting on the different elements that I was viewing until I was sure how each video could be interpreted in light of essential structures.

Thus, in undertaking VS I used phenomenological essential structures and essences to progressively guide my interpretation of what I was observing. As this places some restrictions on what I interpreted, particularly in my later observations, I was using a semi-structured observational technique in which my purpose was to use phenomenological schema as an internal observational guide to my interpretations. (By definition semi-structured observation usually draws on a predetermined schedule or checklist (O'Leary, 2009)). While unstructured interviewing or observation enables different information to be gathered from each participant (Polit and Beck 2012), a semi-structured technique enabled me to collect and collate similar information from each observation (see my observations on semi-structured interpretation using the video schema figure 4.3).

The Elements	***The Schema***	***The Observations***
Realising an intuitive impression of the videos on WiC consultations	The lifeworld	The lived experience
The first step in interpreting these videos of Wi/C consultation using the VS involves a rapid viewing of the videos, in which one forms an initial, intuitive, overarching impression of the story which is followed by a more in-depth interpretation.	In this viewing mode my attention to the details of the video consultation was nonspecific, allowing them to wash over me in a manner similar to skimming a book. I watched the videos with the intention of paying attention to the video materials as a whole to gain an intuitive grasp of the overall meaning. Using this approach helped me to avoid falling into the trap of using a natural attitude.	My intention in the initial viewing of the videos of WiC consultations is to discover the intuition and intended core meaning of my lived conscious experience of the video narrative. I begin this analysis with an open mind. I am non-judgemental and attempt to experience the video without applying any preconceived meanings. As I gain a more intuitive understanding of the communication in the video I begin to pay more attention to the spatial and temporal qualities of the experience as whole. I understand and intuitively grasp the meaning of the narrative as a sense of the whole. I find that the more experience I have with communication in WiC consultation communications, the greater is my ability to grasp an intuitive meaning.
The Interpretation focused on the intersubjective shared connection	The lifeworld	The lived experience
The second step is to replay the video this time experiencing only the relationship of the video materials to the video image.	It is important to try *not* to impose any knowledge that is *not* the experience of the present moment a bit like an abstract pattern. For example. Pointillist impressionist painting is an example of dots of paint viewed closely with the realisation of a representative image when the viewer steps back (Douma, 2006). Audio and visual data is experienced and organised through emotion, knowledge and movement rather than the coloured dots of pointillism.	During this second replay of the video I pay attention to the video material. Sound and visual stimuli run together throughout the chronological order and development of the video image. These materials are as yet unrelated impressions that mirror the living world of consciousness. The video material makes and remakes itself through visual movements and aural sounds. I try not to step back and understand the video images as forms. Rather at this stage I am absorbed and carried along with visual and verbal combined social action. I experience the video image as background without separating the actions of the two consultation participants in the video. This provides a shared and intersubjective experience of the consultation conversations. I pay attention to the video as I might to water flowing in a river and this image helps me to experience a shared connection.
Interpretation of the video conversations	The lifeworld	The lived experience
I listen and observe the different elements of the conversations and their tendencies start to emerge and gather, leading towards a particular object of conversation. Some of the lived experiences are more vivid than others. Again I do not distinguish between the two individual study participants in the consultation, but rather intend the schematic temporal and spatial relations as emotion,	I listen and observe the different elements of the conversations and their tendencies start to emerge and gather, leading towards a particular object of conversation. Some of the lived experiences are more vivid than others. Again I do not distinguish between the two individual study participants in the consultation, but rather intend the schematic temporal and spatial relations as emotion, movement and knowledge conversations. I listen and observe the different elements of the conversations and their tendencies start to emerge and gather, leading towards a particular	I listen and observe the different elements of the conversations and their tendencies start to emerge and gather, leading towards a particular object of conversation. Some of the lived experiences are more vivid than others. Again I do not distinguish between the two individual study participants in the consultation, but rather intend the schematic temporal and spatial relations as emotion, movement and knowledge conversations. I experience these video materials as schematic images are activated and overlaid with a representative material of a mass of sensible qualities of the object. Over chronological and temporal spatial time these qualities become representative of an emotion, movement and

The Elements	***The Schema***	***The Observations***
movement and knowledge conversations. I experience these video materials as schematic images that are activated and overlaid with a representative material of a mass of sensible qualities of the object. Over chronological and temporal spatial time these qualities present an emotion, movement and knowledge conversation as transcendent object.	object of conversation. Some of the lived experiences are more vivid than others. Again I do not distinguish between the two individual study participants in the consultation, but rather intend the schematic temporal and spatial relations as emotion, movement and knowledge conversations. I experience these video materials as schematic images are activated and overlaid with a representative material of a mass of sensible qualities of the object. Over chronological and temporal spatial time these qualities become representative of an emotion, movement and knowledge conversation as transcendent object. In this step I begin to separate the distinct elements integrated across the video image as a whole and do not differentiate between the consultation participants. I pay attention to the visual and aural emotion, movement and knowledge elements in a similar manner to an abstract or a schematic picture filled with different proportions of emotional, knowledge and movement content. I experience these video materials as schematic images activated and overlaid with a representative material of a mass of sensible qualities of the object. Over chronological and temporal spatial time these qualities become representative of an emotion, movement and knowledge conversation as transcendent object.	knowledge conversation as transcendent object. In this step I begin to separate the distinct elements integrated across the video image as a whole and do not differentiate between the consultations participants. I pay attention to the visual and aural emotion, movement and knowledge elements in a similar manner to an abstract or a schematic picture filled with different proportions of emotional, knowledge and movement content.
An *emotional* conversation	The lifeworld	The lived experience
	Examples of emotional conversations could include communicating through facial expressions, sharing expressions, mask like and inexpressive, or emotionally present and filled with interest. The visual elements could include a smile which might generate emotion, movement or knowledge content. A sound may indicate support for either element. It needs to be stressed that it is only my interpretation that makes these decisions that are unique to my understanding of the shared communication.	I experience the patient stating that he is a barista, pausing before he adds that he is a barista in Starbucks. During the pause, the practitioner leans back and appears confused. He holds his pen above his note pad and looks puzzled pondering how or why a barrister would be working in Starbucks. The patient recognises the confusion and actively waves his arms in the air gesturing carefully, miming making coffee using a coffee machine. As the patient moves his arms, the nurse laughs and throws his head back and says that in English a barrister is like a lawyer. The patient laughs too, gesturing with his head while gazing at the practitioner suddenly becoming aware of the confusion. His face expresses understanding over the confusion that of course he is not a lawyer or barrister but a barman. The nurse raises his head and nods exclaiming yes and okay as he chuckles acknowledging his new understanding. I experience these participants enjoying the conversation and clearly articulating a shared ability to be empathic,

The Elements	*The Schema*	*The Observations*
		engaged and readily able to recognise emotional cues.
A movement conversation	The lifeworld	The lived experience
	A movement element is identified as communication through examples as above such as smiles, gestures, touch, body language, posture, or physical distance for example with their bodies relaxed or stiff and immobile, shoulders tense and raised, or relaxed and slightly sloping. Movement is more likely to be visual in effect than audio although the noise from scraping a chair or sneezing, or through eye contacts or movement suggests movement. Communicating includes the mutual gaze when the participants look at each other directly as opposed to looking at the floor.	I experience spatial more than temporal movement as visual body movements provide horizontal, diagonal, and a global understanding of movement. The practitioner uses his left hand to touch the patient's neck as his right hand holds an orthoscope in his lap. I watch the practitioner touching each side of his own neck first to demonstrate what he was going to do in the examination. The patient mirrors his movements verbalising and touching areas of soreness around her neck while moving her head from side to side. The conversation includes emotion and knowledge elements but the overarching conversation in this section of the video is a movement conversation.
A knowledge/information conversation	My lifeworld	The lived experience
	Processing information is perceived through the video materials or wordless and visual cues between people. Pointing, shrugging shoulders, leaning forward, or eye contact could all illustrate sharing knowledge and information. Other examples include audible vocal cues or processing information as a drop in voice volume. The verbal communication includes asking questions (open, directed, affirming for example), shared decision making (facilitative or directive) including verbal information and knowledge	I experience two participants sharing information and knowledge in an empowering manner. They are actively engaged. They talk in slightly raised voices using a deliberate slow speech pattern. The couple share information in different ways. The hand gestures illustrate making coffee and the humorous observation of this demonstration by the practitioner supports an emotion element. These different ways of communicating take place through visual and verbal communication and support an overarching knowledge conversation of understanding.
The overarching conversation	The lifeworld	The lived experience
Reflecting over time I begin to develop a sense for which attributes are providing the overarching shared communication. All the conversations have all three elements, but over time there is a tendency to associate with a particular type of conversation in a consultation.	Elements of the various verbal and visual elements of conversation essences have a tendency to cluster towards an overarching conversation. In the WiC study conversations knowledge was the overarching conversation. However, it should be noted that each interpretation is a unique understanding of the situation.	As I observe the different video conversations in video narrative evolving through the various movement, emotion and knowledge relationships, I find one conversation supported by the others which develops into the overarching conversation. For example, movement was the overarching conversation as the participants favoured shared visual hand gestures and particular body stances alongside various vocal tonal qualities supported by emotion and knowledge relationships.
The objective conversation	The lifeworld	The lived experience
In order to become aware of someone paying attention and to pay attention to them, it is necessary to have distance from the shared interpersonal relationship and shared concrete consciousness. When the orientation is objective a person is intentionally aware of the	The shared connection is the shared pre-conscious orientation. With an objective conversation both participants step away and reflect on this connectedness in the stream of consciousness. As I interpret the video I learn to reflect and objectify the subtext or inner life standing outside the flowing present or shared interpersonal connection.	I interpret an emotional conversation experience through the erect motionless bodily posture of the practitioner and the fidgeting and lack of concentration of the patient. I experience no empathy and the conversation is not engaged. The conversation is objective where the tone, quality and the sound level of the voices lead to an increased recognition of their frustration at the situation.

The Elements	***The Schema***	***The Observations***
other person. One participant affects the other while the second observes a relationship where the two partners experience each other in the lifeworld.		
Empathic or engaged conversation	The lifeworld	The lived experience
An engaged empathic conversation may emerge out of the consultation communication. When this takes place the participants are interpreted as empathic and engaged in the conversation (Schutz, 1967). A face-to-face engaged orientation is where the consultation participants are empathetically drawn to each other following an objective relationship.	The face-to-face social relationship is shared through a community of space and time and these various types of conversations are never only one-sided. I experience the engaged shared connection between the participants as different levels of intimacy, intensity and directness.	I discover the articulation and presence of a bond between the two participants as I experience a trusting empathic and an engaged conversation. This is supported by a particular way of laying a hand on a shoulder, shaking hands, and the touching of a face with a hand. I felt this intimate touch was appropriate within the context of the consultation and experience these gestures, the intensity, pacing and timing as paying attention, being empathic and caring. I listen and watch how these movements; both audible and visual demonstrate personal concern.
Typical situations	The lifeworld	The lived experience
Knowledge of these typical situations is based on practical experience of the world. Schutz included in his pragmatic world, a stock of knowledge at hand, a natural attitude of everyday life and practices of common sense reasoning. Typical situations emerge through an accumulation of conversations falling along a continuum of one of four typical situations (see figure 4.12). Situations are defined through the attitudes of the practitioner and the patient in terms of action and authority. In making a classification, it is important to present a phenomenology of the interactive situation-in-general. These typical situations point to specific behaviours, symbols or spatial configurations that justify the classifications.	A model of action is created through a process where common-sense is continuously under construction derived from practical experience of the world of the video image. The present video model which provides interactions in harmony or tension, offers active partnership in care and directive and passive dynamics. An interpretation might include both kinds of dynamic situation with one ultimately appearing to be more present than the other. I assume that the more knowledge I have of the essential structural typical situations in the context of the WiC NP consultation, the more potential there is for the conversation dynamic to be flexible within the dynamic typical situation. This makes each consultation unique as each participant brings a unique history and there is no way of knowing all these multiple realities.	My understanding of the particular consultation dynamic is influenced by my cultural and individual experience which includes my experience of working with individual NPs and seeing and treating patients in the WiC with minor ailments. What this means is that I have a particular way of experiencing the consultation communication because of my personal, cultural and social biography. So for example one of the essential structural dynamics is a facilitating practitioner. In this particular video, I experience a practitioner open to the patient's active questioning and involvement with their health care. I am also aware that the patient on occasion listens attentively and passively when the practitioner uses more directive communication approaches. The patient and practitioner dynamic evolve through a harmonious interaction where the patient is active and there is little or no tension. There is one moment initially when a misunderstanding occurs with the patient's occupation; the practitioner is directive and the dynamic in tension. However, it is quickly resolved as the participants resolve their misunderstanding through shared, engaged and empathic humour, gesture, and verbal articulation.
Textual consultations	The lifeworld	The lived experience
Ricoeur understood knowledge through action, text, and narrative. These reflections lead to different levels of understanding and objectification. The health	I used Ricoeur to interpret and configure the objective, social action and personal lived experience of the videos. Different kinds of lived experience are dependent on three different kinds of temporal spatial relations. Time is not	In these videos I find that the communicative outcomes are inextricably linked to the conversations and typical situation outcomes. As a patient sits down in a GP's office, the GP immediately begins to present her with difficult and bad news which the patient appears to know

The Elements	*The Schema*	*The Observations*
consultation is always more than a shared connection based on the reflective interpretation of lived experiences. Typical situations as a whole are determined to be either prefigured text, configured text or refigured text for Ricoeur. The interpretation of the video prefigured action is based within a cultural and biographical narrative whereas the video story is configured into a text.	chronological, but can be expanded or contracted dependent on interpretation and reflection. Ricoeur outlined two further kinds of interpretation which he described as configuration and refiguration. Configuration was most likely to occur in problem focused or task oriented consultations. It reflected on constructed spatial and temporal interactions in an extended presence. The video materials substitute and structure the video narrative though vivid temporal and spatial relationships. These relationships occur where the psychological and communicative habits of our pre-figured video narrative are configured through reflective associations and syntheses that are novel in relation my habitual and conventional associations. The VS focuses on the essence of conversations that include emotion, movement and knowledge and the structural dynamics of harmonious and tension situations.	nothing about. The tone and visual aspects of the conversation resonates discomfort and shock. The patient is confused and at first, the GP doesn't seem to be aware that the patient is hearing the bad news for the first time and is in a state of shock. The GP takes a long time to read the patients emotions and gestures which embody this knowledge, and continues to be directive. He is blocking shared understanding of the conflictual situation. The shocked patient eventually moves from a passive to more active position where her bodily stance is more erect. Leaning forward she actively gestures to gain the GPs attention. She asked that the information be shared again with her husband present later in the day. This was agreed. The interaction was in tension throughout the consultation although the GP communicated in a more conciliatory manner following his realisation of the blunder he had made. He attempted to change the outcome to a more harmonious situation but there was very little that he could do to change the patient experience.

Figure 4.3: Semi-structured observations using the video schema

4.5. The present study method

The present study applied a qualitative method integrating both a phenomenological methodology discussed above and strategic action (Habermas, 1987). The video data of primary-care WiC consultations were used for video elicitation which was interpreted through reflexivity, strategic action and narrative. The study findings were checked for rigour applying triangulation.

Audiovisual materials of video were experienced through the organisation of emotion, movement and knowledge. I experienced and reflected on the video image as perceptual, conceptual and narrative content and organised the video into conversations and typical dynamics situations. The videos were interpreted by examining each video session for personal and shared communication, attentiveness, engagement and empathy. These interpreted elements are valid to apply to the WiC consultations as the criteria are similar to the NHS approach that expects the practitioner to provide empathic care using a facilitative patient-centred

approach; and for the patient to be encouraged to become actively engaged in the communication process (Department of Health, 2005a).

4.5.1. Present study environment

The study participants enrolled in the study were all attending or working at a London WiC. The centre was open between 7am and 10pm on weekdays, and between 9am and 10pm at weekends and on public holidays. The centre was adjacent to a large London Hospital Accident and Emergency Department. The WiC saw and treated about 750 patients a week**.** The patients mirrored the ethnic diversity of the local population which was slightly less than half white British and a third being Bangladeshi. The patients did not need to be registered with a GP and were seen on a first come, first served basis but were moved up the queue if they appeared distressed. There were no appointments. Patients visiting the area choose whether to attend the A&E or WiC health service as they felt most appropriate, although, if patients attended the WIC with, for example, chest pains or broken wrists, a red flag protocol ensured that they were redirected to the Emergency Department.

All the nurse practitioners worked in extended roles, seeing and treating patients with undifferentiated health complaints. They were expected to diagnose and manage patients as autonomous practitioners and could supply several medicines under patient group directions and extended nurse prescribing. They also tried to resolve clinical problems through health education, promotion and advice seeing, treating and discharging patients autonomously or in collaboration with other practitioners in the centre or by referral to other health services. The most common presenting illnesses seen at the WiC were sore throat, earache, abdominal pain, rashes, stress, coughs and dysuria; also commonplace were patients presenting in need of emergency contraception.

The WiC saw and treated children too but these were not included in the study. A higher proportion of young people attended the WiC than other healthcare services and the service was available to people with rare and unexpected illnesses who were visiting London from elsewhere in the UK or abroad. Patients were seen and treated for minor illnesses at the WiC but all minor injuries were referred directly to the nurse led minor injuries unit (MIU). The centre occasionally provided healthcare

advice and treatment for long term conditions but did not manage them. The centre did not provide repeat prescriptions or sick certificates, or fill in disability forms.

The WiC was staffed by nurses from various clinical backgrounds - primary care, district nursing, health visiting, midwifery, occupational health, practice nursing and ED nursing - as well as by GPs, receptionists and interpreters. The WiC practitioners were made up of novice, proficient and expert nurses. In general, one of four novice nurses was on duty at any time, with two or three of the more than 10 proficient nurses and one of the four ANPs. One of the GPs usually worked each shift. There was a morning shift that started at 7am and an evening shift that started at 2 or 3pm. The WiC was busiest during the middle of the day so one extra nurse would work from 9 to 5pm. On any one day between 9am and 5pm there would be between 4 and 7 nurses on duty. Practitioner participants were approached to see a study patient if they were not in the middle of another consultation and were available to see a patient. It was essential to maintain the efficient running of the centre so consultations took place as in a normal clinic and practitioners saw patients without appointments and fit into the clinic timetable.

4.5.2 The present study sample

The sampling method was a convenience sample (Parahoo, 2014) . A convenience sample is an inaccurate representation of a larger group of the same population as the research cohort, which in this case is the WiC population. The sample is taken from a group of participants that are relevant to the research question and that were available to be recruited in the appropriate study setting during a particular period. Patients and practitioners were approached to be part of the study if they were working in or attending the WiC. The present convenience sample included both NPs working at the WiC and patients attending the WiC. The participants were approached directly to consider participating in the present study.

The study was discussed with patients and practitioners on the days the research was collected. No exclusion of participants was made based on gender or ethnicity but all of the participants were aged over 18. The research participants were included if they wished to participate and they met the requirements for inclusion. Coyne (1997) in her article discussing qualitative methods of research used in

nursing studies, further differentiated sampling techniques between convenience and theoretical methods. In the present study, theoretical methods were not included because the data collected was not adapted during the data collection to meet the needs of an emerging theory. The video data was collected on four days over two weeks on 9am to 5pm shifts between 22nd and 26th January 2005. The sample included a small data size set of 32 videos. The sample size was arrived at through comparing other studies that used video data for qualitative analysis. So for example, Ariss (2009) analysed twenty-three videos using conversation analysis. However, in a phenomenological study with midwives, fewer study participants were included and were followed over a period of up to a year or more (Olsson and Jansson, 2001). Authors using grounded theory as a method of analysis accumulated data beginning with a small number of participants, adding to their database to upward of 40 participants (Arborelius, Timpka and Nyce, 1992). On the other hand, Henry, Forman and Fetters (2011) used a database of 13 videos and transcribed 36 patients and 18 community doctors' reflections on the videoed consultations.

Time Slots	***21st January 2005***	***24th January 2005***	***25th January 2005***	***26th January 2005***	***27th January 2005***
9-11am	NP (F) (Proficient)	NP (F) (proficient)	NP (M) (Proficient)	ANP (F)	NP (F) (proficient)
11-13:00	NP (F) (proficient)	GP (F)	NP (M) (Proficient)	NP (F) (Proficient)	NP(F) (proficient)
13:-15:00	Nurse (F)	NP (F) (proficient)	NP (F) (Proficient)	Nurse (F)	NP (F) (proficient)
15- 17:00	ANP (F)	ANP (F)	GP (F)	ANP (F)	GP (M)
18-20:00	GP (M)	NP (F) (Proficient)			

Figure 4.4: Practitioners' on duty on days of data collection

4.5.2.1. Nurse practitioners on duty

The number of practitioners on duty on the days the study data was collected were from four to six and each day included a combination of the different practitioners outlined in figure 4.4. The data collection began at 9am and only ran over 5pm on two of the four days (see figure 4.5). The specific roster times for the study participants changed in the day practitioners worked in the main due to patient list and practitioners already seeing other patients when a study patient participant was waiting for a practitioner to see them. If a practitioner who was enrolled down for the

study was seeing another patient when a study consultation slot became available then the first available practitioner saw the patient. So for example on the 21st the GP and nurse saw patients at the beginning of their shift rather than at the end.

No.	*Date*	*Time*	*Practitioner*	*GP Registered*	*Study data*	*M/F gender of patient*	*Patient complaint*	*Diagnosis*
1	21/01/05	10:00	Nurse &GP	yes	No	Female 62	L. eye pain	Stye
2	21/01/05	11:00	Nurse &GP	yes	No	Female 20	Sore mouth	Apthous ulcer
3	21/01/05	11:45	Nurse &GP	no	No	Female 26	Sore throat	Viral tonsillitis
4	21/01/05	12:30	GP	no	No	Female 27	Numb arm	Pulled muscle
5	21/01/05	13:00	GP	no	No	Female 22	Earache	URTI
6	21/01/05	13:30	GP	yes	No	Male 28	Sore throat	Staph infection
8	24/01/05	09:30	NP(F) (ONE)	no	Yes	Male 49	R. Shoulder pain	Muscular strain
9	24/01/05	11:45	NP(F) (ONE)	no	Yes	Female 25	Cough & fever	Viral URTI
10	24/01/05:	12:45	NP (F) (ONE)	yes	Yes	Female 23	Acid feeling in chest	Indigestion
11	24/01/05	13:20	NP (F) (ONE)	no	Yes	Female 24	Itching skin	Allergy
12	24/01/05:	14:00	NP(F) (ONE)	no	Yes	Male 25	Headache	Migraine
13	24/01/05	15:35	NP (F) (TWO)	no	Yes	Male 22	Diarrhoea	Gastroenteritis
14	25/01/05	10:15	NP(M) (THREE)	no	Yes	Female 29	Abdo/chest pain	Musculoskeletal
15	25/01/05:	11:00	NP (M) THREE)	no	Yes	Female 25	Cold/fever	Cold
17	25/01/05:	15:00	NP (M) THREE)	no	Yes	Male 24	Nausea & vomiting	Viral infection
18	25/01/05	15:15	NP (M) THREE)	no	Yes	Female 20	Sore Throat	Quincy
29	25/01/05	16:00	NP (F) (FOUR)	no	Yes	Male 28	Ear infection	Viral
22	26/01/05	10:00	ANP(F) (FIVE)	no	Yes	Male 26	Swollen lymph node	Localised infection
23	26/01/05:	10:30	ANP(F) FIVE)	no	Yes	Male 29	Sore throat	Pharyngitis
25	26/01/05:	11:15	ANP(F) FIVE)	no	Yes	Male 22	Flu	Viral URTI
26	26/01/05:	11:30	NP(F) (FOUR)	no	Yes	Male 40	Dizziness	Positional vertigo
28	26/01/05	13:15	NP (F) FOUR)	no	Yes	Male 26	Ear infection	Otitis externa
29	26/01/05	13:30	NP (F) FOUR)	yes	Yes	Female 20	Fever/cough	Viral infection
30	26/01/05	14:30	ANP (F) (SIX)	no	Yes	Female 19	Sore throat	Tonsillitis
31	26/01/05:	15:00	ANPI (F) (SIX)	No	Yes	Male 25	Cold/fever	Sick Note
32	26/01/05	:15:15	ANPI (F) (SIX)	yes	Yes	Female 46	Bleeding skin tag	Referred back to own GP

Figure 4.5: The video time line

4.5.2.2. Excluded videos from the study

There were a total of 12 videos not included in the analysis; 6 videos were excluded because it was subsequently decided to exclude trainee nurse practitioners and/or GPs from the analysis because the main population of interest were experienced NPs. In the present study novice nurse practitioners are nurses, proficient nurse practitioners have been working in the NP role at the WiC for at least 6 months and the ANPs had completed a recognised advanced practice training qualification (Bickerton, 2010b). Four videos were found to be off and not to have recorded at the end of the consultation and two patients withdrew at the end of the study process but before they left the WiC. These six videos then, were also excluded (see figure 4.6).

No.	***Date***	***Time***	***Practitioner***	***Registered with GP***	***Study data***	***Patient health complaint***	***Diagnosis***
1	21/01/05	10:00	Nurse &GP	Yes	No	L eye pain	Stye
2	21/01/05	11:00	Nurse &GP	Yes	No	Sore mouth	Apthous ulcer
3	21/01/05	11:45	Nurse &GP	No	No	Sore throat	Viral tonsillitis
4	21/01/05	12:30	GP	No	No	Numb arm	Pulled muscle
5	21/01/05	13:00	GP	No	No	Earache	URTI
6	21/01/05	13:30	GP	Yes	No	Sore throat	Staph infection
7	24/01/05	9:15	Video off	ND	No	ND	ND
16	25/01/05	ND	Video off	ND	No	ND	ND
19	25/01/05	ND	withdrew	ND	No	ND	ND
21	25/01/05	ND	withdrew	ND	No	Insect bite	Shingles
24	26/01/05	ND	Video off	ND	No	ND	ND
27	26/01/05	ND	Video off	ND	No	ND	ND

Figure 4.6: Study participants withdrawn from video interpretation

4.5.3. The present study ethical approval process

In qualitative research, the researcher is the instrument and so validity hinges to a great extent on his/her skill, competence and rigour (Patton 1990). Ethical approval is a requirement for all research studies to aid researchers to consider in advance ethical dilemmas that might arise in any research project. As Holloway and Wheeler (2010) suggest the study rigour is determined by the description of the process in enough detail so that the reader is able to determine if the results are rooted in the findings. Additionally, Polit and Beck (2012) stated that study rigour requires the reader to be able to audit the actions and developments of the researcher.

Paratoo (2014) raised a number of reasons why patients and practitioners may feel obligated to take part in a study and one of these issues included the participants feeling that the study might benefit others. Another issue raised by Holloway and Wheeler (1995) was how qualitative studies tend to rely on the close relationship between the study participants and the researcher. This study was no different raising particular issues with the relationship between, not only the practitioner participants working at the WiC who might feel obligated to be supportive of my research but also patients and their vulnerability and lack of power in the clinical encounter. In this particular WiC study the nurse practitioners working on a day of research data collection may have felt obligated to participate. Furthermore, there was the potential for participants to feel that there might be reprisals if they did not participate. As I was aware of these issues I made every effort to articulate to the potential participants how this would not be the case. Every attempt was made to not label anyone as uncooperative if they did not participate. It was not a requirement for either the practitioners or patients to conform but I did share the study information and consent form freely with anyone who wished to learn more about the study. Appendix five contains the information sheet for staff and the one for patients.

The ethical approval process provided an opportunity to think through and try to resolve these ethical issues in advance (Burns, Gray and Grove, 2014). I was the primary instrument in making sure the present study data was ethically rigorous and valid with the data interpretation hinging to a great extent on my advanced nursing skills and video interpretation skills, along with my ability to be flexible and insightful with the ability to build on tacit knowledge (Lincoln and Guba, 1985, Patton, 1990). In my application for ethics approval, I set out to test the transferability of a process of analysis derived from my master's thesis. I had observed in clinical practice that there were many assumptions drawn about the purpose, meaning and experience of the consultation from notions of efficiency and effectiveness in health care delivery. The embodied experience of the consultations for both parties had not been recognised as an important feature. I wanted to interpret the lived embodied experience of the video consultation. I wanted to discover if I could read the video narratives as texts applying phenomenological concepts. I was reassured to discover that I could differentiate the various shared conversations, interpersonal dynamics

and texts. It was not my original plan to compare my understanding of the video narratives with the patients and practitioners understanding of their personal experience of the consultation at this stage of the VS development but is included as a further stage of testing in the recommendations of this study (see chapter seven the VTv2).

The narrative literature reviewed in this thesis demonstrated a growing interest in analysing primary-care practitioner videoed consultations and in particular the GP patient-centred consultation. This interest has continued with the Kings Fund naming patient-centred care as the heart of any consultation (King's Fund, 2009). However, the focus of the published research was on the GP more than shared patient centred communication. One such study Campion et al (2002) found only limited ability for GP registrars to achieve patient-centred outcomes. The present study method examined the shared communication and interpersonal interaction through the video medium rather than an individual understanding of the consultation. So like a dance, the consultation encounter considered the involvement of both parties to engage. Furthermore, I understood the communicative process through the video materials as a whole. Both practitioners and patients were offered the opportunity to watch the videos at the WiC for their personal learning. Furthermore, the video data was reviewed by one of my supervisors (JC), and both good consensus and inter-rater reliability were achieved using a Video tool (VT) when triangulated with those from the video interpretation schema (VS) (see chapter seven).

4.5.4. Ethical issues for video data

It was recognised that consent, confidentiality, and anonymity were of particular concern for data elicitation, data collection and data analysis of audiovisual materials (Wiles et al., 2008). Kuusela et al (2013) suggested that video recording was both a feasible and acceptable tool to assess GP consultations. They found that patients and GPs usually approved video recordings for research purposes and although there was some effect on the participant’s performance and confidentiality there was unlikely to be any negative effects on the quality of the consultation. However, visual data materials have their own particular ethical issues that are often dependent on the particular place where the visual materials were collected. Harrison (2002) raised

some of the ethical issues that relate to visual images more than text. In particular, she noted that the very nature of visual materials made it difficult to obscure identities, confidentiality, and prevent invasion of privacy of its availability to the public gaze. Heath, Hindmarsh and Luff (2010) in their practical book on video analysis emphasised the difficulties of gaining research consent when using video data. The British Sociology Association (2002) provided an ethical statement of required practice and the particular issues related to audio and visual recorded elicitation data are summarised below.

4.5.4.1. Anonymity and confidentiality

Video data provided the picture and sound of the practitioner and patient so there was a lack of anonymity and confidentiality. Where there were written materials the name and date of birth was kept confidential and only the year of birth and month was written on the research data materials. The practitioner was identified by their professional title and as male or female. The age of the practitioner was avoided to reduce the possibility of recognition. The data materials, as with all research data were placed in a locked cabinet where I had access. The participants were offered the opportunity to review their video consultations at any time until they were destroyed.

4.5.4.2. Photos and film identifying individuals

The anonymity and confidentiality of visual images was very difficult. A written name could be anonymised but not facial and bodily features. The consent form included a participant option to ask to have the video destroyed at any time. I gained permission to use the videos for educational purposes. They were kept in a locked cupboard, of which I was the only one with access.

4.5.4.3. Protecting the identity of participants

During the consenting process, permission for the video materials to be used for education until they were destroyed**,** which was to be eight years or until after the PhD viva was discussed, participants indicated their agreement for this when they signed the consent form. As this research study has been ongoing for longer than eight years ethical approval has been extended until December 2015 so that a

sample of the videos could be independently analysed by another member of the research team to ensure rigour. This process is written up and discussed below in Chapter six. The videos will therefore be destroyed at the end of December 2015.

4.5.5. The consenting process

Parahoo (2014) raised a number of reasons why patients and practitioners may feel obligated to take part in the study such as the participants feeling that the study might benefit others. In this WiC study some of the nurse practitioners may have felt obligated to participate in the study if they were working on the particular days where data was collected. There was the potential for the participants to feel that there might be reprisals if they did not participate. I was aware of this issue and made every effort to articulate to potential participants why this would not be the case. NPs put themselves forward to participate in the study and there were NPs who did not offer to participate**.** The practitioners in particular may have felt they would be labelled as uncooperative if they did not take part in the study. Again I tried to address this issue to reassure both patients and practitioners that their care and that of the practitioner's position in the centre would not in any way be affected. Every attempt would be made not to label them as uncooperative if they did not participate. They would be treated in the same manner as potential study participants. Finally, it was not a requirement for either the practitioners or patients to conform. I shared the study information and consent form freely with anyone who wished to learn more about the study. Copies of the consent documents, the ethics committee's letters of approval and the information submitted to the ethics committees in order to obtain approval can be found in appendix five.

4.5.5.1. The patient present study participants

The consenting process for patient participants took place during the time that the patient was waiting to be seen by a practitioner and there was no reward or expenses paid for participating in the study. WiC patients were approached about potential participation in the present study when they talked to the receptionists about seeing a practitioner about a health concern. Interested participants were informed that the present study should not lengthen the time spent at the WiC. If the patient was still interested, they were taken to a room in the clinic where the present

study protocol was explained by me. It was explained to them that the medical records from the visit, along with the videoed documentation, would be inspected by the members of the present study team and shared for educational purposes. It was also explained that students may also view the videos but names of participants would remain anonymous. If they were still interested in participating they were asked to sign a consent form, after they had signed the form, they waited to be seen by a practitioner.

4.5.5.2. The practitioner and study participants

Letters were sent to all practitioners working at the WiC explaining the nature of the present study. The study protocol was presented at a Clinical Away Day and at a team meeting after which the present study was discussed with nurses, doctors, and frontline staff working in the WiC on a one-to-one basis. A calendar was organised with the nurses, NPs, GPs, and interpreters who agreed to participate in the present study. Everyone was given a two hour block for the purpose of videoing time.

At the beginning of each session, each practitioner who had previously agreed to participate in the study was asked to review the consent form with me at the beginning of each session. At the beginning of each study session, the practitioner was asked to sign a new consent form. All the study participants were given copies of their consent forms.

The interpreters were asked if they would interpret for one day. One interpreter agreed to do it for all the days he was on duty and a second interpreter offered to provide back-up support. However, there were no interpreters requested or required during the study.

During the consent, I emphasised the possibility of using the videoed material for teaching purposes and that the participants could withdraw their consent anytime during the next eight years. Thirty two patients agreed to participate in the present study; however, four participants withdrew, and their video documentation was destroyed. These requests were respected by the erasure of all four videos on the same day. No further participants have retrospectively asked to have their videos

erased. A total of six different consenting nursing practitioners' videos were included in the present study data.

4.5.5.3. Benefits and risks of participation in the present study

There were no real benefits of participation for present study participants. However, it was explained that the results of the present study could lead to a different understanding of the patient and practitioner's relationship. For the practitioner, the video also offered the opportunity to review their healthcare interaction skills. If participants wished to complain, or had any concerns about any aspect of the way they had been approached or treated during the course of the present study, the usual NHS complaints procedure was be available to them.

4.5.5.4. The present study time line

The chart outlined below in figure 4. 7 provides the timeline of relative points along the present study journey for the methods chapter.

The study methodology: Phenomenology 1985-	
Methods and Methodology chapter: The study design	• Study environment 2003-2007 • Study context 2005
Visual Sociology 2010	• Phenomenology • Reflexivity • Qualitative scientific method • Video elicitation • Narrative
Data interpretation	• Application of video schema to Youtube videos on healthcare consultations 10/2013 • Applied to WiC videos of primary care consultations with nurse practitioners. 20010 - 14 • Interpretation of videos into conversations, typical situations and narrative. 2005 /2013
The qualitative study method	• Opportunistic study sampling 1/2005 • Study ethical approval process 2003-4 • The consenting process 12/2004-1/2005 • The video data collection process 1/2005
Video elicitation and video schema 2006 adapted-2013	• Text and narrative • Typical situations • Conversations • Shared connection
Trustworthiness and integrity in qualitative studies 2004-	• Strategy and credibility • Data generation and dependability • Data coding and analysis leading confirmability and transferability • Provision for authenticity of the findings
Data management 2004-	• Confidentiality • Organisation

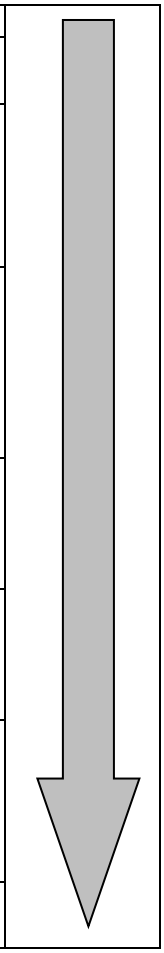

Figure 4.7: Flow chart of method process

4.5.6. Reflexivity

I interpreted the video social action of these WiC video consultations where I worked and my remit in the primary-care trust was to advance nursing practice through research, teaching and clinical practice. Using a reflexive method required me 'to be aware of their subjective and personal influence on the video materials. I worked as a primary-care nurse consultant, advanced nurse practitioner at the London WiC, and had previous experience working as a health visitor in London and as a licensed advanced nurse practitioner in the USA. I also had experience of interpreting videos using phenomenology (Bickerton, 1992a). I bracketed my reflexive and reflective interpretation of videoed WiC consultations to include only my knowledge of advanced nursing practice when interpreting the videos of consultations completed by proficient and expert nurse practitioners seeing and treating patients.

During the interpretation phase I examined shared, personal and subjective communication in the nurse led primary-care encounter recorded on the video (Benner, 1993, Horrocks, Anderson et al, 2002, Bensing, Rimondini and Visser, 2013). Similarly to ethnomethodology the present study I had experience as an advanced nurse practitioner (Eberle, 2012). Issues concerning reflexivity and reflection are discussed in more detail below differentiating between the reflexivity of Husserl (1980) and Sartre (1969) from that of Schutz (1964) and from that of Ricoeur (Ricoeur and Thompson, 1981) where the interpretation had the potential to be both reflexive and reflective. In summary, a reflexive configuration included the subjective and personal; whereas, a reflective refiguration included reflexivity and reflected further on the personal reflexive account.

4.5.7. A qualitative method of narrative interpretation

Qualitative methods of analysis were used to interpret consultation communication. These qualitative methods were different from deductive or quantitative methods that used much larger sample sizes within a clearly rationalised framework for data collection and analysis. In such studies, quantitative and statistically provable results provided generalisable outcomes rather than the patterns and themes interpreted leading to qualitative data outcomes.

The phenomenological study methodology outlined above examined human lived experience involving individual, social, perceptual, and everyday practical experience. Phenomena of everyday living were interpreted through time, space, and body and the experience itself. Phenomenologists argued that science originated in lived experience prior to scientific constructs such as inductive and deductive thinking (Spiegelberg, 1972). This chapter followed Eberle (2012) who referred to Schutz's phenomenological sociology and pragmatism as a broader approach to interpreting interpersonal communication than that of ethnomethodology and conversation analysis.

The present study applied phenomenological sociology to the perceptual experiences of WiC videos. Barry (2002) found that data sources of a study provided different outcomes. The present study VS interpreted the audio and visual elements in the video document directly and focused on shared communication skills. The

schema offered the interpretation of emotional, action and knowledge verbal and visual images.

Video interpretation occurred through video elicitation: the viewer's perceptions of the video narrative. In the present study, the health consultation that took place in the WiC was bracketed and a video of the consultation was the focus of the study. I focused on the video narrative. The social action in the video was organised through a VS where audiovisual materials and the video image of the healthcare consultation provided the healthcare consultation text or narrative (see figure 4.8 below).

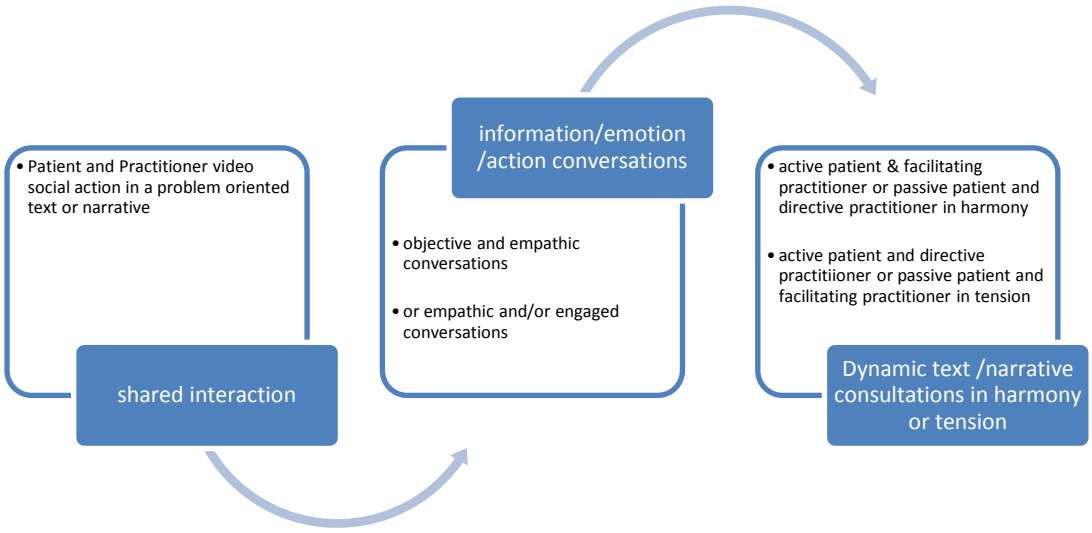

Figure 4.8: Primary-care consultation narratives

The present study provided a VS to bridge these video stories and to organise them through three different levels of audio-visual interpretation. The first level was the conversation, the second level was the dynamic typical situation, and the third was the presentation of the video story as a whole through the interpretation of the text (see figure 4.11).

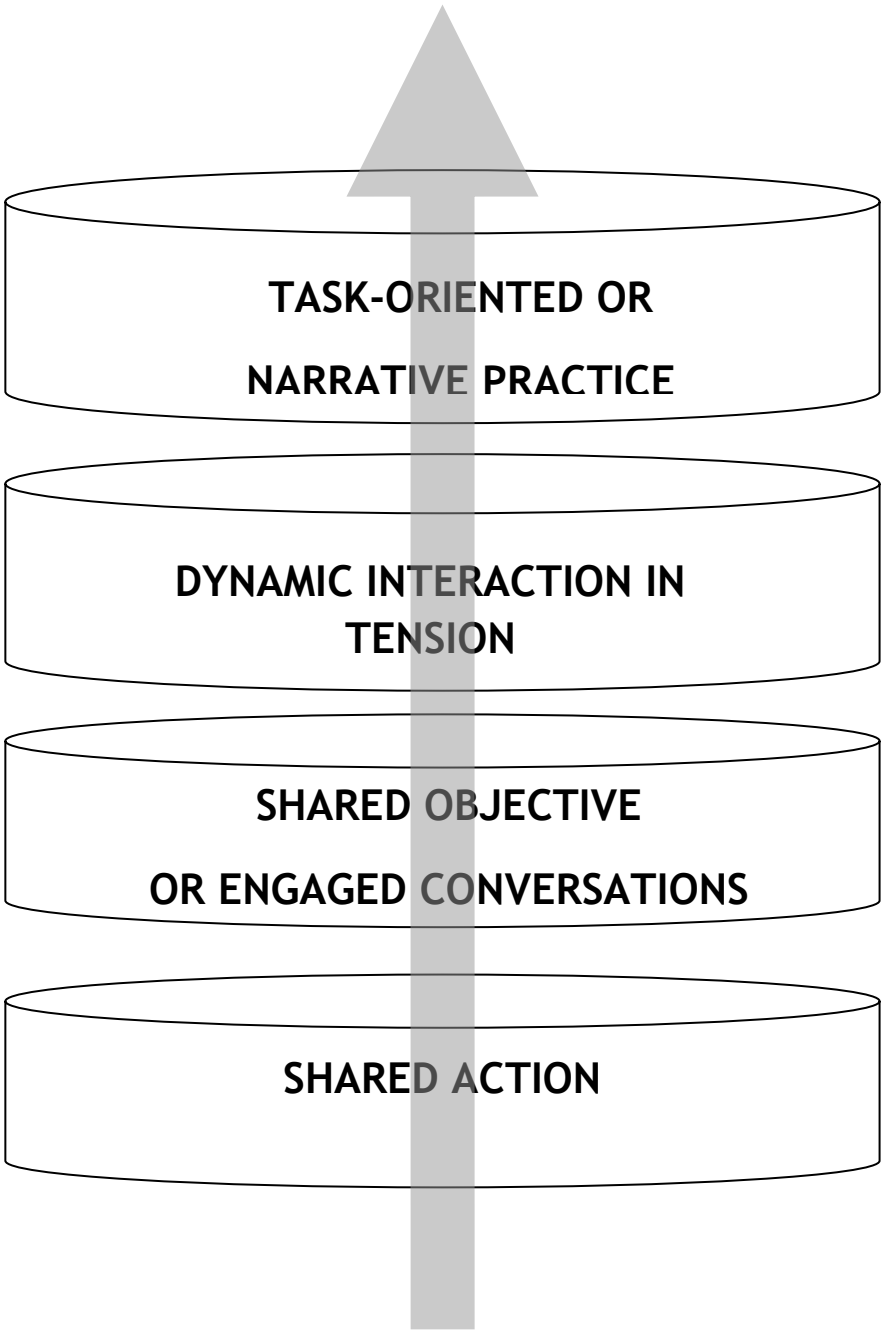

Figure 4.9: Different elements of audio and visual (video) interpretation

The reviewer used ballroom dancing as a metaphor for describing and interpreting these shared video consultation skills (Reykamensky, 2014). The video was experienced at first as a shared experience and the dance as a visual conversation that was experienced as objective or empathic and engaged. At certain points in the dance process one partner can be directive where the other partner followed; or was facilitative when the partner was more active. A passive and reactive and facilitative

partner was experienced as tense rather than harmonious. Where the dance was experienced as integrated with a naturally flowing pattern there was a harmonious experience.

Figure 4.10: An example of visual social action in dance

In earlier research, Bickerton (1992a) examined how video artists constructed fragmented and unified images in video, using video materials to create different images. This research differed from the present study in that the video was creatively edited by individual artists to construct images. In the present study the narrative focussed on primary-care consultation video documents which as one clinician noted:

> "Telling a story and repeating a story were two subtly different forms of action….we construct for us a story about what we think we were hearing. The bridge between the teller and listener of a story turns out not only to carry traffic in both directions, but to carry multiple levels of traffic as well." (Greenhalgh and Hurwitz, 1998:xiii).

4.6. Data interpretation

The video data was interpreted differently from the other studies in the systematic literature review. For example conversation analysis first transcribed video data and later then analysed the transcribed data using a system developed by Gail Jefferson (Sacks and Jefferson, 1989). Grounded theory and ethnography also transcribed the video data first before analysing the research data. However, studies mainly used the audio data of the video recordings (Harrison, 2002).

4.6.1. The video schema (VS)

The VS includes not only Sartre's psychology of the imagination, but also the shared action and typical situations of Schutz and the fictional texts of Ricoeur which were applied to fixed viewpoint WiC video consultations. The VS provided a reflexive approach and is summarised in figure 4.11 of the reflexive process. I interpreted the WiC videos in a private and confidential place where the videos could be played and replayed as needed without interruption. The reviewer was able to see or hear both the verbal and visual elements of the video. The reviewer set aside at least 30 minutes for each video as each video should be viewed in one sitting as many times as required. The video was experienced as a whole to obtain an overall impression and then reviewed at least three times so that the reviewer was comfortable with the video social action and narrative. The reviewer used the VS (see fig 4.12).

The reflexive process	The reviewer should be attentive to the video as a whole and tries not to focus on any particular aspect of the video at first
The shared connection	The reviewer tries to develop an overall general understanding of the video as a whole without focusing on either participant in particular. Are they experiencing anxiety, confidence, concern, happiness etc. from the video images? Are they learning about the health concern presented in the video? Are they gesturing, and if they are, how
An overarching conversation	The video conversations are described in terms of movement, emotion or knowledge. If the reviewer experienced the participants as attentive and empathic, the conversation was engaged. The reviewer expects the social action to be firstly a shared connection, secondly an objective conversation and with an empathic conversation, the social action was engaged.
Discerning a typical situation	In order to determine the typical situation that was taking place in the video, the reviewer focuses now on the interactions. The viewer steps back from the shared conversation to examine how the participants are interacting with each other. These interpersonal dynamics may be directive, facilitative, active, or passive. A facilitative practitioner was supportive of a patient who was active and interested in learning about their health situation. With an active patient and a facilitative practitioner, their interactions are in harmony. A practitioner who was directive with a facilitative patient hinders a harmonious typical situation dynamic and supports a dynamic in tension. However, where a patient was passive and a practitioner was facilitative the practitioner has to become directive in order to change the typical situation dynamic from a tension to harmony. Finally, where the patient was passive and the practitioner directive there was a harmonious dynamic.
What type of text or narrative was it?	Finally, the video may be experienced as an objective or engaged text or a fully engaged narrative. The objective text was where the conversation never moved from an attentive conversation to an engaged and empathic one. The engaged text on the other hand does. The fully engaged narrative was experienced as completely integrated video narrative where the sense of a shared connection comes full circle and the reviewer has the sense of a completely integrated narrative.

Figure 4.11: The reflexive process

In summary, videos were viewed to describe and interpret how participants' gestured and moved, expressed emotion, and verbalised the underlying meaning of shared

communication. I chose one of the three elements of movement, emotion, or knowledge as the overarching focus of the consultation conversation. The video participants' interpersonal dynamics were interpreted as directive or facilitative relationships with either active or passive patients (see VS in figure 4.12 below).

The diagram organised visual and verbal content into three levels of social action: the shared connection, shown in the bottom circle, where all video communication was first experienced; the three types of shared conversation, shown in the middle circle; and the consultation dynamic, shown in the top circle which were experienced as harmonious or tension. The interpretation of the videos progresses through these levels as indicated by the pink vertical arrow. The reviewer also considered whether the participants' interactions were 'objective' or 'engaged' and 'texts' or 'narratives'. Thus, what reviewers saw and heard in the videos was described as objective text where the participants interacted but were not engaged or empathetic, as engaged texts, where the participants interacted and empathised with each other, and narratives, where participants interacted and engaged with each other through empathy, gestures, language and emotion. All narratives were interpreted as fully engaged interactions when conversations and dynamics were fully integrated. In these videos the participants' conversations and levels of experience were unified, and what the reviewer witnessed were fully integrated combinations of conversations and consultation dynamics.

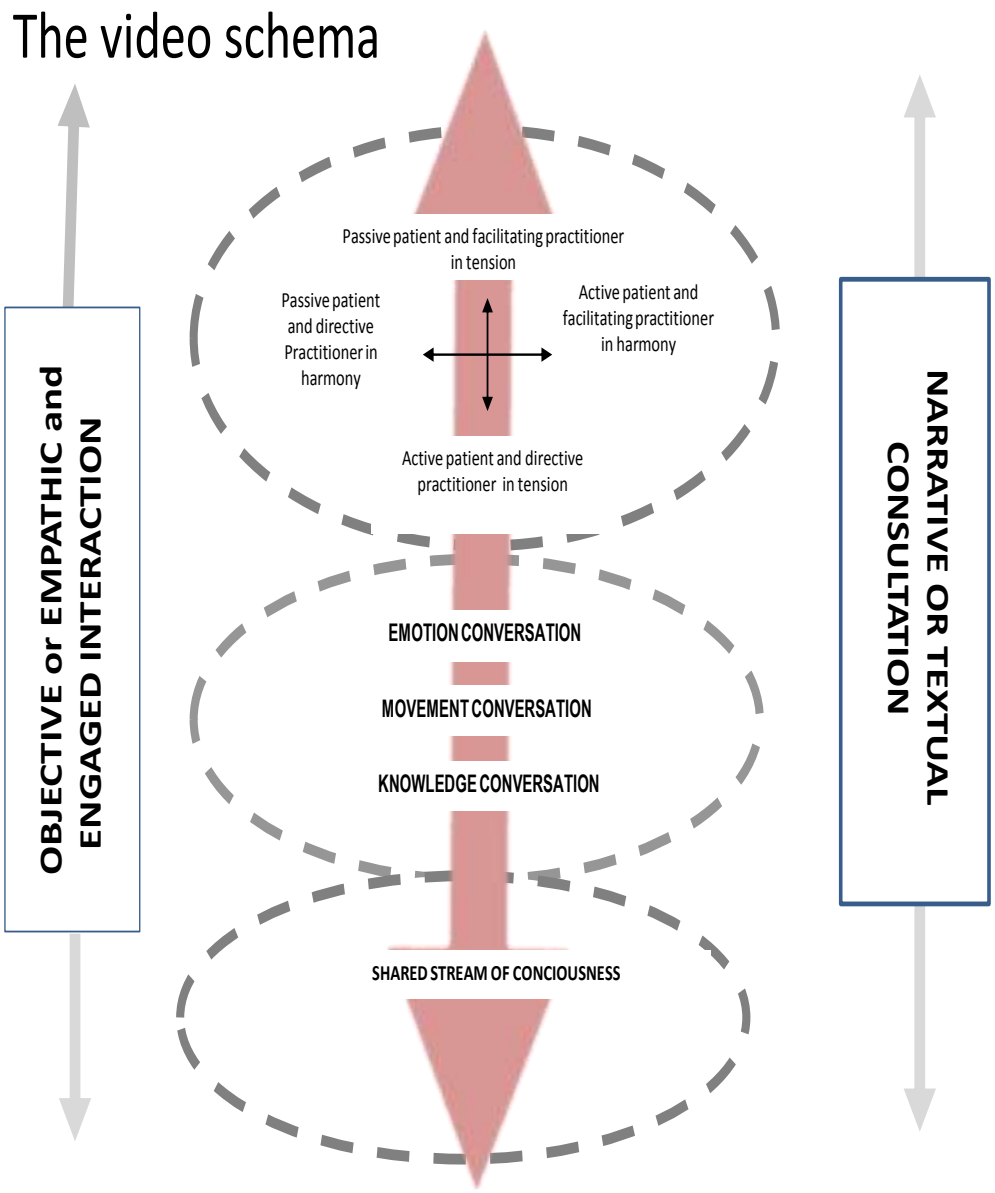

Figure:4.12: The video schema (VS)

4.7. Trustworthiness and integrity in qualitative research

It was important to quality assure the data interpretation process. Lincoln and Guba (1985) outlined four aspects of trustworthiness and integrity required to ensure quality in qualitative research. The four requirements are outlined in the sections below:

4.7.1. Strategy and credibility

The present study method integrated the philosophy of well-known credible phenomenologists into visual sociology; this helped ensure that the interpretation was evidence-based and repeatable. I was already familiar with the reflexive description and interpretation of phenomenological video materials as it was the focus of her master's thesis in philosophy. I also studied phenomenological psychology for my undergraduate degree in psychology. I combined my academic studies with more than 40 years' experience as a registered nurse, of which 15 years were as a qualified advance practice registered nurse in the United States of America. Documented evidence of the video WiC consultations is included in appendix 10 in order to provide an audit trail of the process.

4.7.2. Data generation and dependability

The present study used video consultations to study communication in WiC consultations between nurses and patients. The material was reviewed on many occasions to provide dependability to the data outcomes. The video image was interpreted using three different phenomenological approaches. The socio-phenomenological analysis was developed by Alfred Schutz (1964), the phenomenological analysis described in Sartre's book *the Psychology of the Imagination* (Sartre, 1969), and the phenomenological interpretation included in Ricoeur's book *Time and Narrative* (Ricoeur, 1984).

Video materials provided advantages of being recorded that were that it was possible to return to the audio and visual materials of the consultation without focusing on the interpretation of written transcription. However, one of the major disadvantages included lack of confidentiality because video allowed for face and voice recognition.

4.7.3. Data coding and analysis leading to confirmability and transferability

In my application for ethics approval I set out to test the transferability of the process of analysis derived from my master's thesis to the health practitioner consultation. I had observed in clinical practice that there were many assumptions drawn about the purpose, meaning and experience of the consultation from notions of efficiency and

effectiveness in healthcare delivery. In this thesis it was not my original plan to support my findings through comparisons of my understanding of the video narratives with the patients and practitioners participants understanding of their personal consultations. However, the implication of not interviewing the study participants is a limitation of the study. Jiwa (2013) identified developing new innovations in practice. They suggest that practitioners and patients should be involved in all aspects of the research including the study design, patient recruitment, the development of the study tools, study recruitment, data collection, and interpretation as well as the presentation and or publication of results. Furthermore, Ahlen and Gunnansson (2013) found that the physician's evaluation of the consultation is as important as that of the patient. These studies highlight the importance of actively engaging both the practitioner and the patient in further research and testing of the VT innovation.

Following the development of the VS, my application of the tool, JC one of my supervisors independently reviewed the videos using a video tool (VT) based on the VS.

4.7.4. Provision for authenticity of the findings

I presented the present study findings at the Royal College of Nursing advanced practitioner conference in 2010 and at the International philosophy of nursing conference (Bickerton, 2010a). Both the VS and the results of the WiC video interpretive outcomes have been published in peer reviewed journals (Bickerton, 2010a).These opportunities for the present study process to be peer reviewed added authenticity to the findings.

The results were the perceptual experiences of WiC videos reflexively interpreted through audio and visual nonverbal and verbal structural elements (Schutz, 1964, Sartre, 1969, Ricoeur and Thompson, 1981). Barry et al (2002) found that data sources of a study such as audiotape rather than transcript provided different outcomes. The VS used in the present study interpreted the video document directly and focused on shared communication skills. The schema offered emotion, action and knowledge audio and visual materials equal value in the conversation. The VS also provided a structure of four typical conversation dynamics in the consultation

narrative as a whole rather than only attentive to the shared decision making (SDM) elements themselves. An illustration of the application of the VS is applied below.

4.8. Interpretative data management

The final interpretation of the WiC videos were organised within a table using ‘SOAP’ documentation which summarised the patients notes written up by the practitioner following the consultation (Cox, 2005) and the video interpretation which was discussed above. An example of how the data was organised is found in appendix 10.

4.9. Summary

This chapter has outlined a method of interpreting videoed WiC consultations. Audio and visual materials of video narratives of WiC NP and patient consultations were interpreted by an expert advanced nurse practitioner. The present study provided the opportunity to establish emotion, knowledge, and movement in shared, objective and engaged empathic conversations as well as typical situations dynamics that have the potential to raise awareness of the WiC healthcare situation. The video materials were interpreted in order to demonstrate professional artistry through the different kinds of conversations, typical situations, and texts in video narrative. The ‘SOAP’ documentation demonstrated technical skills of subjective, objective assessment and planning that takes place in every primary-care consultation. The following chapter includes the ‘SOAP’ documentation and reflexive interpretations and findings of profession artistry in video consultations.

Chapter 5: Application of the video schema (VS) to YouTube health consultations

5.1. Introduction

The present study has examined lived experience through the interpretation of video (audio and visual) images. A VS was used to interpret emotion, knowledge and movement conversations, objective and empathic typical situations in the video narrative. A step-by-step process of the interpretation of videos is provided in the present chapter, in addition to web references for the video clips that could be viewed to understand the process of interpretation. In chapter six, the WiC video findings will be presented with a brief summary of the 'SOAP' documentation written up by the practitioner during or following the WiC consultation. These summaries are found along with the video interpretations in appendix 10. There are no videos of the actual WiC consultations included in the present study for ethical restrictions (see chapter four).

5.2. Review of interpretation of lived experience

In this particular study, I interpreted the universal and contextual essences of lived experience. The interpretation of lived experience is both uncertain and controversial because of the subjective nature of the method (Finlay, 2009).

My first step in interpreting videos using the present study VS can be compared to the act of skimming a book or viewing a film clip, in which one forms an initial intuitive, impression of the consultation. The video stories are experienced through an internal or lifeworld communicative understanding alongside structured action (Stevenson, 1981).

5.2.1. The shared connection

I focused on different aspects of the video narrative at each of three or more viewings, even though each video contained all the different kinds of the schema images evolving together throughout the narrative. These conversations, typical situations and the narrative text are interpreted below.

Focus: The first step in interpreting these videos involves a rapid viewing of the videos, in which one forms an initial, intuitive, overarching impression of the story which is followed by a more in-depth interpretation..

I began by experiencing the video narrative through a holistic shared connection. This meant that the video was read and experienced as a whole without differentiating between the video participants in the video image or separating the actions in the video from my personal consciousness of the exterior world. The video materials represented shared communication that for Schutz already existed in all lived experience (Schutz, 1964). For Schutz communication always was at the point of entry, understood as shared embodied space and time: 'I can live in your subjective meaning-contexts only to the extent that I directly experience you within an actualised content-filled We-relationship' (Schutz, 1964: 166). All social action then illustrated in the videos was an initially shared experience. The picture below demonstrates visual connnections (Nayab, 2014). These two visual conversations represented visual, nonverbal, and verbal elements of conversations in the videos.

Figure 5.1: The visual social action connection

5.2.2. Visual and verbal conversations (CSA, 2013d)

Focus: My construction of video materials in relation to my understanding of video image is inseparable. The video image is experienced as a whole image and not separate conversations. I am looking at shared experience elements of a whole conversation. The emotion, knowledge and movement video elements represent the important elements of the shared conversation.

Conversations occurred between the participants about specific subjects or topics. These kinds of conversations using Sartre's categories (1969) included emotion,

knowledge, and movement elements that could be distinguished for the purposes of this interpretation, but were understood as synthetically integrated in everyday natural conversations and situations. In each video, the reviewer distinguished between the three elements (emotion, knowledge and movement) and their relationship in supporting one more than the other two as the overarching type of conversation. In order to try to differentiate and discern the overarching conversation.I replayed the video as many times as necessary to interpret the combined visual and audio materials. I was aware that these phenomenological structures of consciousness were separated for purposes of interpretation, as Sartre separated them in Psychology of the imagination rather than experienced as a synthetic whole in conscious reality (Sartre, 1969). To view the video CSA (2013d) see Headache, CSA -http://www.youtube.com/watch?v=7VGSk4sDKSk [18/07/2013].

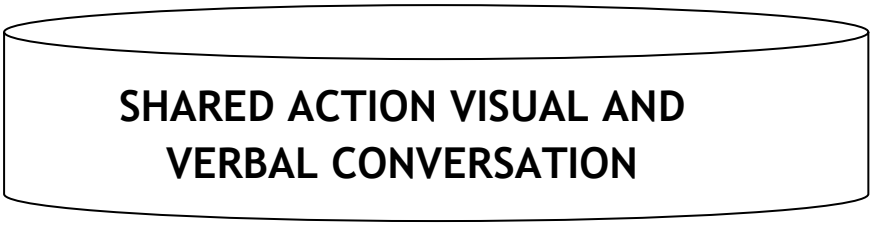

Figure 5.2: Examples of visual and verbal conversations

Examples of the particular kinds of behaviour perceived by reviewers are listed below and adapted from Henry, Forman and Fetters (2011). This table was used to provide examples used for the construction of emotion, knowledge, and movement conversations. Both nonverbal (visual) and verbal behaviours have the potential to provide all the three types of conversations in lived experience. The reviewer marked particular behaviours where it was helpful to gain more clarity by gathering them into categories (see figure 5.3 table of visual and verbal communication below and appendix 8 for a further detailed interpretation).

Examples of visual (nonverbal) communication	*Examples of verbal or non-visual communication*
Processing information that was perceived through light particulars in video or wordless and visual cues between people such as gestural body language, intensity, pacing and timing of video narrative, attention, engagement or disinterest and cool.	Verbal communication such as asking questions (open, directed, affirming for example) shared decision making (facilitative or directive) including verbal information and knowledge.
Communicating with gestures, touch, body language, posture, or physical distance for example with their bodies relaxed or stiff and immobile, shoulders tense and raised, or relaxed and slightly sloping.	Asking someone to carry out a task with clear and specific verbal communication.
Communicating through facial expressions for example sharing expressions, mask like and inexpressive, or emotionally present and filled with interest.	Information provided in different words by both practitioner and patient to support understanding.
Communicating through eye contact for example the mutual gaze when the participants look at each other directly as opposed to looking at the floor.	Communicating an important point with slightly raised voice or deliberately speaking slowly.
Communicating for example through pointing, shrugging shoulders, leaning forward, or eye contact in an overly intense or attentive manner.	Voice tone, speech rate, sighs.
Communicating for example by putting a hand on someone's shoulder, shaking hands, or touching such as your face with your hand. Was it appropriate for the consultation or was it uncomfortable.	Communication through audible verbal behaviours such as caring and concern.
Smile, expression of surprise.	Audible vocal cues or processing information imperceptible to light such as drop in voice volume.

Figure 5.3: Table of visual and verbal communication

Beck, Daughtridge and Sloane (2002), who studied videotapes or audiotapes of nonverbal and verbal physician and patient communication in the primary-care office between 1975 to 2000 in their review of the literature, found a number of approaches that led to better consultation outcomes. Some of these are included in behaviours described above (figure 5.3 of examples of visual and verbal conversations). Beck, Daughtridge and Sloane added and linked verbal behaviours such as empathy, reassurance and support, patient-centred approaches, length of consultation, history taking, explanations, both dominant and health education and information sharing, friendliness, courtesy, orienting the patient during examination, and summarising and clarification. The nonverbal behaviours included head nodding, forward lean, direct body orientation, uncrossed legs and arms, arm symmetry, and mutual gaze. In their conclusion they established a lack of consensus of what to measure. There were conflicting findings, and a relative lack of empirical studies, in particular of nonverbal behaviour. It should be noted that nonverbal behaviour in the present study can only include those senses that are visually available. For example smell and the sense of touch are not available for interpretation.

5.2.3. The video conversations

Focus: All social action in the video documentaries is comprised of knowledge, affectivity (emotion) and movement in various proportions.

Knowledge is the active structure of the image understood in different ways such as a video understood through a fragment of a whole narrative; or as fiction which is different from a documentary. Knowledge may be both meaningful and imaginative. We can only have knowledge in consciousness of our lived experience so each person's access to knowledge is unique.

Emotion is integral to the structure of the object and permeates the entire structure. When feelings disappear, there is depersonalisation and the perception remains intact in an impoverished world.

Movements are integral to the structure of the image or object. All consciousness is conscious of something in the form of equivalences kinaesthetic or movement images may be realised through the editing of the video medium, the setting up of a world through repetition of a movement e.g. the repetition of gestures such as a hand gesture to ensure understanding.

It should be noted that consciousness of image is not the same as consciousness of word. Language can clarify our thoughts and yet the mental image teaches us nothing. Yet we know that language is able to externalise itself and as an object, it is sign. As an internal phrase, language cannot be an image because it is not an observable phenomenon. Since all knowledge tends to express itself in words, all images must have some sort of verbal tendency and this tendency is integral to the system of imaginative consciousness and to its objects. In order for the participants to become consciously aware of each other, they separate and objectify each other. A further step in the conversation may or may not occur leading to the empathic and engaged shared connection.

In the present study, three different types of conversation were elicited through the activity of the video materials in relation to the video image. These conversations were interpreted subjectively and a reflexive interpretation elicited all three conversations in different ways. I applied the categories described in chapter 4 and

made the decision as to which conversation was most prevalent in each video. As the video was viewed, the understanding was expected to vary by viewer, dependent on the viewer's experience with healthcare interaction. The viewer who ultimately determined the final choice and the final decision is always influenced by their personal experience and knowledge. So the findings are expected to differ subtly from practitioner to practitioner.

5.2.3.1. Knowledge conversation: Chest pain (CSA, 2013e)

The interpretation of a knowledge conversation occurred in a video where a patient presented with undifferentiated chest pain (CSA, 2013e). In this video the participants visually and verbally addressed the issue and there was a clear verbal communication exchange that emerged as the overarching knowledge conversation. The practitioner asked many questions and the patient responded. There were both emotion and movement elements, but these were less apparent. The conversation was succinct and knowledge-based. This is common in WiC consultations where patients share information about their complaint and the practitioners share information about minor ailments. An example of a knowledge element of conversation emerged through the visual written and was comparable to the 'SOAP' notes in the WiC video interpretations below. The written captions noted different types of verbal questions that included opened, focused and more directive questions. Practitioners began a conversation with an open question, for example 'How might I help you?' As the practitioner gathered more information, the practitioner began to ask more focused questions such as 'What exactly makes the pain come on?' These questions have a verbal and a nonverbal and visual element and viewing the video images directly I was able to discern the practitioner looking directly at the patient, smiling and encouraging the patient to share more information about the history of the presenting complaint. To view this video, go to CSA (2013e) Undifferentiated chest pain, http://www.youtube.com/watch?v=Fd8_wuJPWq0 [18/07/2013].

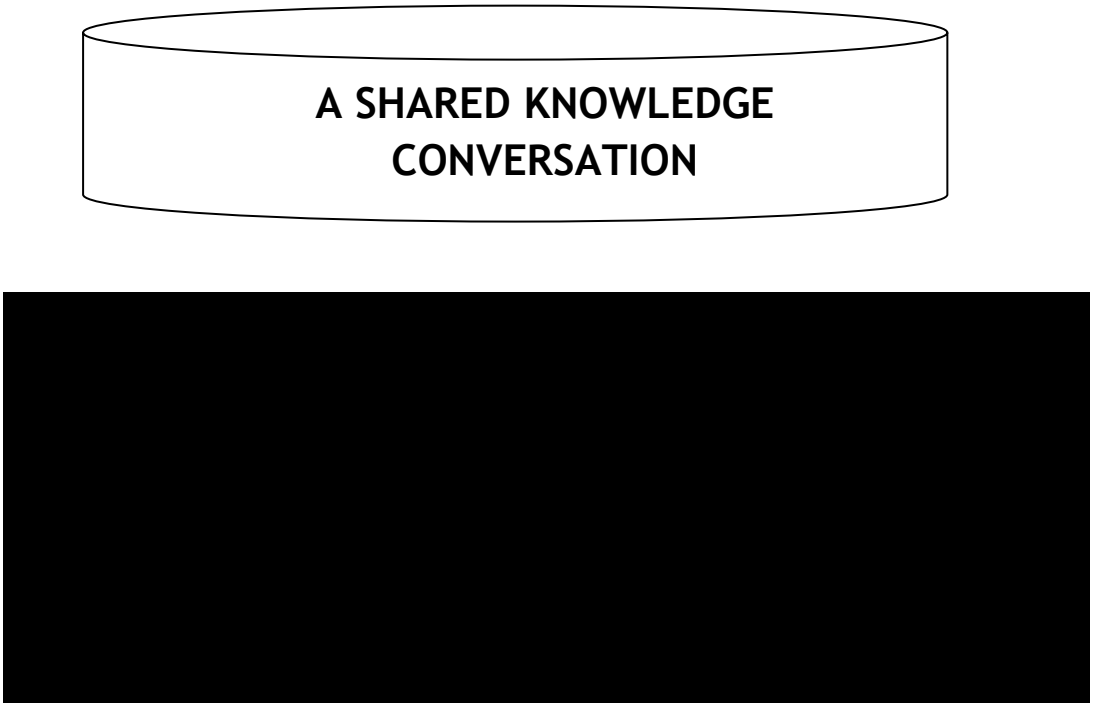

Figure 5.4: Knowledge conversation :chest pain

5.2.3.2. Emotion conversation: Cancer (NHS, 2013)

In this video (National Health Service, 2013) the participants discussed symptoms arising from cancer. I focused on the whole conversation interpreting listening and visual skills that involved emotion, movement and knowledge. Studies have shown that upward of 50 percent of a patient's emotional distress present in primary care, is not understood by the practitioner (Feldmann, Bensing and de Ruijter, 2007). In this particular video, it should be noted, there were edited images. An example of a fixed camera video section is interpreted below from YouTube videos. In this video (National Health Service, 2013) fixed shots and edited shots were used that demonstrated the emotion conversation. The emotional elements were not only associated with visual expressions, but also through the verbal tone of the conversation and gestural movements. All three elements (emotion, knowledge and movement) of the conversation were recognised but both the knowledge and gestural elements were interpreted as emphasising emotional expression that provided the overarching conversation. To view this video, see NHS (2013) Cancer in Primary Care: a Tool Kit, London Deanery http://www. youtube.com/ watch?v=P3X2PjlUDSk [28/07/2013]

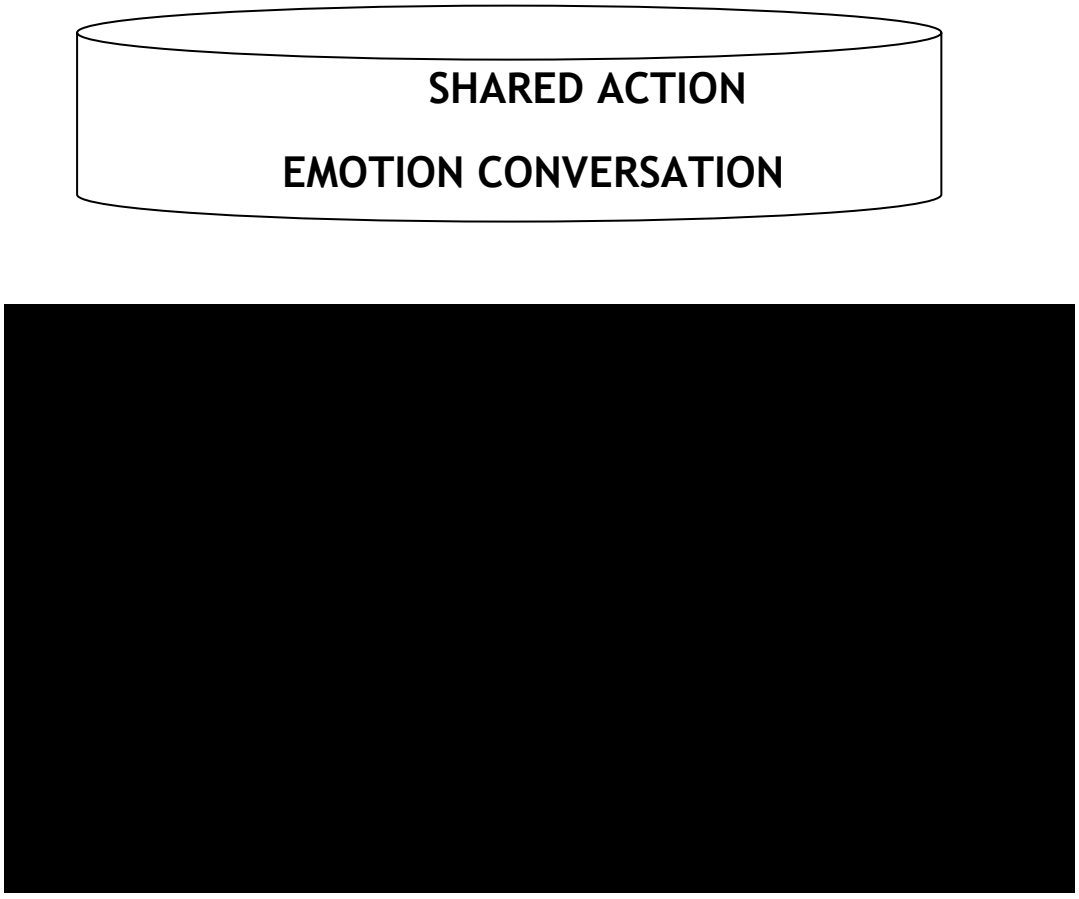

Figure 5.5: Emotion conversation:cancer

5.2.3.3. Movement conversation: Facial pain (CSA, 2013c)

In this video a presenting complaint of facial pain demonstrated a movement conversation that involved kinaesthetic movements (CSA, 2013c). These nonverbal movements included hand and arm gestures that were used to enhance the meaning of verbal elements. Movements of the participants mirrored each other as for example, as the patient leant forward, the practitioner moved backward or forward empowering the patient to share information as he listened attentively. Another example was that participants crossed their legs towards each other or away from each other.

I interpreted visual gestures as movement elements. For example the patient gestured with her hands and nodded her head emphasising movement as she verbally expressed emotional concern. The nonverbal movement provided the overarching conversation. I experienced primarily the gestural movements in the

video image. These video images came from the first minute of the tape with many gestural movements. To view this video, see (CSA, 2013c) Facial Pain, MRCGP http://www.youtube.com/watch?v=eRCf6mN9d3U [28/07/2013.]

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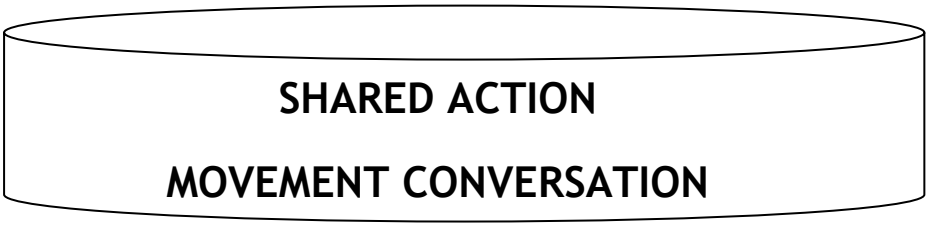

Figure 5.6: Movement conversation:facial pain

These video clips discussed above were chosen because they were illustrative of the three particular overarching conversations. Overarching conversations can be interpreted differently and change throughout the duration of the tape. I made a decision about the most prominent overarching conversation in the short segment viewed.

5.2.3.4. Attentive conversation: A headache (CSA, 2013d)

In this video the participants listened attentively to each other (CSA, 2013d). The practitioner asked open verbal questions supported through the body gestural language and the visual communication illustrated in the video images below (see figure 5.7 the attentive conversation: headache).

Interactions were initially grounded in social action which Schutz (1964) described as a directly experienced social relationship or shared connection. The shared connection always separated leading to objective face-to-face social action. The conversation had the potential to remain objective but also had the possibility of developing into an empathic and engaged conversation. Epstein (2003) found up to 80 percent of a diagnosis was based on the patient history of health and illness, which meant interpersonal understanding, was an essential component for how the practitioner made an appropriate assessment. A consultation usually began with the practitioner inviting the patient to share their health concerns through an open question. The practitioner listened actively to the patient and to any questions about the specific health complaint whilst organising the patient's story into a narrative. The objective rephrasing and summarising of the health story clarified misunderstandings. To view this video, see CSA (2013d) Headache, CSA - http://www.youtube.com/watch?v=7VGSk4sDKSk [18/07/2013]

Figure 5.7: The attentive conversation:headache

5.2.3.5. Objective conversation: Abdominal pain done badly (CSA, 2013a)

The clinical encounter always began through a shared connection when beginning to interpret any video consultation conversations and are illustrated through the visual and audio materials and later moved to an objective conversation. In the video (CSA, 2013a) illustrated below, the conversation remained at this objective level rather than moving towards an empathic engaged conversation. The participant's conversation was expected to be shared and attentive, but unlike an engaged video conversation it lacked empathy and engagement. Both the verbal and nonverbal elements provided typical situations where the practitioner was not paying attention and the patient was trying to engage. The practitioner's posture was distanced from the patient. In the first image, the patient illustrates active attempts to engage the practitioner with her health concerns, but the last image demonstrates a less active and more reserved patient. The practitioner has his arms folded across his chest in a protected and non-engaged gesture and there was little eye contact. This objective type of conversation ran throughout the complete video. To view this video, see CSA (2013a) Abdo pain done badly, RCGP - http://www.youtube.com/watch?v=6vMjh6Wy_II [28/07/2013]

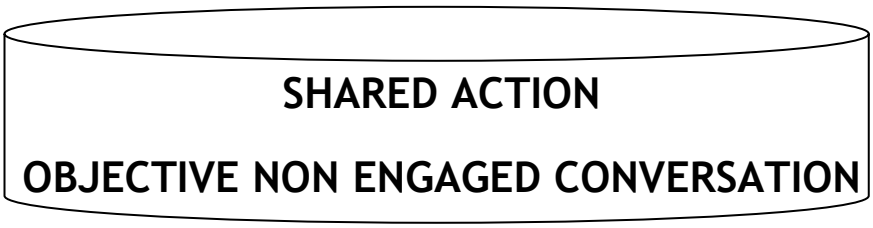

Figure 5.8: Objective and non engaged conversation:abdominal pain

5.2.3.6. Empathic engaged conversation: Abdominal pain done well(CSA, 2013b)

This video featured the same two participants as the video above (CSA, 2013a), yet was interpreted differently because the patient and practitioner paid attention and experienced each other through different levels of intimacy, intensity, directness, and empathy (CSA, 2013b). In the attentive objective conversation demonstrated above, there was always the potential for the development of an engaged conversation where the practitioner empathised and the patient paid attention (CSA, 2013b). However, it was the comparison of the two videos that makes it easier to distinguish in this second video narrative that both participants were attentive, empathic and engaged with each other. This conversation was interpreted as a partially engaged

text and is illustrated in the video frames below: To view video, see CSA (2013b) Abdo pain done well: http://www.youtube.com/watch?v=O2qYU8n4VsA [28/07/2013]

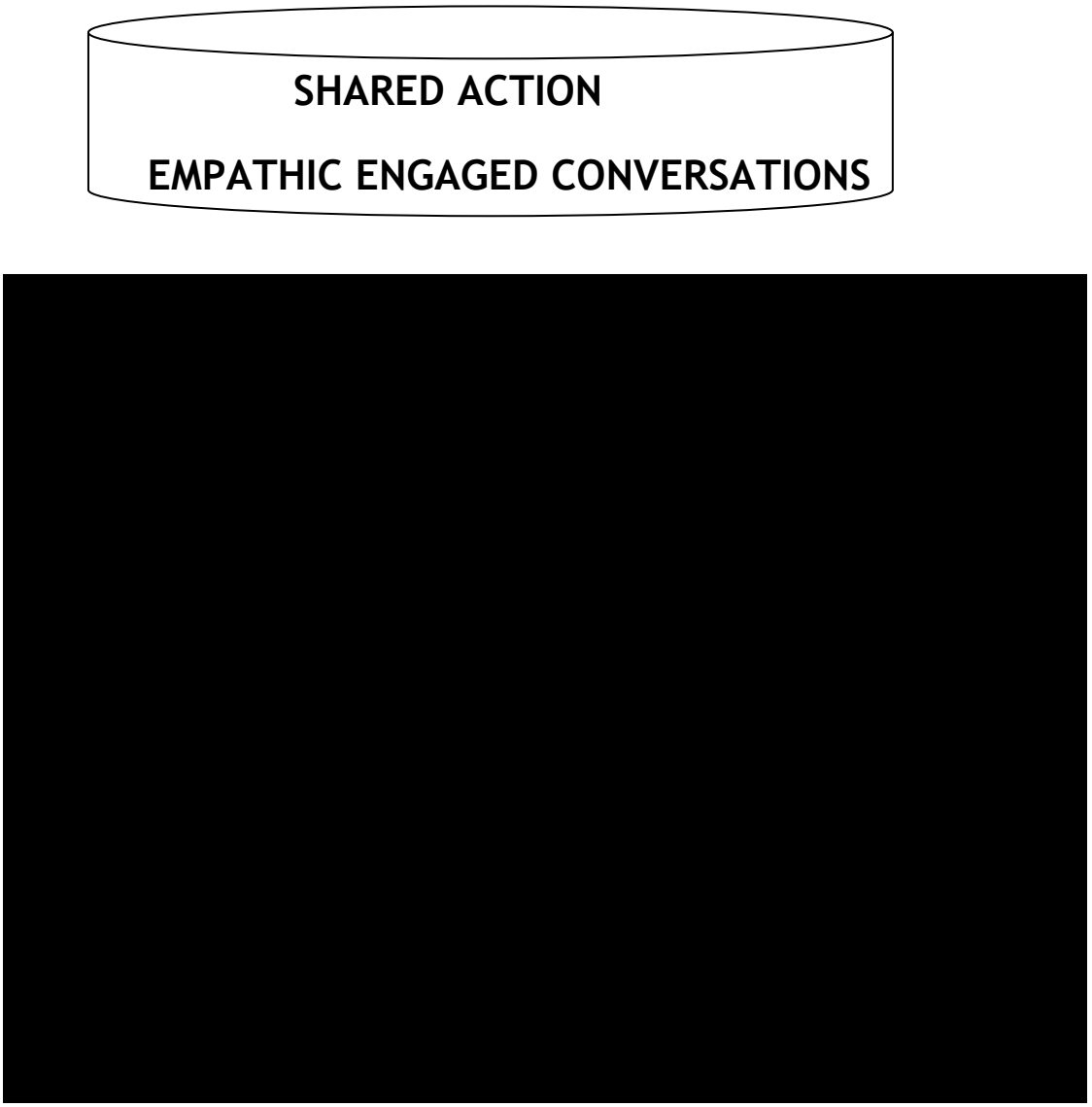

Figure 5.9: Attentive and engaged conversation:abdominal pain

In summary, the YouTube videos illustrated attentive objective and non-engaged conversations, emotion, knowledge and movement conversations and different dynamic typical situations. In the systematic literature chapter, the typical situation dynamic tended to present a directive practitioner and a passive patient although the literature also discovered facilitative practitioners and active patients.

5.2.4. Typical situations

Focus: The interaction between the patient and the practitioner is created through a process where shared conversations that organise into a dynamic of harmony or tension that may provide an active partnership in care or a partnership of directive and passive dynamics. An interpretation might include both kinds of dynamic situation with one ultimately appearing to be more present than the other. The assumption is that the more knowledge I have of the essential structural typical situations in the context of the WiC NP consultation. The more potential there is for the conversation dynamic to be flexible within the dynamic typical situation. This makes each consultation unique as each participant brings a unique history and there is no way of knowing all these multiple realities.

Finally, my reflection on interpreting the videos of the WiC consultations illustrated some of the more frequent communication outcomes. It is important to remember that the outcomes of the interpretations of the videos may vary depending on the experience and personal awareness of the individual using applying the VS.

Schutz (1967) suggested that all social action involved pragmatic typical situations. The WiC typical primary-care consultations organised along a continuum. These typical situations included a directive or facilitative practitioner and a passive or active patient and organised into dynamic interactions in tension or harmony as illustrated in the diagram below.

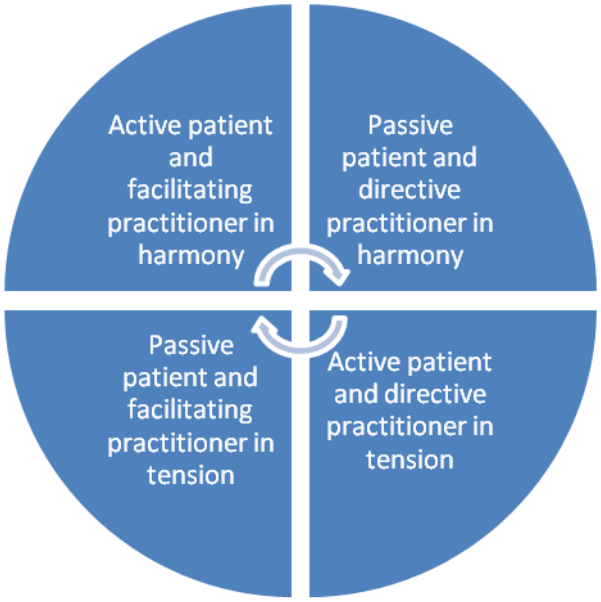

Figure 5.10: Typical situations

Each video was placed along this continuum of four typical situations. As I interpreted the video healthcare action in real time, the various dynamic situations were elicited with one ultimately appearing to be more relevant to the dynamic situation. A successful conversation often moved between different modes and I interpreted which typical situation was more relevant to the overall consultation dynamic. So, for example, a directive practitioner and a passive patient, or an active patient and a facilitative practitioner experienced harmony at different points in the video narrative. Different outcomes depended on each unique healthcare situation and the more knowledge the participants had about healthcare situations the more readily they were likely to adapt to the different typical dynamic situations.

5.2.5. Dynamic typical situations

The four typical situations provided an active or passive dynamic, facilitative or directive, in tension or harmony. Again, the video reflexively interpreted the overarching situation. The typical situation accommodated each situation with its uniqueness in that no one consultation dynamic was the same, but fell somewhere within a dynamic action frame, which was in harmony or tension. Thus for example, the active patient and facilitative practitioner interaction was a harmonious typical

situation, as was a directive and a passive patient dynamic. An active patient and a directive practitioner, a facilitative practitioner and a passive patient, communicated in tension. Where the patient was passive, the practitioner was more likely to become directive in order to support a more harmonious and less tense outcome.

5.2.5.1. Facilitative practitioner in harmony: Chest pain (CSA, 2013e)

This video of chest pain depicted a typical situation in harmony with a facilitative practitioner and an active participant patient dynamic in harmony. To view video, see (CSA, 2013e) Unidifferentiated chest pain, http://www.youtube.com/watch?v=Fd8_wuJPWq0 [18/07/2013]

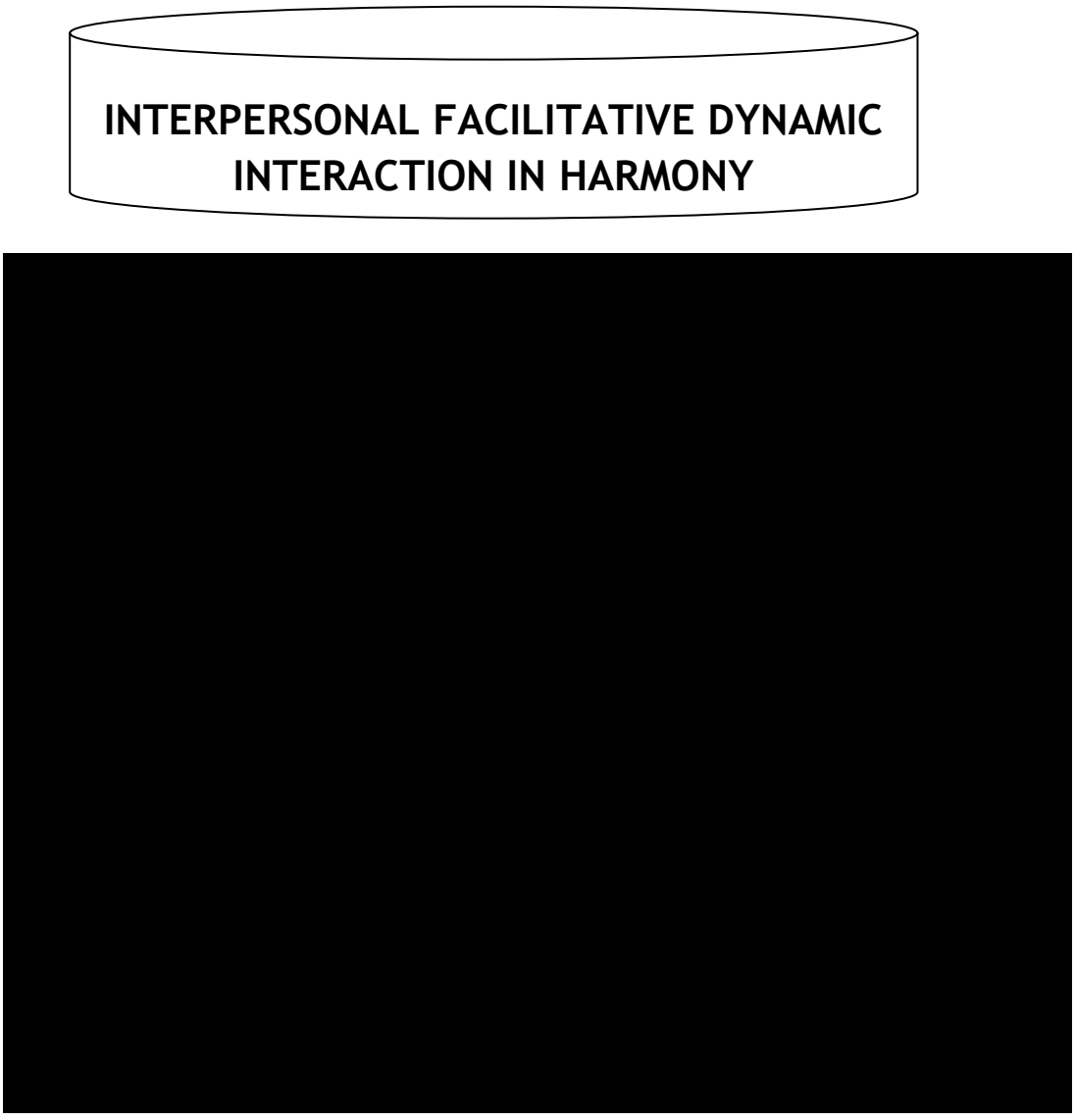

Figure 5.11: Facilitative practitioner and active patient:chest pain

5.2.5.2. Directive practitioner in harmony: Earache (Channel Four, 2013)

In the past a directive practitioner and the passive patient in harmony was the expected typical situation (Parsons, 1975), but more recently patients have been encouraged to take a lead in their health care and practitioners have been trained to be more facilitative and less directive (Department of Health, 2005a). In a television programme Embarrassing Illnesses on Channel 4, there is an example of a directive practitioner and passive patient in harmony (Channel Four, 2013). The consultation was edited but is a good example of this dynamic typical situation. To view video, see (Channel Four, 2013) Pain in ear, Channel four - http://www.youtube.com/watch?v=_NiOct1r7iY [28/07/2013]

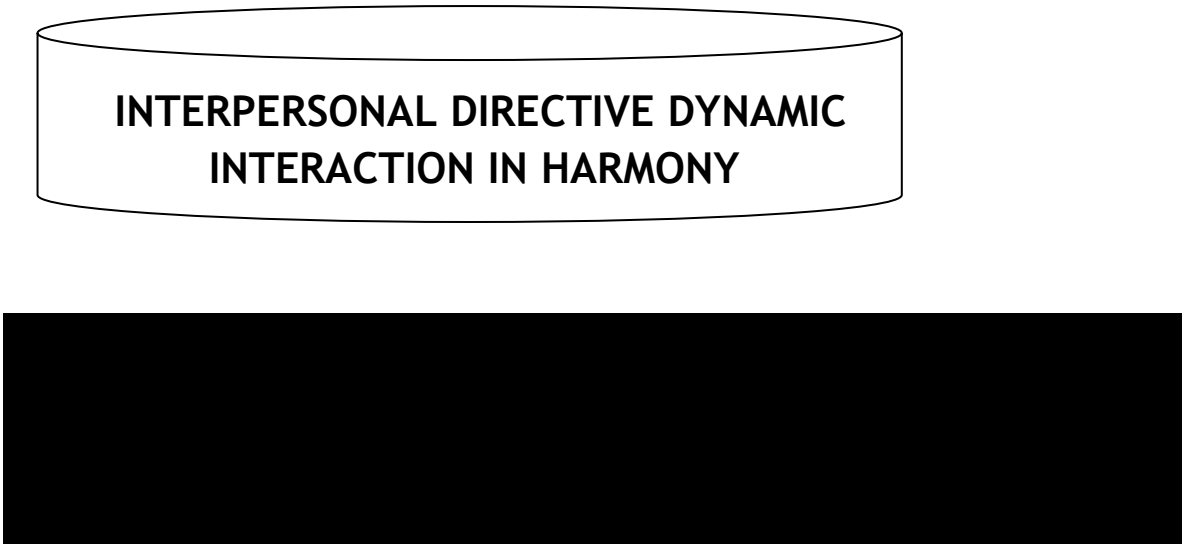

Figure 5.12: Directive practitioner and passive patient:earache

5.2.5.3. Typical situation in tension: Cancer diagnosis (GP training, 2009)

I categorised this video on breaking bad news as a textual consultation in tension (GP training, 2009). The audio and visual conversation included elements of movement, knowledge, and emotion. However, it was the emotion conversation which was the overarching conversation. The patient had made an appointment to receive her cholesterol results. However, the GP told her the results of another test she had had for cancer of the breast and it was positive. As soon as the patient sat down in GP's office, he presented her with this difficult and bad news. From the single shots illustrated below it was possible to observe the discomfort in the situation. At first, the GP dynamic was directive and then became more facilitative as the patient moved from being passive in her approach to taking a more active

stance. The patient appeared in shock at what she was hearing. She asked that the information be shared again with her husband present later in the day. This was agreed. The interaction was in tension throughout the consultation although the GP communicated in a conciliatory manner following his blunder and attempted to change the outcome to a more harmonious situation but there was very little that he could do to change the patient experience. To view video, see GP training (2009) Breaking bad news badly Number 2, Pennine GP training - http://www.youtube.com/watch?v=xCBQUGvSU7k [28/08/2013]

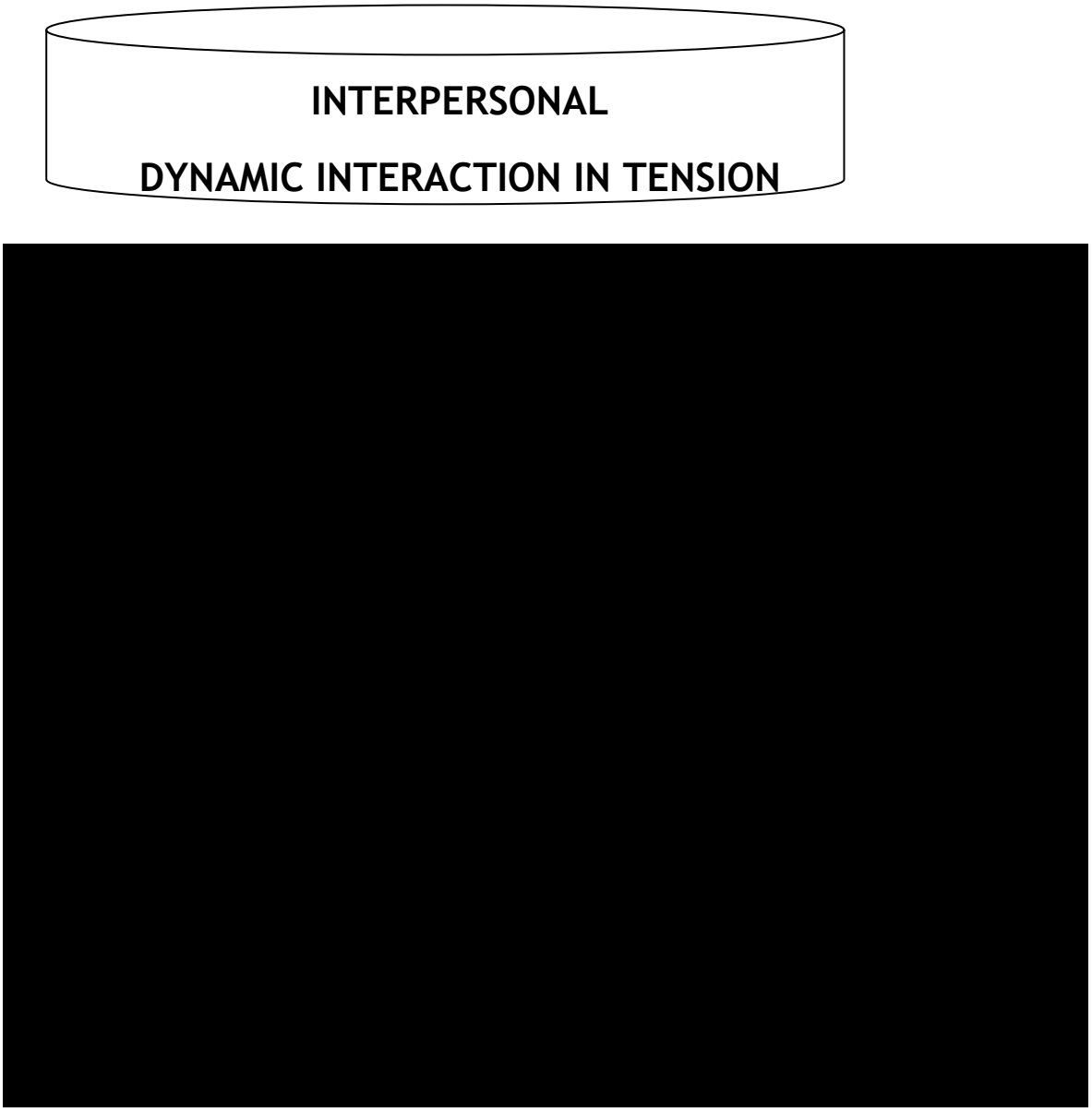

Figure 5.13: The practitioner and patient situation in tension: cancer diagnosis

5.2.6. Text and narrative

Focus: The video text is understood as knowledge through action, text, and narrative. Reflections lead to different levels of understanding and objectification. The health consultation is always more than a shared connection based on the reflective interpretation of lived experiences. Typical situations as a whole are determined to be either prefigured text, configured text or refigured text. The interpretation of the consultation videos are configured texts.

Typical texts and narrative situations in the WiC could be attentive, objective and/or engaged texts, and had the potential to be fully engaged face-to-face narratives. The task oriented objective text or partially engaged empathic conversation is the only professional artistry that is recognised in the narrative of these videos of WiC consultations (It should be noted that the objective text is different from the objective physical assessment included in the SOAPier technical documentation). Fully engaged and reflective narrative are social actions interpreted as a whole rather than associated with one particular aspect of the healthcare communication and created through multi-layered complex narratives.

5.2.6.1. Typical healthcare textual narrative: chest pain (CSA, 2013e)

The video stories were all textual narratives. Either there was task focussed or patient-centred engaged text. In the partially engaged text (CSA, 2013e) the practitioner invited information and listened to patient cues of wellness following up with questions related to the present complaint of chest pain. All the questions related to subjective history in the 'SOAP' documentation (Cox, 2005). The facilitative practitioner and the active patient participant were attentive and engaged with interpreting a partially engaged text, and a shared understanding of the disease process and personal illness. In this process the conversations became an engaged face-to-face conversation. To view video, see CSA (2013e) Unidifferentiated chest pain, - http://www.youtube.com/watch?v=Fd8_wuJPWq0 [18/07/2013]

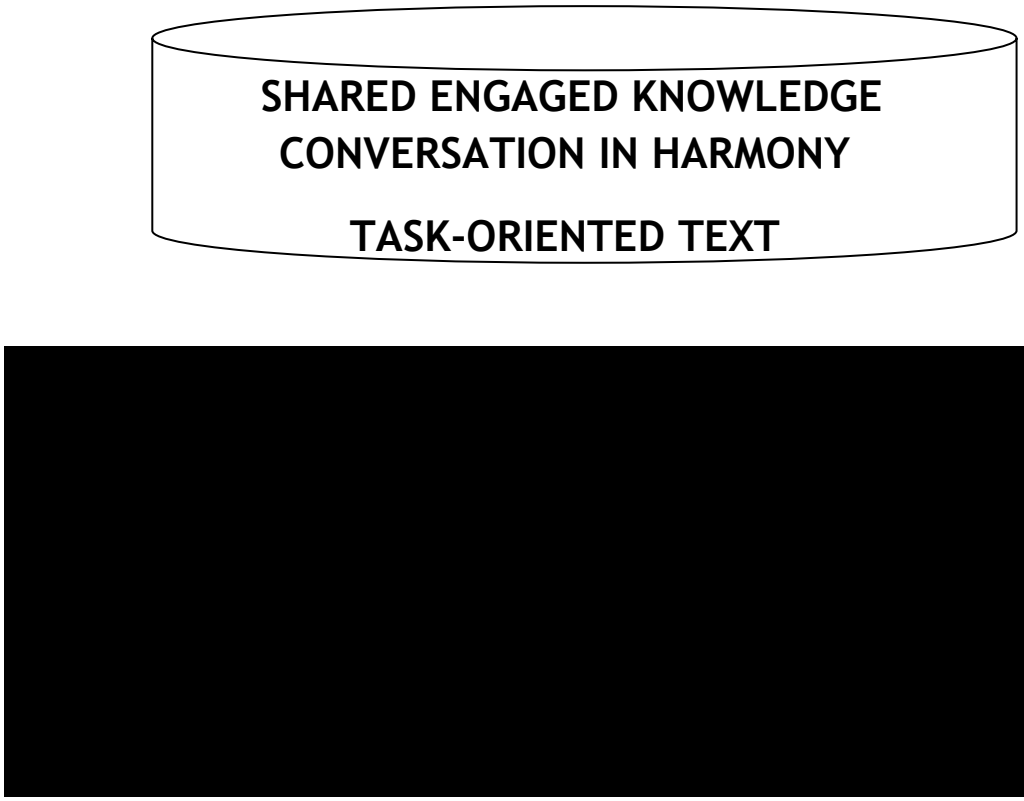

Figure 5.14: Typical problem oriented texts: chest pain

A non-engaged textual outcome differed from this partially engaged textual situation and was more likely to be task driven as in the video where an abdominal examination was done badly (CSA, 2013a). In the abdominal examination done badly (see figure 5.8) illustrates an objective and non-engaged conversation no empathic connection between participants and objective text was not engaged.

5.2.6.2. Typical situation in tension: Seeking a prescription (RCSed, 2014)

In this video consultation (RCSed, 2014) a patient was requesting a repeat prescription and the practitioner refused to write the prescription because the drug had been withdrawn from the market. The practitioner suggested the patient go and buy over the counter medication from the pharmacy. The patient protested because the medication had been maintaining her weight (but she had not lost any weight) and she liked the medicine. The practitioner was directive and insisted that the patient attend weight watchers, rather than take the medicine she was asking for and focus on increasing her exercise regime. There was no empathy in the practitioner's voice and the conversation was disengaged. The conversation developed through an objective emotional conversation where the interpersonal dynamic was in tension.

The practitioner was directive and refused to patient's request without interacting in an engaged and empathic manner Rather, the practitioner provided limited information to justify this decision and the patient actively protested the decision, was not placated, and left the consultation room without accepting the reason for the consultation outcome of non-renewal of her prescription. To view video, see RCSed (2014) Simulated GP consultation 4 for assessment purposes. Communication in the clinical consultation: www.robin-beaumont.co.uk/virtualclassrooom/dprom/web/index/html [accessed 31/03/2014].

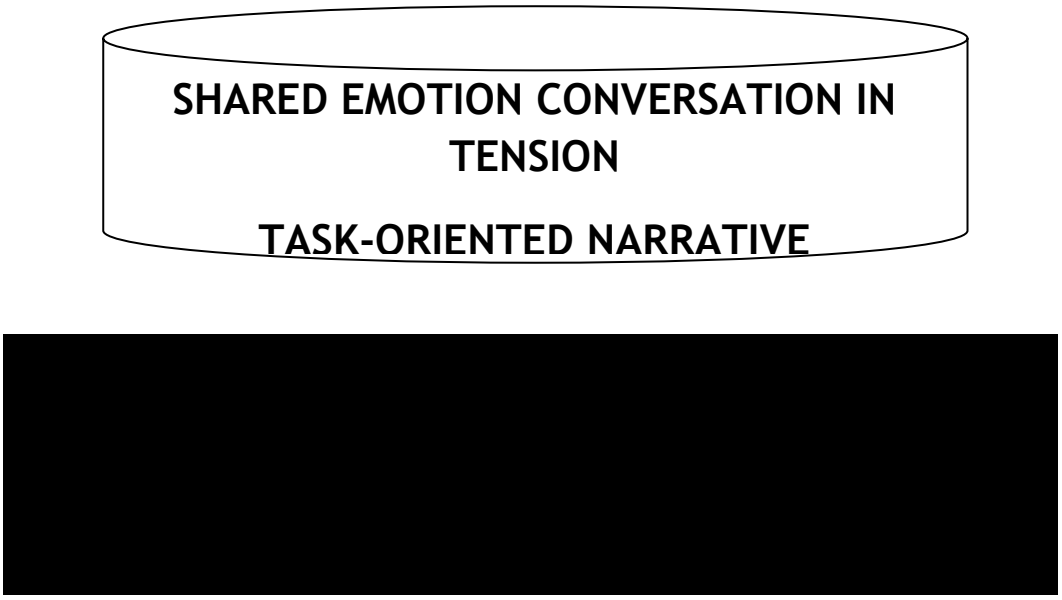

Figure 5.15: GP training (2009) Breaking bad news badly: seeking a prescription

5.2.6.3. Typical narrative situations

The healthcare typical situation narrative also has the potential to develop into a fully engaged narrative when there are multiple worlds and stories shared by both patient and practitioner. However, achieving the fully engaged narrative at first seems unlikely in the context of a short NHS primary-care health consultation where patients and practitioners rarely interact over a lifetime on a regular basis. Nonetheless, within the context of primary care there is the potential for this sort of contact, a fully engaged narrative would be experienced as shared practice grounded through shared reflective action. These reflective dynamics are experienced as embedded in the healthcare interaction process as a whole. This process would be experienced through a reflective construction that integrated

different combinations of perception such as gestural equivalences, linear associations, equivalent resonances discovered through sound, words, or rhythm, which built a pattern of outcomes that, recognised shared reflective communicative action fully integrating lived experience as reflective empathic and engaged narratives. In this process I reflexively interpret combinations of clinical practice that build reflective associations such as mirroring, empathising and engaging with each other. These social actions interpreted as a whole rather than associated with one particular aspect of the healthcare communication and create multi-layered complex narratives. These narratives are reflective and fully engaged.

5.3. Summary

This chapter has provided a template of potential social action, conversations and consultation situations. The video images include examples of knowledge, emotion and movement conversation, an attentive objective, empathic and engaged conversation and the four typical situations that were either texts in harmony or tension. All the video images are organised through a narrative text. Videos of these primary-care consultations and there links are found in the text relating to each video. The following chapter, which provides the findings and interpretations of the original research data interpreted in the present study, for ethical reasons, could not include the original video clips.

Chapter 6: Interpretation and findings

6.1. Introduction

A summary of the interpretation of the WiC videos is included below. The chapter also includes examples of the research data interpretation of video clip conversations, the present study participant communication dynamic and the narrative text. The VS is outlined in chapter four (see figure 4.12) and applied to YouTube videos of consultation interactions in chapter five. The present chapter 6, first describes the sample i.e. provides relevant study participant details, the health complaint, and a summary of the practitioner documentation including the consultation outcome. It is followed by my reflective interpretation of the video narrative (see figure 6.1. WiC patient consultation and video interpretation findings).While I applied the reflexive VS in this chapter, similarly to chapter five, I could not include illustrative video images of the WiC consultations for reasons of maintaining confidentiality of the present study participants (see the ethics approval process in the method and methodology chapter four). I extracted examples of different types of conversations and participant dynamics from eight of the 20 videos. Summaries of all the video data outcomes are found in appendix 10.

6.2. Background

The qualitative approach to interpretation in this chapter applied the VS to unedited fixed view videotapes of patient and practitioner consultations in a WiC.

The Department of Health (2010c) stated that clinical practice involves a range of communication skills and communication technologies that include verbal, nonverbal, and written communication. The NHS recognised the importance of building a culture of compassionate care and ‘communication’ is one of the six ‘Cs’ that were defined as essential components of nursing care (Cummings and Bennett, 2012). Atkinson and Heritage (1984) found that videos analysed using CA deduced that communication in health care tended to be understood in terms of professional concerns. This was further illustrated in a study carried out by Sandhu et al (2009) who found that ENPs and GPs focussed more on health promotion and counselling, than emergency doctors (EDs) who concentrated more on the health condition

treatment. Communication then in the present study focused on the shared relationship between the NP and patient but the outcomes were understood in relationship to NP educational development.

In particular, the primary-care relationship between the healthcare provider and patient was central to the health consultation for Pendleton et al (1984) and for Bach and Grant (2009) the consultation interaction involved subjective and personal relationships such as how people engaged, felt or acted towards each other. For Ong et al (1995) these interpersonal relationships were interpreted through perception rather than precise measurement. Furthermore, a recent systematic review of qualitative and quantitative studies in nurse-led WiCs noted that patients were generally more satisfied with situations where nurses listened and where the communication skills were better than with their GP (Desborough, Forrest and Parker, 2012). Thus, it was important to discern the nature of shared communication in practitioner-patient consultations in WiCs.

Appleton (1993) found that a mutual understanding of caring added to the primary-care NP interaction with knowledge as the essential core of this caring. Hardy et al (2010) provided evidence of holistic nursing practice knowledge demonstrating nursing artistry; whereas, Lyn (1987) used a holistic model of communication that included information gathering, emotion handling, and behaviour management. Lyn argued that this approach supported clinicians including nurses, who in turn motivated the patient to engage with their illness and their treatment. However, there have been only limited studies focussed on the NP; far less than those that have examined the GP relationship.

6.3. Present study findings

The present study participants represented a similar sample of the WiC patient population found in an evaluation of WiCs in England (Salisbury et al., 2002a) (see appendix 13). The population tended to be adults between 19 and 49 with a majority of patients (60 percent), who were between the ages of 19 and 25. Twenty five percent of patients were between the age of 26 and 29 and 15 percent were between the ages of 40 and 49. Only four patients were registered with their own

general practice. The objective findings in the ‘SOAP’ summary found all 20 study participants presented with minor ailments. More than half of the patients presented with an upper respiratory tract infection that included presentations such as a sore throat, fever, cold, and flu. Other diagnoses included gastroenteritis and indigestion, pulled muscle, otitis externa, migraine, and positional vertigo (see figure 6.1) of the table of WiC patient consultation and video interpretation outcomes. Seventeen of the consultation outcomes were seen and treated with advice and or a prescription or medicine and told to return to the WiC if their presenting complaint worsened or did not improve in the next three to four days. The other three patients were referred on to medical practitioners: one to an emergency nose and throat (ENT) specialist and two back to primary-care practice.

The findings are reported below in two sections. The first section provided a brief summary of the practitioner documentation of the consultation. The second section included a summary of my interpretations of the videos. These ‘SOAP’ and video interpretation summaries are included in appendix 10 and in figure 6.1 in a table on WiC patient consultation and video interpretation outcomes. I interpreted 20 healthcare video narratives and interpreted 17 conversations as knowledge-based typical video situations. The other three video narratives included two emotion conversations and one movement conversation. These situations lay along a continuum, constructed through a generalisation of individual cases. The method included a phenomenological interpretation of the video, which was not quantitative or discrete, nor easily replicable or reproducible. Moreover, the interpretation was dependent on the viewer’s (i.e. in the present study the authors) reflexive interpretation. The rationale for the present study was that this method had the potential to be shared and applied by other potential reviewers and could be used for educational purposes such as reflective practice.

The results revealed that the ten engaged texts (with the exception of video 18) were all in harmony and occurred where there was an active patient and a facilitative practitioner. However, with video 18 the typical situation was a directive practitioner and a passive patient situation, rather than a facilitative practitioner and active patient in harmony. The findings are summarised in table 6.2 at the end of the

chapter. All except three of the conversations were knowledge. The three conversations which were not knowledge conversations were either movement or emotion conversations. Nearly as many objective texts (six) were knowledge conversations in harmony and occurred with facilitative practitioners and active patients. There was one more objective text in harmony that was an emotion conversation. Finally, the four typical situations in tension were all objective texts except for one engaged knowledge text, and all but one emotion text were knowledge conversations. The exception was an emotion conversation. The present study illustrated that there was little difference between facilitative practitioners objective and engaged conversations in harmony. The summary of the outcomes are demonstrated below on the next page in figure 6.1. The consultations completed by the six different practitioners are highlighted in different colours.

Date and time	*Patient Video number Patient gender Patient age Registered with a GP*	*Advanced or Nurse Practitioner Female r*	*Patient's description of problem*	*Diagnosis*	*Treatment*	*Type of conversation :knowledge Movement emotion*	*Objective Engage conversation d*	*Typical Situation*	*Interaction in tension or harmony*
24/01/05:: 09:30	08. Male 49 no	NP(F) (ONE)	Shoulder pain	Pulled Muscle	Ibuprofen/panadol alternated and warm pad	Knowledge	Objective	Passive and Facilitative	Tension
24/01/05 11:45	09. Female 25 no	NP(F) (ONE)	Cough & fever	Viral URTI	Paracetamol	Knowledge	Engaged	Active and Facilitative	Harmony
24/01/05: 12:45	10. Female 23 yes	NP (F) (ONE)	Acid feeling in chest	Indigestion	Ranitidine or gaviscon	Knowledge	Engaged	Active and Facilitative	Harmony
24/01/05: 13:20	11.Female 24 no	NP (F) (ONE))	Itching skin	Allergy	Antihistamine e45 cream or an aqueous cream	Knowledge	Engaged	Active & Facilitative	Harmony
24/01/05: 14:00	12. Male 25 no	NP(F) (ONE)	Headache	Migraine	Continue with medicine	Knowledge	Engaged	Active & Facilitative	Harmony
24/01/05 :15:35	13 Male 22 no	N P (F) (TWO)	Diarrhoea	Gastroenteritis	Fluids +++	Movement	Engaged	Active & Facilitative	Harmony
25/01/05: 10:15	14. Female 29 no	NP(M) (THREE)	Abdo/chest pain	Musculoskeletal	Ibuprofen	Knowledge	Engaged	Active & Facilitative	Harmony
25/01/05: 11:00	15. Female 25 no	NP (M) THREE)	Cold/fever	Cold	Paracetamol and fluids +++	Knowledge	Engaged	Active & Facilitative	Harmony
25/01/05: 15:00	17. Male 24 no	NP (M) THREE)	Nausea & vomiting	Viral infection	Rest and not to work with food	Knowledge	Engaged	Active & Facilitative	Harmony
25/01/05: 15:15	18. Female 20 no	NP (M) THREE)	Sore Throat	Quincy	Refer to ENT	Knowledge	Engaged	Passive & Directive	Harmony
25/01/05: 16:00	20. Male 28 no	NP (F) (FOUR)	Ear infection	Viral	Continue with treatment and fluids+++	Knowledge	Objective	Passive& Directive	Harmony
26/01/05 10:00	22.Male 26 no	ANP(F) (FIVE)	Swollen lymph node	Localised infection	Ibuprofen	Knowledge	Objective	Active & Facilitative	Harmony
26/01/05: 10:30	23.Male 29 no	ANP(F) FIVE)	Sore throat	Pharyngitis	Fluids, rest and ibuprofen	Knowledge	Engaged	Active & Directive	Tension
26/01/05: 11:15	25. Male 22 no	ANP(F) FIVE)	Flu	Viral URTI	Fluids, rest and ibuprofen	Emotion	Objective	Active & Facilitative	Harmony
26/01/05: 11:30	26. Male 40 no	NP(F) (FOUR)	dizziness	Positional vertigo	Encouraged to see own GP	Knowledge	Objective	Active & Facilitative	Harmony
26/01/05: 13:15	28. Male 26 no	NP (F) FOUR)	Ear infection	Otitis externa	Locorten-vioform / paracetamol/ ibuprofen for pain	Knowledge	Objective	Active & Facilitative	Harmony
26/01/05: 13:30	29. Female 20 yes	NP (F) FOUR)	Fever/cough	Viral infection	Salbutamol inhaler paracetamol and fluids+++	Knowledge	Objective	Active & Directive	Tension
26/01/05: 14:30	30. Female 19 no	ANP (F) (SIX)	Sore throat	Tonsillitis	Penicillin	Knowledge	Objective	Active & Facilitative	Harmony
26/01/05: 15:00	31. Male 25 no	ANPI (F) (SIX)	Cold/fever	Sick Note	Fluids++ and diet	Emotion	Objective	Active & Directive	Tension
26/01/05: 15:15	32. Female 46 yes	ANPI (F) SIX))	Bleeding Skin	Refer to GP	Refer to GP	Knowledge	Objective	Active & Facilitative	Harmony

Figure 6.1: WiC patient consultation and video interpretation outcomes

6.4. Reflexive interpretation of the present study videos

This chapter section provides examples of my process of reflexive interpretation of the WiC videos. The video clips interpreted below demonstrate the different conversations and typical situations illustrated in the video narratives. The interpretation demonstrates the reflexive interpretive process of differentiating between overarching emotion, knowledge, and movement conversations experienced through visual and audio elements of the videotaped WiC consultations. This process involved interpreting objective and engaged communication using the VS which organises communication within a typical situation dynamic that includes combinations of elements, themes, and situations. This VS (see figure 4.12) was applied to examples of WiC video consultations.

The interpretation began with my reflexive experience of the video narrative as a whole and shared conversation. A structural relationship of emotion, knowledge, and movement elements was elicited through the video and was organised through lived experience as either intended objective or empathic engaged conversations. The shared structural elements of the video materials demonstrated both shared and then objective conversations, which had the potential to become empathic and engaged. These video experiences encouraged reflexive awareness of the participant's interpersonal consultation dynamic which were interpreted as facilitative or directive practitioner with an active or passive patient either relating in tension or harmony.

Finally, as discussed in chapter five, I interpreted objective or engaged textual narratives, rather than discovering fully-engaged reflective narratives, as the latter were not present in any of the WiC videos. As discussed in the previous chapter, each video was watched and listened to on at least three occasions in order to be able to separate out these different aspects of the interpretation.

Each interpretation below includes a summary of the documented 'SOAP' notes written by the practitioner. The notes are the present author's summary of the practitioner's documentation of the WiC consultation called summary 'SOAP' notes. The video narrative outcome are presented first and followed by the summarised

‘SOAP’ notes and finally the video interpretation. Each section includes a summary of the ‘SOAP’ notes and then aspects of the interpretation process that I recognised as useful to enhance understanding of the video narratives found in appendices 10. Each of the 20 videos summarised in the appendices include patient and practitioner details and the presenting health concern while maintaining confidentiality and the patient’s presenting complaint, followed by a summary of the subjective, objective, assessment and plan (‘SOAP’) documentation. The second section includes a summary of the interpretation of the video narrative organised under the subheadings of shared connection, overarching conversation, and objective or empathic and engaged, as well as the video typical situation and the video narrative as text or fully engaged reflective narrative. All the videos were organised by the chronological number of the original video and were numbered from seven up to 32.

The video interpretations chosen to demonstrate the different VS elements (see figure 4.12), were critically interpreted at the beginning of the chapter and later the examples focused on specific aspects of the video narrative. All the 20 videos are summarised in appendix 10.

The first two video clips, Video 17 (V17) and Video 18 (V18), were of the same male NP seeing and treating firstly a male patient, and secondly a female patient. Both videos were interpreted as engaged knowledge conversations within a harmonious typical situation. However, the first video demonstrated a facilitative practitioner and active participant, whereas V18 included two kinds of dynamics and also demonstrated a patient-centred directive practitioner and passive patient in harmony.

6.4.1.Engaged knowledge conversation in harmony (Video 17)

The video consultation interaction took place between two men: a British nurse and a Spanish ‘barista’ (a person who prepares and serves coffee drinks in a café). Initially, I focussed on the elicited content of the video elements in the image. In this manner, the video image was experienced in a similar manner to an abstract or a schematic picture filled with different proportions of emotional, knowledge and movement content. The image elements were elicited through the enlivened aspects of the dots in the video that represented the synthetic relationship of emotion, movement, and knowledge conversation that emanated from the video image as a whole (see the VS

figure 4.12). I applied the schema from the bottom circle to the top. The bottom circle represented video materials representing shared consciousness (Schutz, 1964). The middle circle represented the three different kinds of conversations (Sartre, 1969) and the top circle represented the continuum of typical situation dynamics in the WiC (Schutz, 1964).

Summary of the practitioner SOAP notes (Video 17)

The NP was a male and the patient was a male aged 24

In video 17 the patient presented with nausea and vomiting, that had begun the previous day. The patient was feeling much better and had started eating again. However, he was not drinking much fluid. He did not have a headache, shortness of breath, diarrhoea. He had not taken any other over the counter remedies for the nausea and vomiting and was taking no other medications. He had no allergies. The patient was employed in the food industry.

The objective observations, including urinalysis were within normal limits. The abdomen was soft and there was no tenderness or guarding.

The practitioner diagnosed a viral infection and they encouraged the patient to return to the GP or WiC if the symptoms did not improve or worsened

6.4.1.1. The knowledge conversation (V 17)

Audio and visual elements were enlivened through light and sound. I reflected and structured this lived experience into movement, knowledge, and emotional elements of conversations. In this particular video, I reflected on the experience of the interaction between the three elements and decided the knowledge elements were more significant than the other two elements. This then provided the overall conversation (see figure 4.12). Both audio and visual elements supported the construction of the knowledge conversation. Audio or sound elements represented all the different elements of movement, emotion, and knowledge, and I experienced these elements in different ways. The sounds were understood as language through

words and sentences, but also through tonal qualities, pace, and expressions such as laughter.

Movement elements such as gesturing also demonstrated knowledge and emotion. For example, gestures such as head and arm movements illustrated verbal and nonverbal knowledge conversations and expressed emotional meaning. Tonal quality conveyed emotional colour, and kinaesethic movement through gesture communicated humour, and engagement. A smile supported an expression of emotion or participant engagement experienced through movement of the mouth, tongue, and lips alongside the expression of sounds and words. This particular video segment was less than 60 seconds long. However, I was able to interpret an engaged communication pattern of a knowledge conversation that was clarified and supported through positive emotional expression and movement gestures.

In summary, this particular video image was organised as shared elements or strands of combined audio and visual elements integrated into the three different kinds of conversations with the overriding conversation as knowledge.

6.4.1.2. Empathic engaged conversation (V 17)

The VS illustrated an objective, or empathic and engaged conversation that had the potential to run through the consultation narrative. In this particular video, empathic nonverbal gestures reflected each other's trust as they shared knowledge and shared understanding. The NP interacted in a manner that Arborelius and Bremberg (1992b) described as an interaction between a practitioner and a patient as a person that developed into a real relationship.

The patient and practitioner sat close together in the clinic at approximately the same height. They often leaned towards each other paying attention and being actively engaged in conversation. The two bodies created an open square where legs and knees were directly connected to each other through line and gesture forming a human square separated by a diagonal corner of a desk. The desk both aided to separate and to engage the participants' face-to-face and body movements.

Verbal communication was challenging because the Spanish patient was not completely fluent in English. The patient was a barista at Starbucks. Both participants appeared comfortable and shared information easily. The patient stated that he was a barista, pausing before he added that he was a barista in Starbucks. During the pause, the practitioner leant back and appeared confused. He held his pen above his note pad and was experienced as puzzled pondering how or why a barrister would be working in a Starbucks. The patient recognised the confusion and actively engaged the practitioner through arm gesturing in the air and mimed making coffee using a coffee machine. As the patient moved his arms, the nurse laughed and threw his head back exclaiming that in English a barrister was like a lawyer. The patient also laughed as he moved his head back and gazed at the practitioner realising the confusion. His face expressed understanding around the confusion that of course he was not a lawyer or barrister but a barman. The nurse raised his head and nodded exclaiming yes and okay as he chuckled to acknowledge his new understanding. This video demonstrated how participants clearly articulated a shared ability to recognise emotional tacit cues (Henry, Forman and Fetters, 2011).

6.4.1.3. The active patient and facilitative practitioner in harmony (V 17)

The top circle (figure 4.12) was representative of the participant dynamic that is perceived and organised into a harmonious or tense interpersonal dynamic. Four different dynamics are experienced along a continuum and could be differentiated.

The conversation was understood through elements of the video, which also demonstrated the dynamic between the video participants. The participants acknowledged each other and mirrored gestures by nodding or leaning forward. The practitioner was facilitative and the patient actively engaged in communicating with the practitioner. The clip represented two people sharing information and knowledge in an empowering manner.

This video articulated the presence of a tacit bond between the two participants, which supported a trusting and engaged conversation. The video illustrated a facilitating practitioner with an active patient interacting in harmony with little or no tension, except perhaps initially when a misunderstanding occurred with the patient's

occupation. However, this was quickly resolved through humour, gesture, and verbal articulation.

The interpretation of video 17 then provided an example of an engaged knowledge conversation emerging through an active patient and a facilitative practitioner typical situation in harmony.

6.4.2. A Typical situation in harmony (Video 18)

There are four different kinds of a typical situation in harmony. The NP was a male and the patient was a 20 year old female. The NP was facilitative with an active patient or was directive with a passive patient. The two types of typical situations were either objective or empathic and engaged kinds of communication.

The SOAP summary (Video 18)

In video 18 a 20 year old female presented with a very sore throat which she had had for one day. She was unable to swallow solids. She had no nausea or headache but did have a cough. The patient had tried strepsils but with little effect. She was taking no medications and had no known allergies. She was a medical student.

Her observations were within normal limits but there was a peritonsillar swelling on the right side of her throat and swollen lymph nodes.

The case was discussed with an ear nose and throat registrar to rule out quinsy who agreed to accept a referral to see patient. The patient was given directions and went accompanied by a friend.

6.4.2.1. An engaged knowledge conversation (V18)

I interpreted the video segment below from the place when the practitioner walked into the frame holding an orthoscope in his hand. The practitioner sat down. The patient was sitting down, watched the practitioner attentively, and giggled nervously on occasion. The practitioner started his physical examination touching both sides of the patient's, neck, and throat. As the examination proceeded, the patient became

more anxious and her conversation more animated. The patient was sitting diagonally toward the consultation table and was watching the practitioner as he sat opposite her with the table corner delimiting a boundary between them at waist height. The practitioner appeared to be seated higher than the patient is as he leant forward to examine the neck and throat of the patient. The visual body movements provided horizontal, diagonal, and a global sense of movement relationships supporting a visually mirrored nonverbal dialogue. The patient and practitioner did not look directly at each other. The practitioner used his left hand to touch the patient as his right hand held the orthoscope in his lap. The practitioner touched each side of his own neck first to demonstrate what he was going to do in the examination. The patient mirrored his movements verbalising and touching areas of soreness around her neck while moving her head from side to side. The practitioner then palpated the patient's neck. As the practitioner asked focussed questions, the patient gave concise answers with little expressed emotion and movement. The patient spoke quietly and slowly enunciating her words. The practitioner was more animated in his speech patterns and his diction was light but deliberate.

6.4.2.2. An engaged directive and passive conversation in harmony (V18)

Examining the throat with the orthoscope the practitioner was able to make a quick diagnosis because he discovered an enlarged peritonsillar abscess on the back of the throat wall. The practitioner pushed his chair back quietly and stood up to put the orthoscope back on the wall. As he did this, he relayed his diagnosis of a Quincy. The patient maintaining a sense of calm, giggled nervously as the practitioner explained the diagnosis as a form of tonsillitis. The practitioner laughed, to break the anxiousness in the air, to confirm that even though the diagnosis was a form of tonsillitis it was more than just tonsillitis requiring prompt emergency follow up treatment by an ear nose and throat specialist. The anxiety deflated somewhat and the patient sat back and laughed nervously as the practitioner rang to make the referral.

In summary, the conversation as a whole was interpreted as knowledge rather than emotion or movement and the dynamic changed from one of active patient to a passive stance as the clinical context moved into a more urgent situation. The

practitioner moved from a facilitative to a more directive conversation and the dynamic remained in harmony although the dynamic changed.

In this particular video, clip the health condition required urgent care. The practitioner was sensitive to the clinical and contextual environment and this consultation illustrated a situation where a directive non-facilitative practitioner used an appropriate patient-centred approach with a passive patient in an urgent context. The video narrative, similarly to Thompson et al (2007a), illustrated various patient preferences in different healthcare situations. Thompson et al found that a patient with an acute illness wanted less active involvement in their treatment decision making and put more trust in the practitioner's decision making than the patient who was being treated by a practitioner for a long-term condition.

The previous two video images illustrated engaged typical situations in harmony competed by one male practitioner interacting in two different consultations. Rather than demonstrating how a particular practitioner was both empathic and engaged during a facilitative and directive typical situation, the next five video clip samples demonstrated objective, empathic and engaged conversations completed by different NPs, both qualified and proficient.

6.4.2.3. The engaged conversation and harmonious text (V18)

The subjective history, physical examination, diagnosis, and plan of action all supported an overarching knowledge conversation that was engaged. A patient-centred approach was experienced throughout in a similar manner to that of Arborelius and Timpka (1991). This video illustrated both a facilitative practitioner with an active patient in harmony and a directive practitioner with a passive patient. The interpretation below focused on the latter part of the video narrative where the patient was given a diagnosis, which needed a referral and immediate treatment. The patient was passive listening actively as the practitioner directed the conversation.

6.4.3. An engaged movement conversation in harmony (V13)

The NP was a female and the patient was a 22 year old male.

The SOAP summary (Video 13)
Video 13 documented a patient who complained of abdominal pain after a curry the previous night. The patient had two episodes of diarrhoea during the night without nausea or vomiting. He was drinking fluids and was otherwise well. His physical examination revealed nothing unusual and the patient was diagnosed with gastroenteritis and advised to drink lots of fluids and to eat non spicy food.

6.4.3.1. The engaged movement conversation (V13)

The clip began as the patient told the practitioner about a problem with his tummy, which he called dysentery. The patient talked quietly and the tone of his voice remained quiet and self-contained throughout. He was seated with hands together on his knees and his feet and lower body fitted neatly into the side of the consultation desk. His hands illustrated his words as he gestured and his head and eyes moved from looking at the practitioner to looking down again. These gestures were contained but occurred frequently to support the words he was using. In many of the conversations, the words were also supporting the gestures (Arborelius and Bremberg, 1992b). So for example, his hands were loosely held together, his left thumb gestured outwards and inwards on occasion, while he lifted the hands a little off his lap; and at one instant, he pointed his hand at his stomach to illustrate where he had discomfort. These movements all occurred quickly. The practitioner was seated diagonally across from the patient with her elbow on the desk and her arm across her upper body, leaning forwards speaking as her head moved. The practitioner moved her hand and arm to gesture agreement, disagreement, or understanding. The patient stated the word ‘feeling’ to describe his bowel movement and his need to have a bowel movement. The patient articulated and actively discussed his problem and the practitioner questioned his use of the word dysentery. The patient was quite convinced the problem was dysentery and was guarded when the practitioner did not agree. He made many gestural movements to emphasise his

understanding of dysentery and the practitioner shared knowledge about dysentery and differentiated between diarrhoea and dysentery. I interpreted the repeating of diarrhoea by the practitioner and the rather inpatient tone of her voice as the practitioner initially was not taking the patients symptoms seriously (Arborelius, and Bremberg, 1992).

6.4.3.2. An active patient in harmony (V13).

As the consultation progressed, the practitioner became more focused on the human relationship of the patient rather than the symptoms alone and was more accepting of his concern in particular about dysentery. The relevance of the personal human connection is described in detail by community pharmacists (Hargie, Morrow and Woodman, 2000). The interaction became less tense and more in harmony as the patient could more readily listen to the information the practitioner was sharing. The practitioner continued to ask directed questions and reiterating and confirming the difference between dysentery and diarrhoea. The tone of their voices became less strident and the tempo slower with a better sense of understanding between them. However, the patient continued to be animated using gestures, which were often mirrored between the two participants. I established a movement conversation as the overarching conversation and the tonal qualitative, hand gestures and body stance were tacit clues that led to a better shared understanding and influenced the interpretative outcome (Henry, Forman, and Fetters, 2011).

The mirroring body movement between the participants supported a typical situation in harmony. The reflexive interpretation of the video text supported a typical situation in harmony (Bickerton et al., 2010b) (see appendix 11). In the next video, I describe a typical situation in tension to help differentiate between a typical situation in tension and harmony.

6.4.4. An objective emotion conversation in tension (V 31)

The patient was a 25 year old male and the practitioner was a female advanced practitioner. The patient needed aick note because he was unable to turn up to take one of his final examinations at university. However, practitioners working in the WiC environment were not legally able to provide sick notes so the practitioner tried to

redirect the patient back to his general practice because she was unable to do any more. A notice in the reception area clearly stated this.

The SOAP summary (Video 31)

In video 31 a 25 year old male presented with a cold and fever. The patient had a cold and was asking for a sickness certificate. The patient needed 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 were not legally able to provide sick notes so the practitioner tried to direct the patient back to his general practice and was unable to do any more.

The patient had only just registered with the GP and the receptionist had not offered him the option of a health sickness certificate.

The patient had had a cold and fever for one week and reported he was now feeling slightly better. He had no urinary burning or stomach pains. He had been self-medicating with paracetamol. There had been no recent travel abroad. He was a film and media student. He lived in a flat and other flat mates have similar symptoms. His observations were within normal limits. His throat looked red but had no pus and no raised swollen cervical facial glands. There was nothing abnormal discovered in his ears. There was no pain over frontal or maxillary sinuses and the chest auscultation was clear. He was diagnosed with a resolving virus and advised to drink fluids and to eat a healthy diet. He was also advised that a sick note cannot be provided at the WiC and was given a stamped slip reporting that he had attended the WiC for health advice. He appeared happy with this.

6.4.4.1. An objective emotional conversation (V 31)

The tonal voice qualities of both participants were raised as they talked. They both shared information using words and gestural movements that demonstrated nonverbal emotional elements. The patient was positioned diagonally towards the practitioner and the practitioner was distanced but diagonally seated to the patient

with the corner of the desk separating them. The practitioner was positioned further away than in the previous three consultations. The practitioner moved forward only to write notes on the desk and otherwise lent back. The patient sat upright sorting out his jacket and trying to catch the practitioner's attention with snippets of remarks as she talked. The patient pulled on his windjammer and it crackled like plastic; he placed his ear pieces and radio into his pocket, and pulled his hat on and off his head. The emotion element was illustrated through the erect motionless bodily posture of the practitioner and the fidgeting and lack of concentration of the patient. There was no engagement in the conversation and the tone and quality of level of their voices only increased their frustration at the situation.

The typical situation of the participants was that they talked, but were unable to share, listen, and hear each other. The practitioner repeatedly tried to explain why she was not legally allowed to write sick notes in a WiC while the patient demonstrated impatience, fidgeting, and frustration and looked unbelievingly that he would be unable to obtain a sick note. The frustration for both participants was palpable and clearly demonstrated an objective emotional conversation. The patient saw the consultation as a complete waste of time.

6.4.4.2. An active patient and directive practitioner in tension (V 31)

This video, more than any of the other WiC videos, supported how Ariss (2009) described the style of interaction, which progressed steadily, despite differences of opinion. The typical situation was asymmetrical with the practitioner directing the communication (Arborelius and Timpka, 1991). I wondered if either of the participants had been more open to new knowledge the typical situation might have resolved itself in a more harmonious and facilitative manner. Perhaps if the practitioner had been more respectful of the patient as a person with limited understanding of the NHS there might have been more shared understanding (Arborelius, Timpka, and Nyce, 1992). This video highlighted how a shared personal approach had the potential to build a better rapport between the video participants (Hargie et al 2000).

There was no harmony in their interaction and they talked at each other rather than with each other. The practitioner was not able to provide a therapeutic interaction.

The participants raised the tone and quality of both their and voices expressed frustration. The participants returned repeatedly to their earlier questions and statements in attempts to improve communication. The conversation dynamic moved between an active and passive patient and a directive and facilitative practitioner in tension as the participants tried to find a solution to the problem. The practitioner was unable to help the patient but the patient did not seem to be able to understand this because the ANP did not understand the power her knowledge of the NHS had within the video narrative as a whole (Arborelius and Timpka, 1991). This video clip illustrated a practitioner who could benefit from reflection on their communication skills (Olsson and Jansson, 2001).

In the three interpretations above I interpreted the interaction using the VS from chapter four and I attempted to be more explicit in how the video communication emerged. In the four examples below I provided a more condensed summary of the video interpretation demonstrating a closer association with the interpretations in the appendices. A summary of all of the video interpretations and 'SOAP' summaries are found in Appendices 10.

6.4.5. An objective emotion conversation in harmony (V25)

In this consultation the practitioner was a female ANP and the patient was a 40 year old male.

The SOAP summary (video 25)

In video 25 a 22 year old patient complained of flu for past three weeks. He had a headache, heavy eyes, ears popping, a sore throat, and a non-productive cough. He had no shortness of breath, a good appetite, no nausea, no vomiting, and was able to go to work and college but felt tired. He took no medications and had no allergies. He had a past medical history of pleural effusion 2001. He smokes 5 cigarettes a day, drinks no alcohol, and was a student and working part time.

There was no acute distress and observations were within normal limits. His head eyes ears nose and throat presented nothing of note. His chest was clear.

He was diagnosed with a viral upper respiratory tract infection and was advised to rest, to drink fluids, good nutrition, and ibuprofen as needed and to return to the WiC to be seen here again if worse. He was also advised to register with GP.

6.4.5.1. An objective emotion conversation (V25)

Video 25 illustrated a young man and female NP in an overarching emotional conversation that included knowledge and movement elements. The emotion element was demonstrated through the embarrassed laughing and rather stiff schematic movements by both of the participants. The patient complained of flu for the past three weeks and had been treating it with over the counter medicines including Echinacea. Additionally the patient diffidently shared, overdosing on vegetables. The practitioner asked why this was considered overdosing, they laughed, and both threw their heads upwards and backwards with an accepted agreement that overdosing on vegetables was unlikely.

6.4.5.2. A facilitative practitioner and active patient in harmony (V25)

Throughout the consultation, the practitioner was gentle with the young man and suggested that he should try to rest as much as he could and that he was to continue to eat his fruit and vegetables. In this manner, the practitioner was tacitly attempting to articulate her judgement as an informed intervention (Henry, Forman and Fetters, 2011). The participants discussed different medicines that might work well until the illness resolved. The patient was advised to register with a GP.

6.4.5.3. An objective text (V25)

An objective text although there were instances, where there were engaged remarks the dynamic resolved in an objective text.

6.4.6. An engaged knowledge conversation in harmony (V12)

In this consultation the NP was a female and the patient was a 25 year old male.

SOAP summary (Video 12)

Video 12 is a patient who presented with a headache that had been present for five days. The patient had a history of migraines. He was under stress and was studying on the computer for long periods of time.

Following a physical examination which was within normal limits the practitioner advised to continue with medication and to try other home remedies such as taking regular computer breaks, trying an icepack and a warm pad and drinking plenty of water with an appointment to his GP if there was no improvement.

6.4.6.1. An engaged knowledge conversation (V12)

The participants in the video both came from Trinidad. I discerned an emotional conversation as the patient asked the practitioner where she was from and she replied Trinidad. Excitement resonated in their voices. There was also an uncomfortable break as the phone rang and the practitioner answered the telephone and asked that the caller phone back. A gestural element was illustrated as the patient held his arm for a blood pressure and as the participants chatted and shared experiences there was mirroring of gestural movements. The practitioner shared considerable everyday information about migraines and offered advice on what tended to trigger them. The participants were in natural dialogue and this engaged conversation revealed the overarching conversation as an engaged knowledge conversation in harmony.

6.4.7. An engaged emotion conversation in harmony (V 11)

In this video the practitioner was a female and the patient was a 24 year old female.

The SOAP summary (Video 11)

Video 11 documentation reported that the patient had been itching all over for at least 4 weeks and had been self-medicating with potions. She was taking no other medications and had no known allergies.

She did not smoke or drink alcohol and was a law student. She lived in communal student accommodation which had carpeted flooring. There were no pets and there had been no recent change in her diet.

The practitioner advised the patient to use an aqueous cream instead of soap and to keep a diary of what she was doing and where she was when the itching started.

6.4.7.1. An engaged emotion conversation (V11)

The conversation was animated by a patient who was trying to cope with itching skin. The patient was quite emotional over the problem, which was not improving, and the practitioner shared information about dry skin with her. There was movement between the participants as a personal everyday conversation included useful information about itching skin and allergic reactions. Both the practitioner and the patient had experienced problems with itchy skin. Although the participants gestured and shared information the emotion element was, the overarching element because the interactions emphasised the stress and anxiety related to the condition.

6.4.8. An engaged knowledge conversation and active patient in harmony (V23)

In video 23, the analysis revealed an engaged knowledge conversation with a typical situation where the patient was active and the practitioner was facilitative. The text was in harmony. In the analysis, the bodily positioning of both the practitioner and the patient was guarded and there was nervousness and an emotional barrier between the two participants. These postures demonstrated an underlying emotion with movement and knowledge elements. The emotion was expressed non-verbally

and the movement element was demonstrated by the participants sat with their legs crossed away from each other. There was a light hearted banter as the patient answered and responded with a sense of humour to the practitioner's questions. The patient described and pointed to where the discomfort was in his throat. The participants shared information and ultimately the overarching conversation was knowledge. The practitioner ascertained an assessment of raised lymph nodes and shared information about their function.

6.4.8.1. An engaged knowledge conversation (V23)

The practitioner was an female ANP and the patient was a 29 year old male.

> The SOAP summary (Video 23)
>
> In video 23 the SOAP summary described a patient complaining of a sore throat for two days. He found it uncomfortable to swallow. It was worse on right side of the throat. He was generally tired. He had no fever, no headache, no ear pain, no respiratory symptoms, and no shortness of breath. The patient was a non-smoker, had a moderate alcohol intake and was an administrator. His past medical history was insignificant and he took no medications and had no allergies. Observations were within normal limits and there was no acute distress.
>
> An examination of his ear canal was normal. His throat was red and inflamed with no discharge.
>
> The patient was diagnosed with Pharyngitis of unknown aetiology. The patient was advised to rest, drink fluids, and to treat their symptoms with ibuprofen as needed. They were also advised to return to the WiC or to GP to be seen again if symptoms worsened or do not improve.

6.4.8.2. A facilitative practitioner in harmony (V23)

As the patient and practitioner quietly shared health, information there was a more relaxed feeling. Although the patient was concerned, about the sore throat the practitioner was reassuring and provided him with advice that he was relieved to

hear “it looks okay” and he became more comfortable as he recognised the problem was not serious. The patient did not have a fever and the practitioner explained that although it was difficult for her to know whether his Pharyngitis was bacterial or viral, the treatment was the same. The practitioner expected the problem to resolve within a week.

Typical situations	***Videos***	***Knowledge conversation***	***Emotion conversation***	***Movement conversation***	***Objective text***	***Engaged text***	***Dynamic***	***Total***
Typical situation in harmony	16	14	1	1	7	9	15 AP/FP, 1 PP/PD	16
Typical situation in tension	4	3	1	0	3	1	3 AP/DP 1 PP/FP	4
Total →	20	17	2	1	10	10	20	20
* AP/FP was active patient and facilitative practitioner; in harmony								
*PP/PD was passive patient and practitioner directive in harmony								
*AP/DP was active patient and directive practitioner in tension								
PP/FP was passive patient and facilitative practitioner in tension								

Figure 6.2: Video interpretation summarised

6.5. WiC video interpretation outcomes

These case studies above provided an example of elicited video conversations and texts that I reflexively interpreted and are summarised in the appendices. The VS was applied to both audio and visual materials were interpreted simultaneously providing equal consideration.

The interpretation of WiC videos revealed different typical consultation outcomes (see figure 6.2 above). The present study author interpreted 20 health consultation videos. The present study revealed the practitioner in their everyday consultation interactions was directive or facilitating and the patient as passive or active. The results of the present study demonstrated that 16 (80 percent) of the video narrative outcomes included facilitative NPs and active patients communicating in harmony. These results differed from Rapley et al (2006) who found that doctors alternated between directive and neutral approaches within the same consultation and patients were more likely to alternate between passive or active. In the present study, the interpretation tended to be one particular dynamic rather than a combination. The majority of consultation interactions in the present study were relationships between

a facilitating practitioner (FP) and active patient (AP) participating in harmony. However, there was one video where the practitioner was directive and the patient passive interacting in harmony because the diagnosis required timely attention. There were three videos where the patient was actively involved in the consultation and the practitioner was directive. There were two practitioners who were attentive but not empathic or engaged in any of the videos and the other practitioners were either engaged or attentive and objective.

Practitioner (NP1) was taped five times and (NP3 & 4) were taped four times with (NP2) only taped once. The qualified advanced nurse practitioners (ANP5 & 6) were taped three times each. Three practitioners (NP1, 2 and 3) realised empathic engaged conversations and facilitative consultations in harmony with only two exceptions. In one video, NP1 was facilitative, the patient passive leading to an objective consultation in tension, and in the other NP2 changed the dynamic conversation to maintain harmony with the patient demonstrating both directive, and facilitative approaches both in harmony raising issues of when and how could a practitioner change their communication strategy. Interestingly there was only one empathic, engaged text interpreted from the six videos between patients and advanced nurse practitioners (5 & 6), and two of the six typical situations were in tension with the practitioner being directive with an active patient. All 20 of the videos were interpreted as textual narratives and there was no interpretation of a fully engaged reflective narrative.

1 videos	***3 videos***	***4 videos***	***5 videos***
			Number ONE(NP)
Number TWO (NP)			
		Number THREE (NP)	
	Number FIVE (ANP)		
		Number FOUR (NP)	
	Number SIX(ANP)		

Figure 6.3: The number of videos for each nurse practitioner

6.6. Rigour and video interpretation outcomes

Investigator triangulation was completed by JC as well as myself to check for rigour (Polit and Beck, 2012). Polit and Beck outline how this triangulation provides an opportunity to check the consistency of the VT (coding and process guide, and

coding form in chapter seven). In general there was good agreement between JB and JC with 94 out of 100 consultation elements independently agreed within in 20 videos. There were however, six coding item differences across five videos. These differences were first reviewed by JC who found she had made an error in coding two of the videos (three elements), followed by a discussion with JB, where all the remaining three coding differences were resolved (see figure 7.5). Thereby consensus was achieved between the reviewers for all 20 WiC consultations.

6.7. Critique of interpretation of YouTube and the WiC videos

My previous learning about video as an art medium fundamentally constituted of imagistic materials and images, led me to the possibility of investigating urgent care consultations within the imagistic structure of video. The value and usefulness of such an investigation is in determining a form of health care practice that reveals inherent structures that serve as a background for the interaction of the practitioner and the patient as well as for the consultation's outcomes. I believe using the VT has the potential to raise practitioners' awareness of the variety and potential outcomes of interactive situations in which they engage in their working day.

Earlier research on video had a phenomenological framework and foundation in the treatment that Jean Paul Sartre gave to the image in his work Psychology of the Imagination (Sartre, 1967). In the present study WiC videos are interpreted to give access to our human lifeworld and reveal how our consciousness organises and consciously synthesises materials into images. This interpretation of the fundamental role that images, and in particular audio visual images, provides a novel way to view human experience and shared health care communication.

I found that when I was reviewing the videos it was important for me to put time aside to watch each one at one sitting. As I have become familiar with interpreting video materials it has become easier to identify the particular categories. To gain expertise I watched videos of consultations from the WiC and from YouTube. I interpreted in detail the video categories. The WiC videos were more vivid than the You Tube consultations but of course, I knew the nurse practitioners and they presented with a far more vivid presence than the You Tube videos where I did not

know personally the participants (Sartre, 1969). It is important to watch the video the first time all the way through to grasp an overall feeling or intuition of the video as a whole. For viewers, who have never watched and interpreted videos, it may take time to understand the different categories of the VS. The VT is structured and will hopefully be easy to undertake. The initial feeling and personal interpretation of a video provides an overview followed by identifying and differentiating shared conversations, the participants combined styles including their gestures, emotions, talking, and engagement, etc.

The advantage of using video is that it can be reviewed as many times as are necessary. The conversations can be followed as they move through stages. At one moment there might be more emotion than gesture or information sharing. The practitioner may ask the patient to tell them about their problem through an open question and later be more talkative. The patient may be quiet or gesture to try to explain their illness. Deciding which shared conversation is most important can be difficult because it is a combination of both participant approaches. Additionally, the conversations are objective or engaged conversations. For this reason, it is helpful to begin the process of using the VS watching and interpreting videos where one style of conversation can be clearly interpreted as the overarching approach. I found the typical situations easier to grasp. The typical consultation interaction tends to fulfil the different situations without having the same lack of definition that the conversations have. I have been impressed at how I am able to distinguish quickly between the empathic and objective communication. However, this skill may require development over time depending on the ability of the reviewer.

6.8. Summary

This results chapter reviewed the qualitative differences and similarities between 20 videos of WiC consultations, and the differences between individual nursing practices. There were six practitioners taped in the 20 videos and I noted subtle and individual differences between the consultation outcomes (see figure 6.2 of the summarised table of video interpretations). There were also differences in the number of videos of different nurses**.** This was unfortunate, but was dependent on the practical issues discussed in the earlier methods chapter.

Overall, the results demonstrated that all but three of the consultations completed episodes of care with health advice and or a prescription. The remaining three patients were referred to medical practitioners: one to an emergency Ear Nose and Throat (ENT) specialist and two back to their primary care practice. All but three conversations were interpreted as primarily knowledge conversations and there were two movement and one emotion conversations. Seven of the conversations were objective and nine were empathic engaged conversations. Sixteen of the videos illustrated a typical situation in harmony and all but one of the dynamic situations was facilitative and active. The different narrative developed with an active and facilitative dynamic harmony at the beginning of the consultation and changed to a directive practitioner and passive patient at the end of the consultation. This occurred when the conversation moved to a potential emergency situation and the patient moved from an active position to a passive presentation. However, both dynamic situations in this video were in harmony. Finally, my reflection on interpreting the videos of the WiC consultations illustrated some of the more frequent issues I found when interpreting videos.

Chapter 7: Development of a video tool (VT)

7.1. Introduction

In the previous chapter six the presentation of the findings of this study are based on my personal interpretation of WiC videos using the video schema. They reflect my own experience of the videos alongside my professional experience as a nurse practitioner seeing and treating patients in a primary care WiC. The video medium is used in a variety of ways in health care**,** such as sharing health information and raising awareness of illness and disease processes (NHS, 2011). Greenhalgh, Robb and Scambler (2006) analysed communicative and strategic action using transcripts of audio tapes. Video in the present study represents human consciousness. Perceptual and imaginative consciousness are understood through the video action of kinaesthetic movements organised into spatial arrangements: conversations, different dynamic interpersonal interactions, and texts (Bickerton, 1992). In this chapter, the video interpretations (VS) findings are triangulated with coding undertaken by JC using the Video Tool (VT). Following this process consensus was reached on all the videos coded and good/excellent inter-reliability was established for the VT. This process of interpretation was followed by the development of a reliable coding tool for supports and confirms the utility of the VT for practice and research.

7.2. Background

Phenomenological reflection was used to develop a video schema. The schema was comprised of conversations and dynamic typical situations within a narrative text. Additionally, these elements were organised into a video tool and helped establish qualitative rigour of the VS using investigator triangulation. Using a coding guide, scoring sheet and process outline (Polit and Beck, 2012) enabled good consistency between the reviewers to be attained.

7.3. Data collection method: structured observation

Structured observation is undertaken to record identifiable activities or events using a formal set of tools that help the observer record what they are seeing and/or hearing (Polit and Beck, 2012). There are two broad approaches to structured

observation, molar and molecular (Polit and Beck, 2012). In a molecular approach every single unit of speech or action or event is recorded but for molar observation large units e.g. the global or whole of the consultation, as in this analysis, are coded. VT consists of three elements 1) coding guide of mutually exclusive conversational categories e.g. knowledge or movement conversations 2) a process guide 3) and a coding form. This was so that any observers can consistently generate a numeric record of events they observe. It was essential to generate good definitions of the conversational elements to reduce the amount of observer inference and hence improve inter-rater reliability (or agreed categorisation between scorers) even for observers who may have little observation experience. This allowed me to develop a tool that practitioners or novice researchers could use. The VT was applied to the video data by JC (one of the study supervisors) as part of a structured observation data collection method to verify the video schema. Inter-observer reliability for the VT in comparison to the VS was assessed and Cohen's Kappa was calculated (Cohen, Manion and Morrison, 2000).

7.4 The video tool

A coding guide, a process guide, and a coding form (see the final VT below in figures 7.1, 7.2 and 7.3) were developed from the video schema used by JB (see chapters four to six). JB and JC met to discuss the video schema process and after this developed a draft version of the VT, this draft version was further refined following discussion between JB and JC before being piloted by JC (see appendix 9 for pilot version).

JC reviewed the 20 videos interpreted in chapter six using the VT. The coding form identified 11 main elements to be coded as predominant (or not): knowledge/emotion/movement shared conversations, objective or empathic engagement, typical situation (active/directive practitioner, with a passive/active patient) which is in harmony or tension. Five types of conversational elements are recorded for each video. The first version of the VT can be found highlighted in Appendix 9 and the final version of the VT includes the consensus elements agreed in figure 7.5. For the final version of the VT see sections 7.4.1, 7.4.2 and 7.4.3 below.

7.4.1. The VT form

Typical Situation				
Practitioner		*Patient/Client*		*Harmony/tension*
Facilitative		*Active*		*Harmony*

'SOAP' Summary	
Subjective	
Objective	
Assessment	
Plan	
Shared connection Summary	
Conversation	
Emotion/knowledge/ movement	
objective or empathic engaged	
Typical Situation	

		Passive		*Tension*
Directive		*Active*		*Tension*
		Passive		*Harmony*
General comments				
Reflection Narrative, configured or reconfigured text				

Figure 7.1: The coding form

7.4.2. The process guide

Step 1: Shared action in the video story

Focus on the video elements rather than the individual participants. The whole communication process involves visual (non-verbal) and audio (verbal, sounds, words). Similarly to meditation practice focus your mind on experiencing a combination of sounds and the visual elements without becoming engaged with the consultation content. Your mind is clear, relaxed, and inwardly focused. You are fully awake and alert, but your mind is not focused

on the representations of the consultation taking place in the video. The video materials are the material acts of inner consciousness where your mind is calm and tranquil. Where the practitioner left the room the video data is not included because of its potential to have an effect on the overall outcome.

Suggestion: Focus on stilling your mind.

Step 2: Psychology of perception, conception and imagination

Focus on shared action across the video image as components of three different kinds of conversations. Focus again on the combination of audiovisual video elements and try to identify how emotion or knowledge or movement elements are experienced within the image. Look, watch, listen and hear linear movements, different colours and hues of emotion and listen to the meaning in the words. In verbal communication consider the type of questions (open, directed, affirming for example). Communication skills include building rapport, nonverbal communication, explaining, questioning, listening, suggesting/advising, opening, closing, assertiveness, disclosing personal information and persuading. Pay attention to understanding emotion, knowledge and movement as separate elements across the video image without separating the elements from the participants in the video. These particular elements are combined into conversation types.

Suggested questions:

What elements of conversation content hold your attention?

What is it about these phrases that you find interesting in the video narrative?

How do you understand the meaning of these phrases?

Step 3: Elements of conversation

Focus on the predominant element of the conversations under 'emotion' 'movement' and 'knowledge' which lead you to identification of an overarching conversation that is named either knowledge/movement/emotion across the audio and visual narrative. Distinguish between emotion, knowledge and movement elements in the conversation and include not only words but also aural, verbal and visual elements such as gestures and visual expressions. Visual cues include facial expressions, gestural movements, and audio cues such as laughing out loud or conversations. All conversations have the potential to develop into an empathic engaged conversation i.e. to be with that person, rather than seeking to act upon them. Be aware that the placement of chairs and tables represents aspects of personal boundaries and space.

Suggested questions:

How are the different elements of the communication conversation separate and shared?

What feelings or emotional response do you have to the video story?

If sign language was being used to impart knowledge what type of conversation might you have?

What makes you choose one of the conversations over the others described below (emotion/knowledge/movement)

Are the participants in the video engaged in conversation and empathically listening to each other?

Predominant Emotion conversation	***Predominant Knowledge conversation***	***Predominant Movement conversation***
Emerges from a combination of all three elements where the emotional content is supported by movement and knowledge elements. So, for example, words express emotion more than information or knowledge and gestures also support the emotion more than the emotion supporting the gestures.	**Emerges from a combination of all three elements where visual and verbal information and knowledge is supported by gestures and emotional sharing. So, for example, a verbal sound may be expressed that supports understanding or an emotional nod or verbal sound that acknowledges and supports facts in a knowledge conversation.**	**Emerges from a combination of all three elements and is realised through the movement conversation which can involve gestures and hand movement, for example, as movement delineating personal space and boundaries. The space is not named but rather articulated through space as the hands express an emotional concern.**

Step 4: Social interaction between the participants

Focus on the social action between the participants. How are they interacting? Interpret these interactions through an accumulation of various interaction approaches that are 1) active or 2) passive, 3) facilitative or 4) directive. These approaches organise along a continuum of four typical situations which are either in harmony or in tension. The patient may be active or passive and the practitioner facilitative or directive. An active patient interacting with a facilitative practitioner and a passive patient interacting with a directive practitioner realises a consultation outcome in harmony. An active patient interacting with directive practitioner and a passive patient interacting with facilitative practitioner realise consultation outcomes in tension. Communication has the potential to change and adapt and so the final outcome may be the result of various typical communications that fall along a continuum and may be difficult to differentiate.

Suggested questions:

How does the overall communication between a practitioner and patient lead to a harmonious outcome?
How does the overall communication between a practitioner and patient lead to a tense outcome?
Are there barriers to communication?
What are the barriers to shared partnership working?
Can you identify any transparent moments of sharing?
How does the patient speak for themselves?
Does the practitioner listen, understand, and care?
Is the practitioner an unreachable person?
Is the practitioner open and receptive to the patient?

Step 5: Kind of video story

There are three kinds of video story that are the narrative, the pre-figured, configuredt and the refigured text.
The narrative is where the focus is on describing the video story as a document in a similar manner to transcribing an audiovisual document through close reading.
The configured text is making associations with your own experience of communicating as a healthcare consultation and configuring a text?
The reconfigured text is when communication in the consultation creates moments where understanding the video text is reconfigured and entangled with your life experiences in such a manner that the video consultation takes on an existential form that changes your personal understanding of healthcare communication?
Suggested questions:
Can you give an example of how the video participants are paying attention?-
Are the participants really listening to what is being asked and said?
Can you determine the outcome for each typical situation? i.e. active, passive etc. outlined in step 5.
Are there examples of typical situations where the patient-practitioner tension exists?
Does tension matter to the outcome?
Does the practitioner who is most in harmony with the patient have the fewest "inconclusive" outcomes?
Is the practitioner most able to switch from being directive to facilitating on a case-by-case basis the most effective?

The process requires further checking by another reviewer

Figure 7.2: The process guide

7.4.3.The coding guide

The coding guide	
Emotional conversation	
Definition	Communication through feelings and emotions through verbal or non-verbal actions.
Indicators	**Pay attention to a consensus of shared actions that lean towards different forms of emotion supported by knowledge and movement. The communication content tends to settle towards a type and a consensus although it is not easy to identify how these different elements are building towards a particular overarching conversation.** **Look, watch, listen and hear emotion clues and expressed feelings.** **Visual cues may present that are suggestive of emotion such as smiles and frowns.** **Body movements such as withdrawal or moving forwards.** **Sound elements such as sighs, tonal qualities, level of voices.** **Word statements such as 'I feel sad' or 'I feel happy'.** **Eye contact suggestive of confusion, disagreement, disbelief, resistance or understanding can be identifiable through acoustic clues such as pitch, amplitude and spectrum cues**
Differentiation	**NB emotional, knowledge and movement elements or actions are defined as parts of a whole organised in varying amounts. E.g. these can be visualised as three different segments of a cake, if having difficulty distinguishing the contributions of the three actions try drawing it to see if a visual representation of a cake divided into emotional, knowledge and movement slices and see if this helps you decide which action predominates.** Visual and verbal actions have multiple meanings and are understood differently. Understanding can vary because of cultural, gender, economic, political, and individual patient's physiological situation. A deaf personal may communicate through visual sign language; the mother tongue may be different from English meaning that some nuances in the spoken language may be lost. Social interaction takes place in a geographical space which is where the participants get close maintaining psychological distance.
Examples: Emotion	**In video (National Health Service, 2013) the participants discussed symptoms arising from cancer. The listening and visual skills involved emotion, movement and knowledge. In this particular video, there were edited images. Fixed and edited shots were used that demonstrated the emotion conversation. The emotional elements were not only associated with visual expressions, but also through the verbal tone of the conversation and gestural movements. All three elements (emotion, knowledge and movement) of the conversation were recognised but both the knowledge and gestural elements emphasised emotional expression that provided the overarching conversation.**
Movement conversation	
Definition	**Communication through movement, gestures or use of space.**
Indicators	Pay attention to communication through gestures and touch, body language or posture or physical distance e.g. hand on someone's shoulder, touching oneself, participants with their legs crossed towards or in opposition to each other. Using appropriate hand gestures. Hand and foot gestures supporting each other. Reinforcing with gestures what is said by leaning forward. Moving foot up and down or rocking forwards and backwards. To shake hands when meeting for the consultation. Including visual and wordless kinaesthetic movements in social action perhaps to enhance the meaning of words. **Look, watch, listen and hear for these different elements in the conversation. There is usually a tendency for the use of a particular conversation. It is not always easy to ascertain but the more readily available element in the video becomes the overarching conversation. A spoken sentence is experienced through audio as well as visual expression. The words may be spoken in a loud authoritative manner where the finger is pointed and shaken to emphasise their importance. The understanding of these words is shared through knowledge, emotion and movement**
Differentiation	**NB emotional, knowledge and movement elements or actions are defined as parts of a whole organised in varying amounts. e.g. these can be visualised as three different segments of a cake, if having difficulty distinguishing the contributions of the three actions try drawing it to see if a visual representation of a cake divided into emotional, knowledge and movement slices and see if this helps you decide which action predominates.** There are many visual and verbal actions that are understood differently. Understanding can vary because of cultural, gender, economic, political, and individual patient's

	physiological situation. A deaf personal may communicate through visual sign language; the mother tongue may be different from English meaning that some nuances in the spoken language may be lost. **Social interaction takes place in a geographical space which is where the participants get close maintaining psychological distance.** Where a participant is deaf the audio materials play a lesser role in the video consultation.
Examples: Movement	A presenting complaint of facial pain demonstrated a movement conversation that involved kinaesthetic movements (CSA, 2013c). These nonverbal movements included hand and arm gestures used to enhance the meaning of verbal and knowledge elements. Movements of the participants mirrored each other: as the patient leant forward, the practitioner moved backward or forward empowering the patient to share information as he listened. Another example was that participants crossed their legs towards each other or away from each other. These visual gestures were interpreted as movement elements. For example the patient gestured with her hands and nodded her head emphasising gestural movement as she verbally expressed emotional concern.
Knowledge conversation	
Definition	**A communication predominately in which information is shared or gathered.**
Indicators	**Pay attention to knowledge non-verbal information sharing which occurs through pointing, eye contact or shrugging shoulders. Audible vocal cues such as change in voice volume can also occur. Reading thoughts by watching facial expressions. Practitioners may use their medical knowledge authority on matters of diagnosis, illness management or treatment rather than sharing and explaining.** **Look, watch, listen and hear for these different elements in the conversation. There is usually a tendency for the use of a particular conversation. It is not always easy to ascertain but the more readily available element in the video becomes the overarching conversation. A spoken sentence is experienced through audio as well as visual expression. The words may be spoken in a loud authoritative manner where the finger is pointed and shaken to emphasise their importance. The understanding of these words is shared through knowledge, emotion and movement.**
Differentiation	**NB emotional, knowledge and movement elements or actions are defined as parts of a whole organised in varying amounts. E.g. these can be visualised as three different segments of a cake, if having difficulty distinguishing the contributions of the three actions try drawing it to see if a visual representation of a cake divided into emotional, knowledge and movement slices and see if this helps you decide which action predominates. There are many visual and verbal actions that are understood differently.** **Understanding can vary because of cultural, gender, economic, political, and individual patient's physiological situation.** **A deaf personal may communicate through visual sign language; the mother tongue may be different from English meaning that some nuances in the spoken language may be lost.** Social interaction takes place in a geographical space which is where the participants get close maintaining psychological distance. Where a participant is deaf the audio materials play a lesser role in the video consultation.
Examples: Knowledge	**The participants visually and verbally addressed the issue and there was a clear verbal communication exchange (CSA, 2013e). The practitioner asked many questions and the patient responded. There were both emotion and movement elements, but these were less apparent. The conversation was succinct and knowledge-based. This is common in WiC consultations where patients share information about their complaint and the practitioners share information about minor ailments. These questions have a verbal and a nonverbal and visual element and viewing the video images directly the practitioner looks directly at the patient, smiling and encouraging (movement and emotion) the patient to share more information about the history of the presenting complaint.**
Objective conversation	
Definition	**The participants take part in a conversation where the focus of the conversation is the facts of the presenting complaint and the purpose of the conversation is to resolve and treat the illness.**
Indicators	**Look, watch, listen and hear the conversation attentively, pragmatically and objectively addressing the health consultation. The consultation follows the SOAPier approach making it possible to stay on track acting upon the patient seeing them as object of health care rather than**

	as a person. The patient may see the practitioner as only a healthcare practitioner rather than a person. The participants are may not able to be fully open to what each other are saying.
Differentiation	Look for a connection in which the patient and/or practitioner have a person-detached viewpoint, this conversation is transactional but there can also be different levels of involvement present or involvement based on different perspectives. **Focus on the participant and their own communication in the video narrative.** Separate and experience the participants as individuals.
Examples of objective conversations	**The relationship between the practitioner and patients is task-oriented communication. The participants are in a shared interpersonal relationship and there remains an objective distance between them.**
Empathic conversation	
Definition	**The participants' conversation is shared and attentive; the conversation is more people focussed than presenting complaint focused.**
Indicators	**Look, watch, listen and hear the conversation attentively, the participants should be able to be fully open to what each other are saying.**
Differentiation	**Look for a shared and reciprocal relationship, in which the participants have reciprocal levels of intimacy, intensity, directness for example. This may be because the practitioner is engaged and works on equalising the relationship.** **Focus on the participant communication in the video narrative.** Separate and experience the participants as individuals Discover whether the participants are engaged and empathic to each other , remember that the practitioner is taught to empathise with the patient
Examples: empathic conversations	The participants chatted and shared experiences. There was mirroring of gestural movements and the participants were in natural dialogue.

Typical situation 1- facilitative practitioner, active patient (in harmony)	
Definition	**A facilitative practitioner is attentive the patient and an active patient responds by actively engaging in the conversation. This situation is in harmony as both participants are appropriately responding to each other.**
Indicators	**The patient's voice is an essential part of the consultation process whole-person' practice, where the practitioner was open to all of the dimensions of the patient's problems. The concordant approach involves practitioners listening, hearing and supporting patients to understand and agree in partnership about their health status and treatment. Using patient-centred interaction approach, involves understanding the patient's unique illness experience, exploring their Ideas, concerns, expectations, feelings, thought, and the effects of the illness on the patient. Their consultation styles respond to the styles of patient self-presentation with the aim of maximising patient satisfaction and adapt their consultation styles to help resolve tensions. The practitioner aids the patient through information sharing in an appropriate format and the practitioner has an understanding of the kind of involvement needed for decision making, such as responding to patient's concerns. Look, watch, listen and hear for how the tension or harmony emerges along a continuum in the social interaction. The patient and practitioner have corresponding specific behaviour to explorative, listening, and emotional behaviour such as reciprocal eye contact. The practitioner having the patient as the starting point. The practitioner communicates through ways for caring. The patient asks questions in an atmosphere conducive to dialogue, openness, sharing and curiosity.**
Differentiation: Facilitative in tension	**A harmonious situation will have a facilitative practitioner and an active patient. A tension situation would be a passive patient with a facilitative practitioner (no one in the driving seat).**
Example:	**A facilitative practitioner is able to share information with a patient through active listening and empathic responses. The practitioner invited information and listened to patient cues of wellness following up with questions related to the present complaint of chest pain. (CSA, 2013e). All the questions were related to subjective history in the 'SOAP' documentation. The facilitative practitioner and the active patient participant were attentive and engaged and there was shared understanding of the disease process and personal illness.**
Typical situation 2- Directive practitioner, passive patient (in harmony)	
Definition:	**In the past a directive practitioner and the passive patient in harmony was the expected typical situation, and this video demonstrates such communication. The practitioner directs the consultation in a professional manner. More recently patients have been encouraged to take a lead in their health care and practitioners have been trained to be more facilitative and less directive in a patient centred approached. However, there are situations such as a very ill patient or emergency situation where a more directive approach is appropriate.**
Indicators: Directive in harmony	**Look, watch, listen and hear the conversation attentively, pragmatically and objectively addressing health consultation. The practitioner is directive and the patient in this typical situation. There can be adverse consequences with the lack of patient participation. There are many reasons why the patient may be passive. The practitioner may be very directive and the patient does not feel comfortable participating actively. Most patients want to participate in their consultation but are not sure that are allowed to and often don't know how to. In a consultation where the patient has an emergency condition patients prefer a more directive approach from a practitioner. Where a health condition has long term consequences patients usually like to be involved in shared decision making. Reasons for a more passive and directive patient may include whether the practitioner is more interested in developing their own line of thought or that of the patient's.**
Differentiation: Directive in tension	**A harmonious situation will have a directive practitioner and a passive patient. A tension situation would be an active patient with a directive practitioner (two people in the driving seat).**
Examples:	**The older patient often feels more comfortable with the practitioner taking the lead. However, in a television programme Embarrassing Illnesses on Channel 4, there is an example of a directive practitioner and passive patient in harmony (Channel Four, 2013). The consultation takes place between a young woman with an ear complaint and a young practitioner. Both**

	provide an excellent example of this directive situation on a programme developed specifically to educate TV watchers on health care.
Typical situation 3- Facilitative practitioner, passive patient (in tension)	
Definition:	**A facilitative practitioner is attempting to share the conversation with the patient, however the patient is not sharing in the dialogue (maybe they feel this is inappropriately culturally or the patient is too unwell)**
Indicators:	**Look, watch, listen and hear how practitioner uses their facilitation skills with a patient who does not actively engage with the consultation process and realises a tense situation. The practitioner attempts to share the conversation with the patient and involve them in their health care. They encourage the patient to share their understanding of their illness whilst considering both the disease process and the patients' illness experience. These positions are challenging because the patient may not feel able to participate or that they can say nothing and are not in a position to negotiate. The facilitative practitioner and the directive patient in tension may occur due to many factors including social, political, ethnic, cultural and or educational background.**
Differentiation: Facilitative practitioner, passive patient (in tension)	**A facilitative practitioner and passive patient are in tension as 'no one is in the driving seat' and the shared goal of the conversation will not be attained.** **To achieve an harmonious outcome the practitioner may change tack and become more directive**
Examples:	**The participants raised tone and quality of both their voices expressed frustration. The participants returned repeatedly to their earlier questions and statements in attempts to improve communication. The conversation dynamic moved between an active and passive patient and a directive and facilitative practitioner in tension as the participants tried to find a solution to the problem.**
Typical situation 4- Directive practitioner, active patient (in tension)	
Definition:	**There is no shared partnership and the practitioner is directive and an active patient finds themselves in a tense situation where a practitioner cannot listen or hear their attempt to share their story The practitioner may want to direct the patients' health care but the patient wants to be actively involved. The practitioner is not listening to the patients wish. The practitioner does not see or hear the patient and maintains control of the content of the narrative. These practitioners think they know what the patient wants and do not realise that patients are different and that they don't automatically understand the disease process and can separate it from their personal illness process.**
Indicators:	**Look, watch, listen and hear the conversation attentively, pragmatically and objectively addressing health consultation. Complex and dynamic interaction between practitioners and patients involves social, cultural, and ethical considerations. The practitioner does not provide the patient with choice and has strong opinions, they may be unaware of the patient's social space or empowerment needs. The patient's social status, age, ethnic group and gender may conflict with the practitioner. A knowledgeable patient about their condition may threaten the dynamics of a hierarchical relationship The patient may speak actively and loudly, make strong movements to try and force the practitioner to pay attention to them. The practitioner may use direct eye contact to maintain control.**
Differentiation- Directive practitioner, active patient (in tension)	**This situation is in tension because 'two people are in the driving seat'.** **If the practitioner becomes more facilitative then the situation will become more harmonious**
Example: The directive practitioner and active patient in tension	**The audio and visual conversation included elements of movement, knowledge, and emotion that illustrated some flexibility in the social interaction as the practitioner moved from directive to a more facilitative stance as the patient moved from being in shocked active stance to slightly more active conciliatory stance. The interaction was in tension throughout the consultation as the GP denied his blunder in a directive manner but finally attempted to change the outcome to a more harmonious situation which did nothing to improve the patient experience.**
Type of text	

Narrative text	
Definition:	**A narrative text is one which the reader/viewer/observer understands the elements of the story/consultation but it not integrated into the experience or learning of the reader/viewer/observer.**
Indicators:	**This approach takes place as you follow the communication in the video of a primary care consultation story. The video narrative illustrates an everyday understanding of the story where the reader and viewer accepts what the video tells and has not reflected on how associations between the different video materials configure to demonstrate shared conversations and dynamic typical situations. Often in the beginning when we are becoming familiar with a consultation we see the narrative as a document, and we do not reflect on the video or make associations between our own, emotion movement and knowledge experiences and the video constructed narrative.**
Differentiation:	**At the configuration stage we start to interpret and find meaning/associations within the data At reconfiguration we start to use the conversation to raise awareness of our current actions and plan to make these different in future.**
Examples:	**A viewer understands the elements of the consultation but does not see the experience as anything more than understanding a narrative (or story).**
Configured text	
Definition:	**A configured text emerges where associations are made between the different social actions and the consultation dynamic. Historically and socially understanding is moulded and formed by personal experiences and are associated and connected by what we have previously learned**
Indicators:	**Look and listen while reading and viewing the video without reflecting on the narrative. Are you able to find associations between actions and outcomes?**
Differentiation:	**A narrative text lacks associations and deeper understanding A reconfigured text gives inspiration, insight, recognition, or comprehension that changes our world view of consultation communication for us in our future.**
Example:	**The video stories in this thesis were all configured texts in that the author was able to find meaning and association between the various elements of the conversations/consultations.**
Reconfigured text	
Definition:	**Reconfigured textual consultations demonstrate grounded interactions where sharing experience is reconsidered. The video/consultation materials evoke perceptive, imaginative and conceptual images that evoke combinations of movement such as schematic linearity, emotion through colour and gestures through rhythms and resonances. Knowledge combinations of words and verbal social action such as giggles and smiles express comfort or embarrassment. In this way the video story the text is refigured through an existential and biographical turn.**
Indicators:	**Look, watch, listen and hear the conversation attentively, pragmatically and objectively addressing health consultation. Does the consultation give your insight, understanding or inspiration for your own practice? The reconfigured text has the quality of being understood through our own personal situation in an 'ah ha moment' of sudden realisation, inspiration, insight, recognition, or comprehension that changes our view of consultation communication for us in our future.**
Differentiation: Reconfigured text	**A narrative text has a storyline but we are unable to make connections and associations with that story. A configured text makes connections and associations within that story but does not change our own world view.**
Examples:	**If you understand the components of the conversations and how they relate to each other and you have thought through how to apply this as new knowledge to practice then you have successfully reconfigured the text.**

Figure 7.3: The coding guide

7.5: Consensus and validity of VT outcomes

The VT was used by JC to review the 20 videos interpreted using the VS in chapter six. The coding guide, process guide and coding form identified 11 main elements to be coded as predominant (or not): knowledge/emotion/movement shared conversations; objective or empathic engagement; typical situation (active/directive practitioner, with a passive/active patient)**,** which is in harmony or tension. These are coded as one type of shared conversation**;** an engagement type**;** a practitioner, patient and tension/harmony type (five types of conversational elements are recorded for each video). In total, 100 elements were coded for 20 videos by two coders (JB and JC), see chapter seven. There was initial disagreement on six elements within five videos. This indicates an overall initial 94 percent agreement.

A consensus between both reviewers was discussed and was ultimately reached for all the videos (see chapter six). However, based on the pre-consensus and discussion data, Kappa (κ) was calculated to determine the 'inter-rater reliability' of each of the 11 conversations and dynamic elements within the text i.e. based on the VS results). The Kappa equation $K=\frac{P(a)-P(e)}{1-P(e)}$, was applied to calculate inter-rater reliability, where *P*(a) is the proportion of agreement and *P*(e) is the likelihood of agreement arising by chance (Hallgren, 2012).The table cells highlighted in yellow in table 7.1 indicate the number of conversational elements (by presence and absence) that were agreed by the researchers and the green highlighting.was individually assessed elements. Figure 7.4 outlines what the cells are composed of using a knowledge conversation example and figure 7.5 provides the Kappa values for each conversational element that was coded. These inter-rater reliability K values ranged from 0.79 to 1 (for knowledge and movement conversations respectively).

The number of times JB and JC agreed a video contained a knowledge conversation	The number of times JB didn't think a knowledge conversation was in a video but JC did	The total in this cell is the total number of times JC thought a knowledge conversation present.
The number of times JC didn't think a knowledge conversation was in a video but JB did	The number of times JB and JC agreed a video did not contain a knowledge conversation	Total number of times JC thought no knowledge conversations present
The total in this cell is the total number of times JB though knowledge conversation present.	Total number of times JB thought no knowledge conversation present	Total number of videos screened

Figure 7.4: Interpreting cell content for first level inter-reliability

In accordance with Landis and Koch, also Krippendoff K interpretation criteria (as cited in Hallgren (2012)), these values indicated substantial inter-rater agreement; thereby providing evidence that the original coding guide can be used tentatively (for knowledge conversations and facilitative practitioner classifications) and more definitively for all the remaining conversation elements (see figure 7.5 for K values).

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	17	1	18
Not Identified	0	2	3
Total	17	3	20
			κ=0.79

Knowledge conversation

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	1	0	1
Not Identified	1	18	19
Total	2	18	20
			κ=0.95

Emotion conversation

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	1	0	1
Not Identified	0	19	19
Total	1	19	20
			κ=1

Movement conversation

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	10	1	11
Not Identified	0	9	9
Total	10	10	20
			κ=0.93

Objective conversation

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	9	0	9
Not Identified	1	10	11
Total	10	10	20
			κ=0.94

Empathic conversation

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	13	0	13
Not Identified	2	5	7
Total	15	5	20
			κ=0.8

Facilitative practitioner

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	4	2	6
Not Identified	0	14	14
Total	4	16	20
			κ=0.89

Directive practitioner

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	17	0	17
Not Identified	1	2	3
Total	18	2	20
			κ=0.79

Active patient

	Researcher JB		
Researcher JC	Identified 2	Not Identified	Total
Identified	2	1	3
Not Identified	0	17	17
Total	2	18	20
			κ=0.95

Passive patient

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	4	1	5
Not Identified	0	15	15
Total	4	16	20
			κ=0.95

In tension

	Researcher JB		
Researcher JC	Identified	Not Identified	Total
Identified	15	0	15
Not Identified	1	4	5
Total	16	4	20
			κ=0.87

In harmony

Figure 7.5: Data inter-rater reliability

As the coding differences were resolved by consensus, some changes were recommended and made to the final coding, processing and recording documentation. A precedent for this process is given by Dallas (2009:5) who undertook work to ensure that: “differences between the two coders were resolved by refining definitions and discussion until an interrater reliability of 90 percent on the codebook was reached to meet these resolutions.” In the present study areas of

initial disagreement, consensus process, decision and changes to the coding guide are outlined in figure 7.6 below. The original coding guide, the process guide and the video form (see appendix 9) were edited and where post-consensus changes were made (see figures 7.1, 7.2, and 7.3 for the final version of the VTv2).

Video	***Issue***	***Consensus process***	***Decision***	***Action***
1. Video 26. A 40 Male and a female NP discuss a presentation of dizziness. The diagnosis is positional vertigo and the patient is encouraged to see own GP	JC experiences the NP as directive and /in control of consultation. The NP asks a large number of questions which makes the patient nervous. Patient actively giving lots of answers but is also passive as not directing consultation-60percent. JB interprets an active patient and facilitative practitioner	JC reviewed the video and changed decision to an active patient and facilitative NP (taking into consideration of turn taking and that this video has relatively more appropriate verbal assessment than others). Consensus reached.	JC is aware that at this point in the interpretation was tired and thus she made a mistake on initial screening.	Information added to the process diagram about checking results.
2. Video 28.A 26 year old Male and female NP presenting with an ear infection diagnosed as otitis externa and treated with Locorten--vioform & paracetamol or ibuprofen if in pain	JC experienced the NP as directive and the patient as exasperated, knowledgeable actively replying to the NPs closed questions . NP leaves room and the conversation ends abruptly in mid-point and there is tension. JB interpreted the typical situation as an active patient and facilitative practitioner in harmony. The practitioner pieces together the facts and provides a treatment. However, there is a sense that the treatment was not what the patient expected but he said nothing but appeared resistant to treatment. The tape is turned off when the practitioner leaves the room to talk to the GP.	JC reviews the video and notes that the consultation narrative seems to end well after video break and session resumes. JC could see that the conversation type depends on how the main conversational content is determined. JC asked JB for clarity in terms of volume or lasting/final impression. Thereafter consensus obtained.	It was concluded that the NP is working to facilitate an active patient throughout the video. While there are episodes of tension during the video this is resolved by the end	Additional information about how to make a decision about selecting one main conversational element was added to coding and process guides.
3. Video 30 of a 19 year old Female and female ANP. The	JC interpreted the ANP as directive interacting with an active patient. Patient offered a lot of information, not all	JC reviewed the video and changed decision to a facilitative ANP (noting on second occasion ANP tone	JC is aware that at this point in the interpretation was tired and thus she made a mistake on initial screening.	Information added to the process diagram about checking results.

Video	*Issue*	*Consensus process*	*Decision*	*Action*
presentation of a Sore throat that was diagnosed as Tonsillitis and was treated with prescription for penicillin	accurate, and Practitioner asks a lot of questions. JB identifies a facilitative and active situation in harmony. Although, the patient does smoke and the practitioner suggests that smoking might aggravate the sore throat. The patient asks unrelated questions to the presenting complaint which the practitioner addresses and then checks on the social history to make sure she is not missing anything because the patient is quite reticent and keeps adding to the illness symptoms.	and pacing), which was then a harmonious consultation. Consensus reached		
4. In video 22. A 26 year old male and a female ANP. The patient presented with a swollen lymph node and was diagnosed with a localised infection and treated with Ibuprofen as needed	JC thought the conversation was empathic- 60percent and 40 percent objective- where the nurse tries to keep the conversation objective because the patient appeared to be flirting. JB thought it was an objective conversation, which included engaged and empathic aspects. JB noted that the participants enjoyed talking with each other. However, also shyness existed between the two	1) JC reviewed the video alone and still found it difficult to decipher between objective and empathic. JB reviewed the video and discussed the findings with JC. Thereafter consensus was reached.	JB also agreed that it was difficult to assess whether the conversation was empathic or objective and agreed there appeared to be a sexual presence which was difficult to code as sexual tension is not considered empathic or objective but rather an emotional attribute	Additional coding descriptor and differentiation information was added to the coding guide about objective conversations. Alterations to empathic coding directions were also made to help coders differentiate between the two types.
5. Video 25 a 22 year old male and female ANP presented with flu and was diagnosed and treated with an upper respiratory viral infection. He was treated with ibuprofen as needed.	In this video JC interpreted mostly a knowledge conversation where the ANP style was experienced as asking a lot of questions with the patient providing considerable information. JB experienced the conversation as an emotion conversation but knowledge, and movement elements apparent. There is embarrassed laughing as patient shares treating flu for three weeks with over	JC relooked at video and found that the conversation begins with knowledge and ends with emotion as a giggly ANP has some shared laughter with patient. JC could see that the conversation type depends on how the main conversational content is determined. JC asked JB for clarity in terms of volume or lasting/final impression. Thereafter consensus reached.	It was concluded that an increasing undercurrent of emotion conversation runs throughout the video narrative which peaks in intensity at the end of the video.	Additional information about how to make a decision about selecting one main conversational element was added to the coding and process guide.

Video	*Issue*	*Consensus process*	*Decision*	*Action*
	the counter medicines including Echinacea and he says diffidently that he has been overdosing on vegetables. ANP asks why this is considered overdosing and they laugh. ANP is gentle with the young man and suggests that he should try and rest and continue to eat his fruit and vegetables.	2).		

Figure 7.6: Consensus in the elements of video outcomes.

7.6. Conclusion

The VT consists of a coding guide, process guide, and coding form. There is evidence that the VT has good inter-rater reliability. However, it is acknowledged that the VT should be further psychometrically tested using a variety of raters and different practitioner videos before being used in practice and research.

Chapter 8: Discussion

8.1 Introduction

This discussion chapter considers the previous chapters (findings and interpretation) in relation to the systematic literature review, and the video method that was used to integrate the visual and verbal elements simultaneously within a qualitative method of interpretation. Specifically, the video medium is discussed in terms of the phenomenological intention, illustrated through the relationship between the video materials and video image outlined in Chapter four (the methodology). The video materials elicited visual cues, verbal cues, and elements of nonverbal communication within a narrative form. The findings in Chapter six demonstrated the usefulness of the VS for reflection on communication in clinical practice with the likelihood that this schema could alter consultation outcomes.

The interpretation of the videos examined intersubjective or shared lived experience in an innovative way and demonstrated how an audiovisual tool may add to knowledge in the field of WiC nursing practice, education and research. In the narrative and systematic literature review there was research that related to WiC nursing in general, but none that interpreted the NP consultation using a phenomenological video schema to interpret the video narrative. The present study opens up the possibility of new areas of research and raises new questions in relation to consultation communication in other healthcare services. I argue that the application of a VS allowed the understanding of narrative through a synthetic interpretation of the audio and visual elements in video. In summary, the chapter will revisit the original present study question, literature, method, findings and interpretation in relation to a wider literature and indicate how the present study has contributed the contributed to clinical practice, education and advanced practitioner research today.

8.2. Revisiting the original question

I was interested in examining the NP professional artistry of subtle communication skills in the WiC environment. Technical and information skills were taught using medical models of primary-care practice, whereas the nature of the interpersonal

relationship was based on the NP professional and personal learning and experience (Gilbert and Hayes, 2009). I discussed technical educational needs in the her chapter in *Developing Expertise: Professional Issues in Practice and Walk in Centre Nursing (*Bickerton, 2010b) (see appendix 14). The present study has investigated a different aspect of NP practice, the holistic and often invisible aspects of practice defined by Fish (1995) as professional artistry. Professional artistry is the reflexive understanding of values, insights, and priorities demonstrated by the nurses participating in the WiC present study environment.

The original research question emerged following a systematic review of eight papers. None of these eight papers explored NP communication in a primary-care WiC using video interpretation only, although one of my articles examined consultations that included both nurse's and doctor's communication in a WiC (Bickerton et al., 2010b). Desborough, Forrest, and Parker (2012) examined WiC nurse-led primary healthcare centre outcomes in a recent systematic literature review. Desborough, Forrest, and Parker noted that because WiCs were relatively new there were only a limited number of quantitative and qualitative studies available for review and most involved small sample sizes. The implication from their literature review was that there was no demonstrated need for WiCs. They also found a lack of research which examined the nature of consultations at WiCs; and it was to this issue in particular that the present study question and objectives were applied. The final present study question was formulated as follows: What is the nature of videoed consultations between nurse practitioners and patients aged 18-65 years attending a WiC with a minor ailment?

8.3. Revisiting the development of WiC services

The NPs in the present study provided a minor ailment 'see and treat service' adjacent to a large A&E in London. The WiC nurses were offered professional advanced practitioner educational courses, participation in a research programmer at the WiC, extending their clinical practice, and encouraged to attend every six weeks clinical supervision. The professional development of WiC practitioners was supported by the local University, the local NHS Trust and the Department of Health.

8.3.1. The present study WiC service

One of the advantages of using this particular WiC for the present study was that all the NPs were providing a similar service in the same facility, and there was an expectation that the NPs were developing advanced practitioner nursing skills. This situation was quite unusual, as most NPs in England worked in specialist areas or general practice alongside medical practitioners and there was often only one NP in the particular practice environment.

The videos were taped in a nurse-led WiC context where there were upwards of 15 different NPs working together. The present study focused on the NP communication skills seeing and treating patients with minor ailments, the present study received ethical approval and used a sampling method that was opportunistic as I had the opportunity to recruit in the WiC setting (Patton, 1990). The criteria for inclusion in the present study were patients, who were over 18 years of age and had presented with a minor and treatable illness at the nurse led WiC. Additional criteria were that they were not participating in another study, had not been a participant during the previous twenty eight days, did not have a learning disability, did not have a mental illness or dementia, were not a prisoner or a young offender; and they spoke English as the first language (or there was an interpreter available to translate). The practitioners all worked at the WiC and were willing to be videoed during a healthcare consultation.

The present study participants consented for a camera to video them from a fixed viewpoint during the healthcare encounter with no one else present in the room, and were all collected in early 2005. Thirty two videos were collected and 20 of these videos were included in the interpretation of the present study data.

The video data was interpreted by the present study author using the study phenomenological video schema (see figure 4.12) to recognise shared, objective and engaged empathic conversations that emerged through a typical harmonious or tense interpersonal dynamic narrative, discussed in detail in the methods chapter of the present study. It was the video data and not the WiC consultation participants that were the object of interpretation in the present study.

The NPs came from various nursing backgrounds including community healthcare experience such as district nursing, health visiting and mental health backgrounds where the consultation time was not usually measured. This was different from the research findings of GPs and PNs who were expected to see and treat their patients within specific time slots, although GPs often willingly spent longer but patients felt pressured by the shortage of time available (Pollock and Grime, 2002).

There was no required length for the consultation and all the practitioners worked at a pace that suited their own way of working. Even though nurses were more likely to take longer with their consultations than GPs, they achieved similar health outcomes and gave more information (Laurant et al., 2005). Working at their own pace gave the NPs the opportunity to develop their technical skills, provide health promotion, self-care, and incorporate their previous professional nursing experience and artistry in the WiC environment.

8.3.2. WiC research findings

The present study findings included 17 of the 20 video recordings interpreted as an overarching shared knowledge conversation, two shared movements and one emotion conversation. Sixteen of the communication styles were patient-centred with a relationship outcome in harmony with seven of the overarching conversations objective and nine empathic engaged conversations. Fifteen of the videos demonstrated facilitative and active typical situation outcomes. A further video narrative was more complex developing firstly an active and facilitative dynamic harmony, later changing to a directive practitioner and passive patient with the development of a potential emergency situation. In addition it should be noted that both dynamic situations in this video were empathic, engaged and in harmony.

There were only a total of four consultations presenting with a typical situation in tension, where three of the interpersonal relations were a directive practitioner and active patient. Only one communication style presented a facilitative practitioner with a passive patient in tension.

The present study consultation narrative was always interpreted as a whole narrative and the video outcomes demonstrated shared conversations and dynamic typical

situations through a video narrative text. These narrative outcomes included shared emotion, movement and knowledge conversations where the VS accounted for visual and verbal communication.

8.3.3. The systematic literature and the present study findings

The present study demonstrated professional artistry of NPs through shared conversation patterns of emotion, movement and knowledge. However, none of the other studies reviewed in this literature chose to distinguish equally between these three elements of consciousness. The present study, similarly to other studies discussed, tended to demonstrate information sharing. Henry, Forman and Fetters (2011) suggested that video elicitation offered a more complete understanding of different kinds of information such as tacit and explicit knowledge as well as accurate and misleading information. They also examined the use of gestures and body language and recognised that doctors had different levels of nonverbal sensitivity to emotions, tacit clues and often had difficulty explaining what made them feel uncomfortable in particular situations. Furthermore Arborelius and Timpka (1991) recognised the importance of the client's role in shared understanding of knowledge and emotional concerns.

The literature then recognised the role of gestures, knowledge and emotion in communication but unlike the present study did not give these three different elements equal consideration. Also in the present study the interpretation focused first on the shared conversation through the video materials and then on the interpersonal dynamic typical situation. Hargie, Morrow and Woodman (2000) examined the different behaviours in the pharmacist and patient clinical encounter dividing the communication process into building rapport, explaining, questioning, listening, nonverbal communication, suggesting/advising, opening, closing, assertiveness, disclosing personal information and persuading.

The present study was interested in the relationship as whole rather than breaking the relational aspects down into specific behaviours. The relationship was interpreted as practitioner facilitative or directive in harmony or tension with an active or passive patient. Arborelius and Timpka (1991) found that doctors focused on task-oriented issues while patients tended to focus on the relationship with the doctor. Olsson and

Jansson (2001) also recognised different patterns of facilitative and directive midwife behaviour. Arborelius and Bremberg (Arborelius and Bremberg, 1992a) noted that there was an association between the doctor's behaviour and patient's compliance. If the doctor was paying attention to the patient and their concerns, then it was more likely to promote the patient's cooperation. Asymmetry existed in the doctor and patient relationship for Arborelius and Timpka (1991) and was found to be related to the doctor's medical knowledge and power. For Ariss (2009), asymmetry was related to the boundaries of the patient's knowledge and how sharing was sequenced during the consultation.

Professional artistry is complex and Arborelius and Bremberg (1992a) noted that a satisfying relationship with a doctor corresponded to specific behaviours such as explorative, listening, and/or emotional responses from the doctor. Also, there are many different forms of communication, relationships and interpersonal interaction dynamics that require more understanding. This concerns clinical interaction across professions and within professions. Finally, the research method itself inevitably affects the study outcomes and in the present study it was subtle behaviours of the participants and practitioner in consultation. It also is argued that healthcare communication has its most important role in providing satisfactory clinical outcomes.

8.4. Revisiting the present study outcomes.

The present study outcomes demonstrated subtle differences in the NPs communication style, and the majority of interpersonal dynamic outcomes were in harmony. The individual findings are discussed in the sections below in the context of the wider literature. In the present study, I watched and interpreted the verbal with the visual component of video in real time (see figure 4.8).

Berry (2009) found that the individual practitioner communication style was consistent from one patient to another. This is less apparent in the present study but the practitioner tended to remain consistent throughout their consultations. Of the three practitioners who realised mainly empathic engaged typical situations (9) there was only one added objective conversation, and with the three practitioners who

articulated objective conversations (9) there was included only one further empathic engaged conversation. These findings suggest that NPs need to reflect on flexible communication approaches that could improve patient satisfaction.

The majority of the present study outcomes were patient-centred and knowledge based which was contrary to Berry (2009) who recognised that NPs were more likely to be practitioner-directed than patient-centred, and to use information-giving slightly more often than information-seeking. Partnership-building was used but not with great frequency in Berry's study; yet, in the present study four fifths (16) of the outcomes occurred in partnership or patient-centred communication, and only four consultations presented with an outcome in tension. It should be noted that Berry (2009) in her review of the literature on NPs analysed only audiotaped consultations and recognised the lack of visual communication as an important limitation. One of Berry's recommendations suggested further research and study of the analysis of NPs use of open-ended questions. In the present study outcomes verbal open-ended questions were not addressed specifically but there were facilitative, open verbal, visual gestural, and movement communication. In light of the present study findings and Berry's recommendations, there is evidence of facilitative activities that involve the visual and verbal in the interpersonal interaction.

8.4.1. Patient-centred and holism in communication

The interpretation of the video narratives began with phenomenological reflexive interpretation that included a holistic biopsychosocial approach to communication involving a patient's psychological, social, and wellbeing in clinical practice and the biological aspects (Engel, 1978). For Britten (2010), the primary-care communication was organised around values that included not only holistic but also patient-centred and comprehensive methods of practice that were not well defined. Stewart (2003) included patient-centred care or 'whole-person' practice that was demonstrated through lived experience such as emotion, cognition and intuition. For Todres, Galvin and Dahlberg (2007) this lived experience was understood through the temporal and spatial interconnection of personal horizons. For Svenaeus (1999) lived experience of health and wellbeing required an active process of balancing by the patient. It should be noted that the present study recognised all these patient-centred

approaches discussed above (Svenaeus, 1999, Stewart, 2001, Todres, Galvin and Dahlberg, 2007, Britten, 2010).

In the present study, a patient-centred approach included biopsychosocial aspects of communication, and more importantly involved a phenomenological understanding of shared lived experience which was experienced through video. The interpretation of the video narrative was understood through the phenomenological structures of understanding, conversations, typical situations, and narrative. Furthermore, the video narrative was interpreted as a whole rather than divided into the various aspects of the consultation, which was the case when examining SDM. For example, Ong et al (1995) differentiated between communication which was an interpersonal relationship, an exchange of information, and a SDM context. In the present study the exchange of information would be understood as a shared conversation, the interpersonal relationship as a dynamic situation, and the development of SDM ran throughout the course of the consultation narrative. Thompson (2007b) argued that the type of communication in a consultation was often dependent on the type of presenting problem and patient involvement, and Collins et al (2007) argued that the patient did not necessarily have SDM competencies. The practitioner tended to focus on the disease process and the patient on the illness. Furthermore, Stevenson (2007) found that due to engrained perceptions about doctor-patient relationships, patients tended to lack understanding and strategies to engage actively in their care and did not always feel supported by practitioners to do so. Yet, Ogden et al. (2004) found that a practitioner who listened and paid attention to what was being said was more inclined to support an environment where the patient felt satisfied and able to participate. What the present study offered was an opportunity for reflexive interpretation to begin from a shared ground that by its nature encouraged partnerships and later developed into a particular interpersonal dynamic between the individual participants. The implication of studying visual and verbal social action in video real time was that the focus of the communication was on the holistic process. The interaction dynamic as it occurs is defined in the writings of Ricoeur, i.e. writing a reflexive interpretation of the video narrative, and is contrasted to the more analytic reading of a transcribed written document (Ricoeur, 1984).

The present study interpretation of practitioner participants, overall, recognised that the NPs listened attentively, were empathic, and engaged in conversation. The patients appeared on the whole relaxed and shared their health problem story in an active personal manner rather than a non-engaged and objective manner. I interpreted only one video (V31) where there was visual recognition of dissatisfaction on the part of the patient. The NP in most videos rephrased the conversation and noted whether the patient was in agreement with their summary. When the video participants demonstrated an engaged conversation they were more likely to lean forward, sit closer and meet each other's gaze rather than for example looking at the floor using passive or directive communication.

8.4.2. The shared knowledge conversation

In the present study all but one movement and two emotion conversations focused on information and knowledge sharing. This finding is supported by Zeldow and Makoul (2006) who recognised that patients attending a WiC with a health complaint often considered it an emergency, the patient felt concerned and required information, and most appreciated information sharing communications from the practitioner.

Appleton (1993) identified 'knowledge' as the essential core of a phenomenological shared understanding of caring in the NP primary-care interaction. Barratt (2005) recognised that NPs adapt their interpersonal relationship to incorporate the needs of the patient and their understanding of their health concerns. Anden, Andersson and Rudrbeck (2005) also found that patients benefited most from understanding their health concern in addition to symptom relief or cure, reassurance, confirmation, change in self-perception and patient satisfaction. This supported Collins (2007), who found that nurse's explanations began from the viewpoint of a patient's responsibility and behaviour.

8.4.3. The shared emotion conversation

The inclusion of shared emotional, movement and knowledge conversations in the present study provided an opportunity for consideration of the impact of emotions on illness and disease. Interestingly, in total I only interpreted two of the 20 consultation

conversations as more influenced by emotion than movement or knowledge elements, which suggested that either a patient needed information rather than emotional support, or that the emotional aspects of the conversation were not addressed. Perakyla and Ruusuvuori (2007) named emotional reciprocity as one of five components required for adequate patient participation.

Stewart and Gilbert (2005, 793) emphasised the importance of a practitioner being able to ‘meet the patient at an emotional level’ and in the present study patients were interpreted as seeking information rather than emotional support. However, patients with psychological difficulties such as stress, anxiety, depression, and problems in coping have been found to associate their problems with lack of information. Health information made them calmer and feel safer (Chapman and Sonnenberg, 2000).

Suchman et al (1997) in their study found a similar lack of acknowledgment of both direct and indirect expressions of affect. A research team examined the verbal expressions of emotion patterns in 11 transcripts and 12 videotapes of primary care visits to 21 physicians. They found that patients rarely verbalised their emotions directly and spontaneously, but tended to offer clues instead. Suchman et al recommended further research to discover why these clues and direct expressions went unacknowledged with the focus more on a diagnostic exploration of symptoms.

Jackimowicz, Stirling and Duddle (2012) maintained that it was the way in which the practitioner communicated about emotional concerns that affected consultation outcomes. In the present study the NPs demonstrated a lack of conscious awareness and verbal acknowledgement of the emotional subtleties shared in the conversation encounter and how emotions have a powerful effect on communication and mostly shared knowledge information. Nonetheless, a reduction in anxiety was shown to occur as patients with long-term conditions become more educated about their illness and its disease process (Thompson, 2007b).

8.4.4. The gestural or movement conversation

The gestural conversation in the present study appeared to support rather than provide the overarching conversation. However, there was little discussion in the research in the wider context that addressed this issue. However, Stevenson (2014)

in a recent study found nonverbal movement gestures especially useful where there was no shared language.

8.4.5. WiC nurse practitioner patient-centred communication

The present study outcomes demonstrated mainly patient-centred facilitative interpersonal skills. Similarly to Barratt (2005) who found patient-centred styles of communication were used by NPs in practice to resolve tensions between the patient's reasons for attending the WiC and their ultimate plan of treatment. These outcomes in the present study would be interpreted as empathic and engaged conversations where a facilitative practitioner uses patient-centred communication. The conversation elements in the WiC consultations were found in Lyn (1987) an ENP who used a three function model in A&E to teach information gathering, emotion handling and behaviour management. The approach provided a greater awareness of the relationship between knowledge, emotion, and how the practitioner motivated the patient to engage with their health concern and develop their own treatment plan. Additionally, Jackimowicz, who trained as a psychotherapist prior to training as a nurse, emphasised the importance of gathering information through perceptions of person-centred care, and argued that such evidence was a crucial way of monitoring the success or failure of a service (Jackimowicz, Stirling and Duddle, 2012).

The present study, then adds to the limited understanding on NP communication confirming that nursing professionals always put the patient's needs, expectations and understanding at the centred of holistic care (Rapport et al., 2014). The patient was both a recipient and object of care, and also a force of resistance and focus of negotiation (Rapport et al., 2014). Similarly, the present study examined communication dynamics that often contradicted each other.

8.4.6. Objective and empathic engaged conversations

Kleiman (2004) found similarly to this study that NPs valued openness and connection and included attending to patient's authentic concerns at the level of the intersubjective consciousness. The present study also valued openness and connection and the NPs tended to realise task-oriented consultation outcomes; of

which half were empathic and engaged with a total of 17 of the patients actively involved. Bensing et al (2006) studied GP relationships with patients and found a marked shift towards a task-oriented communication pattern with less actively involved patients. This was a similar result to Collins (2007) who suggested that the patient needed to have a broader perspective of their role in the consultation process because they tended to lack the ability to engage actively with the GP, even though they liked the opportunity to participate in their own care. In part, this was because they continued to feel it was inappropriate to be an active participant (Stevenson, 2007).

8.4.7. Facilitative and active typical situations

In the present study then the NPs were most likely to be facilitative and the patients actively involved in their healthcare consultation. This approach supported the patient-led NHS communication dynamic of more active patient involvement, and a shared practitioner-patient relationship in the consultation (Department of Health, 2005a).

Moreover, there was the potential for the practitioner and patient to be in directive and passive typical situations either in tension or harmony. Berry (2009) examined asymmetries between these patient-centred and practitioner-directive interactions and Thompson (2007b) argued that in emergency situations a more directive approach was appreciated by the patient. Ariss (2009) found that the asymmetries in the healthcare interaction related to the sequential structure of knowledge and the boundaries of knowledge with the practitioner and patient worked from different knowledge bases.

8.4.8. The consultation typical situation in tension

There were four consultation outcomes which were in tension and were suggestive of patient dissatisfaction in the present study. The interpretation does not address the specific reasons why this might be. However, Arborelius and Timpka (1991) examined interaction approaches that satisfied or dissatisfied consultation participants. Using video and CA they discovered that the patient and doctor were interested in different aspects of the consultation: the patients commented on the

effect of the relationship itself whether positive or negative, whereas the doctors usually discussed the patient's ability to share adequate information about their health concern.

Arborelius and Bremberg (1992a) commented on the importance of patients' thinking that the doctor was giving them all their attention. Specifically, this did not include the reading and writing of notes by the doctor during the consultation, even though, the reading and writing of notes was experienced as one of the doctors' primary concerns. As these results suggest, the doctor and patient concerns about the consultation were often unrelated.

Jackimowicz, Stirling, and Duddle (2012) in their systematic review of the nurse-led literature on the patient subjective experience recognised three essential components for patient satisfaction that were establishing a therapeutic relationship, effective communication, clinical skills and collaboration. Patients found the quality of nursing care in WiCs to be highly satisfactory for minor ailments. Salisbury et al (2002a) determined quality as the most important dimension of a WiC's success and this definition of quality was based on the 'subjective experience of patients'.

8.4.9. Flexibility in the use of the various relational approaches

Flexibility in the use of the various relational approaches was limited in the present study. The NPs tended to favour one approach over the other and lacked flexibility (see figure 6.1). This contradicted Brown et al (2002) and their findings, which pointed to the importance of flexibility as an essential component of participant communication. However, Barratt (2005) demonstrated that NPs were able to be flexible in adapting to the patient's concerns. These NPs were providing a similar service in a WiC in London to that of the present study.

Half of the NPs in the present study were empathic and engaged. An empathetic interaction should be the heart of health practitioners' communication when a patient seeks advice for a health complaint (Carter and Berlin, 2003). Where the NPs were consistently objective in their communication style in the present study there was the potential to teach a more flexible approach through reflective practice in clinical supervision.

Nonetheless the context i.e. the healthcare settings and health complaint both affect health and social-care interaction relationships and sometimes determine the different communication approaches that a practitioner adopts (Rashid, 2010). In an emergency setting, the patient tends to be more passive and may expect the practitioner to take a directive role in their care, whereas in long-term conditions discussions the patient often prefers more engagement (Thompson, 2007a). Thus, both the patient and the practitioner affect the quality of the clinical consultation and the outcome of care. Within the WiC situation most NPs were educating patients to identify the red flags of their health concern, and supporting patients to self-care for their minor ailments.

8.4.10. The nurse practitioner shared communication narrative

In the present study the communicative narrative of the video has been interpreted in its entirety rather than in different parts as discrete elements. This contrasts to the approach of others like Henry, Forman, and Fetters (2011), who differentiated between the communication used for SDM and collecting the subjective information. Long and Byrne (1976) divided the consultation into six phases of which the first three phases included establishing a relationship, determining the reason for the visit, conducting a verbal, and physical examination to solve the problem; and the last three included considering the condition, details of further management and terminating the consultation. Elwyn et al (1999) suggested that these last three phases were neglected in clinical practice research. The reflexive interpretation applied in the present study demonstrated how the communication throughout the whole consultation led to the consultation outcome.

Henry, Forman, and Fetters (2011) reflected on the intuitive and tacit content of communication interactions that moved along a continuum from analytic and deliberate content to intuitive tacit content. The intuitive interactions included gestalt patterns (see glossary) and nonverbal behaviours used by both patients and doctors. Henry, Forman, and Fetters recognised asymmetrical interaction and the relevance of emotional content in the tacit clinical interaction (see appendix 10). However, in the present study the study participants tended to experience emotion and movement elements of the shared conversation as supportive of an overarching

knowledge or information conversation. However, in the interpretation of an objective emotion conversation in tension (see video 31) it was the emotional element which was the overarching conversation and the typical situation was asymmetrical and in tension. The practitioner and patient could not hear or listen to what each other were saying. It should be noted that Henry, Forman, and Fetters (2011) found no research that specifically related to emotion and knowledge judgements functioning as tacit clues.

Fourteen of the conversations in the present study occurred with actively involved patients and facilitative practitioners communicating in harmony (specifically eight were empathic engaged conversations and six were objective conversations). There were only five videos in the whole present study that did not meet these criteria. Four of these 'not in harmony' videos were objective conversations with three which were information-based. There were only two emotion conversations where the emotional content of the conversation was more apparent than movement and knowledge. These two typical situations demonstrated uncommon dynamics for the present study, in that one was a directive practitioner and an active patient relating in tension, and the other relationship demonstrated a directive practitioner and passive patient in harmony. These results of the present study suggest that the NPs are approachable, person-centred, engaged and empathic in their interactions with their patients. Overall, the present study practitioners were facilitative, receptive to the patient's personal story, providing treatment, information, advice, and reassurance. The practitioners demonstrated various forms of professional artistry found through the application of the VS (see figures 4.12).

8.4.11. Holistic care in nurse practitioner communication

The present study defines holistic as a phenomenological term that considers the phenomenological spatial and temporal dimensions of any event or moment as part of a bigger picture. Phenomenological holistic care understands relationships in terms of temporality, spatiality, intersubjectivity; embodiment and mood dimensions that are all interconnected (see methodology in the method chapter). Holistic care used in the present study is loosely defined as patient-centred and working with the 'whole-person' where the practitioner uses professional artistry and is open to all of

the dimensions of the patient's problems. Benner (1984) understood holism through phenomenological intuition and differentiated between novice, proficient and expert levels of holistic intuitive knowledge.

Holism in the present study used professional artistry to distinguish subtle visual and verbal clues. Sartre (1969) described how these clues emerged through the phenomenological organisation of different combinations of emotion, knowledge and movement elements separated for the purpose of interpretation, rather than understood synthetically as in consciousness. Whereas Sartre described these elements through reflexive personal experience, the present study interpreted shared personal experience through the organisation of video materials into intended conversations and narratives. The interpretation of video images in this manner was innovative. Previously, Bickerton (1992a) used Sartre's phenomenological method to interpret video narratives created by performance artists. The focus was on the individual artist and their creation of aesthetic images through both edited and unedited video, whereas in the present study I examined the shared narrative of unedited video documents between NPs and patients taped from a fixed position in real time.

The definition of holistic care is dependent then on the context. So for example a biopsychosocial holistic approach to care combines the biomedical, psychological, and social whole person rather than only biomedicine. Manley et al (2005) provided a patient-centred and holistic model of psychosocial nursing care that included the biopsychosocial approach and offered patients more involvement in their healthcare outcomes. Hardy et al (2010) provided evidence of interconnected components that constituted expert nursing practice knowledge. Their research model articulated professional artistry as the development of values, insights, and priorities in nursing practice. They recommended that 'more attention should be paid to helping practitioners and patients to co-construct narratives' (Manley et al., 2005:30). Stacey (1988) described this 'holistic' approach as an opportunity to develop a positive rather than a negative definition of health. Other definitions of holistic care included wellbeing and a wide variety of health promotion activities. For the present study population attending with minor ailments, for reassurance and advice, a positive

approach to health and wellbeing, a shared approach to biopsychosocial clinical practice, and individual openness to different views on healthy living, supports holistic caring practice.

8.4.12. Reflection on WiC communication skills

In general, the literature indicates a tendency for patients to be passive with low levels of participation with the consultation interaction as a whole led and directed by the practitioner (Olsson, Sandman and Jansson, 1996, Robinson, 2003). Yet, in the present study each NP demonstrated subtle communicative differences within conversations as well as different ways of responding to patients who were either active or passive. The NPs had considerable clinical and educational support to arrive at the required standard for advanced nursing (Royal College of Nursing, 2012). Furthermore, it was assumed that community specialist practice nurses would quickly adapt to the first contact nursing role but were often constrained by their lack of knowledge of 'seeing and treating' minor ailments.

8.4.13. Summary of present study outcomes

In summary, the WiC NP role was new and there continues to be a limited number of (see appendix 15) well-trained advanced nurse practitioners in England (Bickerton, 2010b). The NPs developed their learning technical skills through university and in-house education and communication skills were supported through monthly reflective practice. The present study outcomes suggest that there are gaps in first contact nursing knowledge with the recommendation that NPs use video to reflect on their personal consultation styles to develop awareness of facilitative and more flexible approaches to consultation communication.

The empathic and engaged NPs were more likely to have the potential to be more flexible in interpreting verbal and visual aspects of shared consultations. Moreover, Higgs et al (2013) maintain that these subtle and less apparent aspects of communication are essential to meet patient satisfaction outcomes. Yet these aspects of communication are often neglected in the research literature. Thus, the phenomenological method applied in the present study interprets these relationships within a holistic paradigm.

8.4.14. Validation and reliability of the study outcomes.

The study video data was interpreted in light of five types of conversational elements (Schutz, 1964, Schutz, 1967). The five conversational elements are phenomenological essential qualities (Spiegelberg, 1982). These essential qualities then offer a way to provide rigour in this study. These essential qualities then provide sufficiently precise categories where different coders are expected to arrive at the same findings when interpreting the same body of work(Seale and Silverman, 1997). These elements were developed into a VT and used by JC (see Appendix 9) to code the 20 videos I had originally interpreted using the VS. Following this initial VT use JC and I achieved an overall initial 94 percent agreement with regards to the 5 coded elements in each of the 20 videos. Inter-rater reliability was calculated for each of the 5 coded elements (k =0.79 to 1), suggesting that the VT had good to excellent reliability. Nonetheless, through a consensus reaching process (between me and JC) the coding and process guides were further refined to reduce the likelihood of further coding discrepancies in VT use. The VT included in this chapter seven should now be tested further on new video WiC consultations and with new coders.

8.5. Walk-in centre research methods

The present study used video as the object of research rather than as an intervention or document for transcription and analysis, and the visual sociological method was applied directly to the video materials and image. In this manner the present study author was able to experience, describe and interpret what Greenhalgh and Hurwitz (1998) named subtly different forms of narrative action. Whereas Barry et al (2000) as well as Henry, Forman, and Fetters (2011) argued that these unvoiced realities should be interpreted in depth through transcribed video observations, in the present study, I developed a theoretically derived method validated through the work of well-respected philosophers (Spiegelberg, 1982). Furthermore, the present study provided a repeatable video method for simultaneously interpreting both visual and verbal elements of videos that were subtle and difficult to quantify. The video could be shared, replayed, and used for discussion in reflective supervision.

Professional artistry enabled the development of insights, and priorities starting the interpretation from the video materials and image understood as shared ground rather than creating a common ground as was described by Kristjanson and Chalmers (1990). Visual sociology is outlined below (see figure 8.1). These types of phenomenology (Spiegelberg, 1982) were chosen because they provided the opportunity to examine in video real time the phenomenological dynamic of healthcare interactions in everyday lived experience.

Visual sociology (Harper, 2012)	***Method***	***Application***	***Advantages and disadvantages***
Scientific model	Qualitative method of interpretation	The scientific approach originated in lived experience prior to scientific constructs such as inductive and deductive thinking	Is subjective and reflexive and has the ability to interpret attention, engagement, empathy reflective practice, and narrative. Is difficult to measure and quantify but has the ability to generalise and be transferrable to other studies
Phenomenology	Phenomenological description, social action, and interpretative narrative	Intentional acts and objects described, interpreted and organised into emotion, movement and knowledge conversations, pragmatic kinds of typical situations, interpretative text and reflective narratives	Provided a method where personal stories that resonate with others. The focus was personal preference rather than objective measurement
Image elicitation	Visual and audio materials in video	video materials electronically supported by millions of dots per second with only a few dozen dots each instant enlivened and elicited	Video provided a model for audio and visual understanding of shared communication through attention engagement and conversations. It supported reflective practice.
The video narrative	The video consultation	Interpreted through dotted impressionist images organised into conversations, typical situations text and/ or narrative	Video provided an understanding of holistic approaches to narrative and was not interpreted though statistically measureable discrete elements

Figure 8.1: Table showing the visual sociology method used in the present study

The interpretation of the video occurred while the video was being played. The quality of the NP face-to-face shared communication provided a comprehensive and integrated interpretation of the visual and verbal elements from the beginning to end of the video. It was rare to consider combined audio and visual materials without analysing a transcription of the video conversation (Heath, Hindmarsh and Luff, 2010). Harrison (2002) recognised this lack of consideration for the visual materials

of video as she discussed how health disciplines and health related research have only recently begun to include the visual world of consultation as a unique topic of sociological study.

8.5.1. Qualitative methodologies in the systematic literature review

The systematic literature review (SLR), in chapter three distinguished various qualitative methodologies as a means of understanding communication in primary-care consultations. These methodologies included inductive theory, conversation analysis, and phenomenology and they all used video data for the different methods of analysis and interpretation. The three Scandinavian studies used grounded theory, inductive analysis and sequential analysis and organised the study data into different study results through the identification of units of meanings, patterns, categorising and establishing outcomes (Arborelius and Timpka, 1991, Arborelius and Bremberg, 1992b, Arborelius, Timpka and Nyce, 1992). Specifically, Arborelius, Timpka and Nyce (1992) used a grounded method and found the patient relationship with the GP influenced the course and choice of intervention in the consultation. Grounded theory then, used an inductive method and focused on process and outcomes (Parahoo, 2014). Ariss (2009) used CA and found that asymmetry was a typical orientation to the practitioner and patient roles that developed during the course of the consultation. CA focused on analysing specific fragments of social action at the beginning and end of sentences such as ‘turn taking’ and the order of interaction (Sacks and Jefferson, 1989).

The present study argues that the transcription of fragments of talk and nonverbal comments in CA has the potential to limit expressive consideration and the conversation process as a whole dynamic narrative. Bickerton et al (2010b) (see appendix 10), applied socio-phenomenology to video. Schutz et al (1964) understood interpersonal interactions as unique structural relationships and in the present study are represented through the relationship of the intentional video materials and the video object (Bickerton et al., 2011) (see appendix 12). The methodology focused on the whole narrative, rather than being based on discrete elements of transcribed data abstracted from the beginning and end of sentences (Heath, Hindmarsh and Luff, 2010). The present study is concerned with

phenomenological temporal and spatial elements of perception (emotion, movement, and knowledge), in addition to empathy, engagement, typical situations and textual narrative.

8.5.2. Video in qualitative research

The phenomenological trajectory is discussed in figure 4.3. Stevenson (2014) analysed the gestural communication between pharmacists and patients who did not have a common language and found they were used to make the study participants more visible to each other. The VS has the potential to add understanding to such a situation through the interpretation of shared movement, knowledge and emotion conversations.

8.5.3. Socio-phenomenology and video interpretation

The phenomenological methodology as used in Bickerton et al (2010b) (see appendix 11) perceived naive universal essences existing prior to scientific paradigms. A pure phenomenological approach then, excludes inductive and deductive thinking and interprets lived experience through a reflexive temporal and spatial dynamic that included movement, knowledge, emotion, empathic action present in intersubjective consciousness. The presence of naive universal essences in phenomenology was often misunderstood as for example when Husserl's phenomenological methodology was referred to within a positivist paradigm (Dowling, 2007). Positivism assumed deductive approaches to analysis, which were antithetical to phenomenology. Schutz's theory included Husserl's understanding of phenomenological naive universal concepts. Schutz (1967) also included a more pragmatic method than Husserl that involved typical situations involving social constructionism and practical social relationships (Eberle, 2012).

Berger and Luckmann who based their work on Schutz are also concerned with the structure of the knowledge of the common sense world of the everyday life. However, their discipline is sociology rather than philosophy. They examine common sense knowledge and outline cultural differences of meanings. This common sense knowledge is comparable with common sense interactions that take place in the

healthcare consultation and this knowledge of everyday life is structured and socially distributed.

8.5.4. Video elicitation in the present study

In the present study video elicitation was reflexively interpreted by the viewer applying the VS (see figure 4.12). The video was played and replayed in real time as many times as necessary in order to code and theme the narrative. I was careful to meet the ethical requirements suggested by the British Sociology Association (2002) included in the methods chapter. Harrison (2002) noted the difficulty of obscuring identities, confidentiality and privacy due to the potential for the public viewing. The importance of the consent process was also emphasised (Wiles et al., 2008). For all of these reasons I did not include the audio and visual examples of the present study data itself in the present study. I found little evidence that the actual process of video recording was likely to influence the consultation behaviour of either practitioners or patients themselves (Coleman, 2000). Similarly, Themessl-Huber et al (2008) found that videoing consultations showed little evidence of changed patient or practitioner behaviour. However, when the collected video data was analysed, Barry et al (1999) found that the perception of the consultation differed markedly according to whether the source was an audiotaped consultation, the transcript of the consultation, or differing accounts offered by doctor and patient, which were reviewed at different times, in different settings and between consultation participants. They found that the research team of five members confounded accounts of the same data rather than clarified it and that the detailed dissection of the consultation viewpoint was not helpful, was time intensive and required difficult to find skilled experienced authors (Barry et al., 1999).

8.6. Role of video in primary-care education

The WiC NPs reflected on their clinical practice through peer monthly action learning sets (Brockbank and McGill, 2007). In these clinical supervision sets the members used conversation to reflect on clinical practice. I thought that the VS could be useful to raise awareness of clinical communication but never had the opportunity to use it. In medical education video film clips are used as a reflective tool for learning and education (Alexander, Hall and Pettice, 1994) and GPs reflect on their own practice

using videos of their consultations (Royal College of General Practitioners, 2014). Zeldow and Makoul (2006) found that videoed encounters were useful to review and were particularly helpful for developing communication skills. Zeldow and Makoul used both contrived and videoed consultation clips. Jackimowicz, Sterling, and Duddle recommended qualitative research to evaluate patient-centre approaches in relation to clinical outcomes, clinical practice, and educational programmers for novice, proficient and expert advanced practice nurses.

NHS choice videos provided health information in real time as patients and practitioners shared their personal illness and knowledge of a disease (National Health Service, 2011). These sharing experiences were not concerned specifically with health consultation communication and relationships. Internet sites such as MD web (2007) provide examples of information clips on diabetes, high blood pressure, migraine headaches and peptic ulcer disease. However, the present study literature narrative search did find some examples of GP videos in primary care that were taped from a fixed position mostly for educational purposes. Examples such as these were used to illustrate the application of the VS and the outcomes interpreted in chapter five using the VS.

8.6.1. Video and reflective practice to support educational learning

The present study author was also interested in the use of video and cinematic clip examples of different consultation interactions to enable consultation participants to build a repertoire of consultation communication skills familiarising themselves with everyday consultation communication, Macdonald et al (2013) in their study describing the nature of nurse-patient communication in diabetes management suggested that video could be used as a powerful VS for reflection and peer review to balance the needs of both patient and practitioner. Their study incorporated video and ethnographic interviews and interactional analysis and interpreted 35 patient participants. The results found that the nurses organised the consultation around their agenda and the patients felt their concerns were not necessarily discussed. We also suggested that this situation may have been due in part to the overwhelming volume of forms, checklists, and protocols that needed to be completed at every visit.

Machin and Pearson (2014) in a recent article discussed using action learning sets for newly qualified nurses and midwives to aid development of their clinical and leadership skills. They discussed how action learning theory provided a framework that is flexible and able to be inclusive of the personal and different realities of the individual set participants. The set presenter considered open questions related to the presented issues and through a process of considering these issues the outcome was expected to influence the individual's perceptions. The evaluation suggested that these action learning sets when facilitated through a positive stance have the potential to impact and change clinical practice. They propose further research is needed for this type of educational approach.

The sharing of video clips offers a method to raise awareness of healthcare communication for the public at large. The present study author shared her experiences of interpreting video narratives of NP and patient consultations at the Royal College of Nursing Advanced Practice Conference (RCN, 2010). At this conference a step-by-step method was used to demonstrate the phenomenological process of video interpretation. The presenter noted that the video reflection resonated with many of the NPs. In fact the present study incorporated many of the factors from the RCN study of changing patient's worlds through nursing practice expertise (Manley et al., 2005). The underpinnings of these two studies were similar even though the methods were different. The present study applied a reflexive phenomenological schema to the interpretation of video materials, whereas Manley et al applied action research and appreciative inquiry.

It is important to remind the reader that application of the VS used video differently from other educational video packages. These educational video packages shared health information on the television and health clinics providing health promotion, self-care and health education (Department of Health, 2001b). At the time of completion of the present study I found no video or cinematic clips on internet that aimed to support development of shared communication interaction between patients and practitioners, or more specifically first contact patient-centre consultation interaction practice. Where there are examples of videos of primary-

care consultations, they are normally for GPs and on occasion, for pharmacists in training.

8.6.2. Future research using the video tool (VT).

The findings of the WiC video consultation study suggest that it is possible to use a statistically significant measure to better understand the subtle communication skills between NPs and patients in a WiC environment. These communication skills are based on nursing communication rather than medical communication skills (Bickerton et al., 2010b). These subtle often invisible aspects of practice provide the opportunity to share values, insights, and priorities shared between NPs and patients during a consultation in a primary-care WiC.Desborough, Forrest, and Parker (2012) only a limited number of quantitative and qualitative studies, in their systematic literature review on WiC nurse-led primary healthcare centre, and also noted a lack of research which examined the nature of consultations at WiCs. The present study addresses the nature of the WiC consultation and provides first stage validation raters. However, the validation process does demonstrate that the process and coding guide along with the video forms can be used for further research on videos of consultation practice (see appendix 9). Furthermore there is potential to compare communication skills between different professions and to gather information to assess what kinds of communication work best in different kinds of practice.

8.7. Strengths of the present study

The present study offered the opportunity to revisit the videos again and again. These videos can be used to reflect on shared communication in clinical practice. The present study approach commenced with a phenomenological interpretation (VS) supported by a structured analysis of the data (VT). I looked at a total of 20 videos in which I noted the organisation of essential essences of everyday experiences The study used the relationship of the video materials with the video image as the philosophical ground for an interpretation rather than a descriptive study of the video story. The interpretation included emotion, movement and knowledge conversations that were objective and/or empathic and engaged. These conversations were also identified as dynamic interactions in harmony or tension within a configured text. Thereby, the study was designed to develop awareness of

patient-centred communication. The VS provided an interpretive understanding of videos of WiC consultations and analyzing video materials offered the opportunity to revisit the narratives again and again. Interpreting video text provided a detailed view of my lived experience as an advanced nurse practitioner working in a WiC.

Using my VS experiences drawing on Schutz's (1967) structural essences provided an opportunity to develop the structured VT. Additionally, the VT applied by JC provided an opportunity to provide evidence of the consistency and confirmability of the VS findings.

8.7.1. The relationship of the video materials to the video object

The study used the relationship of the video materials with the video object as the philosophical ground for an interpretation rather than a descriptive study of the video world. The universal essences interpreted in the video included emotion, movement, and knowledge conversations that are objective and/or empathic and engaged. A shared dynamic emerged between the participants that was a typical situation. The video narrative was a configured text.

8.7.2. The study design

The study design is organised in two phases which starts with a phenomenological interpretation of 20 WiC consultations using Schutz's (1967) essential qualities of social action. In phase 2, JC data coded the same 20 videos using a coding and a process guide, and a video form (a video tool or VT that I developed based on my theoretical knowledge and experiences in interpreting videos). This video tool (VT) was piloted, tested and further developed; it is presented in appendix 9.

8.7.3. Interpretation of the data

The study provided an interpretive understanding of videos of WiC consultations. Video offers the opportunity to revisit the social action in narratives again and again. The video was initially interpreted using semi- structured observations (see figure 4.3). Following the interpretation of the videos by me, JC applied a structured observational method and these findings with my original data at which point agreement data were statistically analysed to provide evidence supporting the use of

my coding and process guides along with the coding form (collectively form the VT that others may use (see chapter seven). The VT demonstrated evidence of good inter-rater reliability.

8.7.4. Communicative action in professional artistry

The present study videos provided the opportunity to better understand professional artistry in first contact nursing, where experienced community nurses in the same nurse-led service were extending their practice to see and treat minor ailments. The present study outcomes recognised mainly facilitative communicative approaches that were receptive to the patient's personal story and provided patients with information, treatment, advice, and reassurance. The typical situation continuum was developed by the phenomenologist Angel Medina in collaboration with me.

The practitioners demonstrated various forms of professional communicative artistry that were interpreted applying the reflexive application of a VAT.

The present study interpreted NP conversations, interpersonal dynamics, and patient-centred holistic narrative in first contact primary-care consultations. Understanding these video conversations through the shared material of video changes the nature of understanding the subtlety of patient centred and holistic consultation outcomes.

8.7.5. The study findings

The findings illustrate audio and visual NP holistic professional artistry in its multiple subtle manifestations that can contradict one another and adds to the sparse understanding of professional NP artistry and communication in first contact clinical practice.

A phenomenological interpretative approach starts with the essential structures of consciousness and text which is shared action and interpretation of essential structures of video conversation and interactive essential structures of typical situations. These essential structures used in the video are from the phenomenological descriptions of earlier philosophers. Every person completing a phenomenological interpretation brings their unique perceptions and the consultation

outcomes can only reflect what they know. Only two other nurse-led WiC studies examining communication were found in the literature: Barratt (2005) and Bickerton et al (2010a), of which one was completed by the present study author.

8.7.6. Future work and possible impact of video tool (VT).

The findings of the present WiC video consultation study suggested that the VT is a statistically reliable measure that can be used to assess communication between NPs and patients in a WiC environment. The communication skills interpreted in the present study are based on nursing communication rather than medical communication skills (Bickerton et al., 2010). These subtle**,** often invisible aspects of practice provide the opportunity to examine values, insights, and priorities shared between NPs and patients during a consultation in a primary care WiC. Desborough, Forrest and Parker (2012) identified only a limited number of quantitative and qualitative studies, in their systematic literature review on WiC nurse-led primary healthcare centres, and furthermore noted a lack of research which examined the nature of consultation practice in primary care WiCs. Jennings et al.(2014) also found a lack of qualitative research in their systematic literature review of emergency nurse practitioners working in emergency care. The present study then adds to the research on ANPs, addressing the nature of the primary care nurse practitioner WiC consultation and provides a VT that has been rated by two people independently using one set of consultation videos**.** However, the VT needs further testing and validation i.e. using the newly developed a process and a coding guide along with the video form in different samples and contexts. Additionally, there is potential to address the current lack of research on communication skills between practitioners in different professions and their patients through using the tool in these settings and to gather information to assess what kinds of communication work best in different kinds of practice.

8.8. Limitations of the present study

The original analysis included only my interpretation of the videos although I discussed the video narratives with my supervisors. The credibility of the study outcomes is based, for the major part, on my biographical experience. Using Harper (1988) and his definition of reflexivity, my experience in advanced community

nursing practice, being a patient, and producing and interpreting videos. To provide rigour, one of my supervisors (JC) analysed the videos using a video tool (VT) developed from my video schema (VS) and this is presented in chapter seven. JC has considerable experience working in practice as a health visitor and thus has a different but complementary perspective on the delivery of primary care.

8.8.1. Lack of anonymity of video images

Video images are audio and visual images and cannot be anonymised. For this reason all the audio visual examples discussed in the method section in this study document have been taken from the internet where they are freely available.

8.8.2. Videos of consultations from You Tube

The videos that were used as examples to demonstrate the use of the video interpretation schema were directed, edited and created for education, and available on the internet, and tend to support different learning outcomes than the present study amateur videos taped in the WiC. The internet video materials were contrived and so I found the lived experience was not as vivid as the WiC videos.

8.8.3. The presence of a video camera

Neal et al (2004) found that out of 260 consecutive attenders in nine GP surgeries the overall consent rate to be videoed in a primary care consultation was 77.3 percent. They highlighted that there were no significant differences in consent rates between ethnic groups.

8.8.4. Personal interpretation of the videos

I interpreted the video narratives using an interpretative method followed by JC who applied structural observation based on VT to the videos. Similarly to Reiners (2012), I believed the depth of my experience, which included working in the WiC, being a nurse, health visitor, advanced nurse practitioner and a patient, and working for many years with video materials, helped ensure the credibility of the personal interpretive nature of the data. However, the findings are not generalisable but are suggestive that the various different communication approaches may have a place in reflective practice. The further development of a VT also offers the opportunity for

further research regarding the effect of various forms of communication on patient or healthcare professional outcomes.

8.8.5. Cultural competences

Another limitation was that the research did not make any distinction between cultural competences and their effect on the consultation outcomes. Overall, Campbell-Heider et al (2005) found that knowledge of group differences did not guide individual communications between the patient and practitioner. Additionally, further study showed little link between cultural competence and evidence-based practice (Owiti et al., 2014). The present study found the nature of NPs communication tended to be facilitative with both objective and empathic shared action approaches used to meet the patients' needs. Additionally, Matteliano and Street (2012) found NPs to be distinct in their approaches to cultural competences. They established culturally sensitive partnerships, encouraged self-advocacy, addressed contextual considerations, and adjusted practices to meet the needs of the patient emphasising a holistic approach. In the present study 75 percent of the typical situations were completed by facilitative practitioners.

8.9. Recommendations

The present study findings suggest that reflexively interpreting amateur videos of first contact consultations between NPs and patients recorded from a fixed point of view has the potential to affect the quality of the clinical consultation and the outcome of care. These findings could be used in practice, for education, reflective practice, and health policy. Action learning in particular offers the opportunity to reflect and learn with others about various understandings of communication approaches. A reflexive interpretation of the communication throughout the whole consultation provides insights into shared action and the interpersonal dynamic that emerge in real time during the entire consultation process. Shared action or intersubjectivity in the present study has been understood through interrelating phenomenological horizons of consciousness. And in the present study are the video materials in relation to the video image. The present study VS offers an alternate innovative way to understand the consultation dynamic as a whole.

Primary-care services need to identify how the diversity of staff qualifications and many years of experience working in the various community roles impacts on different health service outcomes.

8.9.1. The shared conversation

Communication in a consultation requires not only appropriate practitioner communication skills but also patient skills. Practitioners should recognise that they may need to spend additional time with patients who have poor communication skills in order to facilitate them to fully express their needs and concerns. There are fundamentally three types of consultation conversations ‘knowledge’, ‘movement’, and ‘emotion’ in different combinations that are either objective or empathic and engaged task focused narratives. Examples of these conversations are given below:

8.9.1.1. The knowledge conversation

An overarching shared verbal and visual knowledge conversation is interpreted where gestures and emotional elements support the sharing of information e.g. nodding in agreement and smiling in support of the information.

8.9.1.2. The emotion conversation

An overarching emotion conversation is where gestures and knowledge support emotional action e.g. bowing the head whilst crying, and shouting in an emotionally distressed manner with the information and gestures supporting the overarching emotional content.

8.9.1.3. The movement conversation

An example of an overarching gesture conversation could be experienced through the synchronised movement of an engaged and empathic shared conversation where the participants share gestures in a heart-warming emotional manner and are supported by knowledge content.

8.9.2. The interpersonal dynamic

The patient and practitioner interpersonal dynamic is understood in four different ways that occur along a typical situation continuum (Schutz, 1964). These dynamic

situations are an object or engaged knowledge, emotion or movement conversation in harmony or tension.

8.9.2.1. The interpersonal actively involved dynamic

A patient is actively engaged in the consultation conversation asking questions and the practitioner facilitates the process. A patient is actively engaged and the practitioner is directive lecturing or instructing in a manner that the patient finds they can no longer actively engage. A tension builds between the two and in this situation the practitioner is unavailable and not patient centred.

8.9.2.2. The interpersonal passive involved dynamic

On the other hand where the patient is passive and the practitioner is facilitative there is also a tense interpersonal relationship. In this situation the practitioner can only harmonise the relationship through a more directive and instructional approach. This dynamic poses the most complex issues for the practitioner because in order for the practitioner to facilitate a harmonious relationship they need to communicate in a directive manner. More than any of the other relationship dynamics a patient-centred communication style has implications in this relationship with directive practitioner communication.

Where the patient is passive the practitioner demonstrates a directive interpersonal dynamic and the relationship is in harmony. In an emergency situation this communication style is more appropriate than in a primary-care environment where self-care and health and wellbeing advocate patient-led communication.

8.9.3. Education and reflective practice

Studying the visual and verbal social and personal actions in video real time means that the focus of the communication is on the holistic process and interaction dynamic as it happens. The video recording can be replayed.

8.9.3.1. An educational teaching tool

There is the potential to develop an educational teaching tool based on real primary-care consultation videos or contrived scenarios, with actors used to replicate each of

the different styles of communication (in order to preserve anonymity and gaps in types of consultation styles seen).

8.9.3.2. Action Learning

VS could be used to provide material for personal and group supervision practice for practitioners (this is already done on a regular basis by GPs). The videos could also be used in the Expert Practitioner Programme (Department of Health, 2001a).The present study maintains that reflecting on the video document alone supports personal learning and reflection particularly on the potential subtleties of shared clinical action.

8.9.4. Further research

The VS and VT have the potential to support both a communicative and strategic understanding of WiC consultations. Strategic action is able to address and measure outcomes. The application of an audiovisual VT has the potential for use by other researchers across a wide range of healthcare contexts. For example A&E triage, health visitor home visits, palliative cancer home care, practice nurse long term condition management contacts, to see what communication/consultations are like for different types of patients and different types of settings.

Another novel way to use digital images is outlined in the book *Cinemeducation* (Alexander, Hall and Pettice, 1994). This approach uses a series of questions such as “What did you see, what did you hear, what did you feel, what did you think and how might these film clips affect your future clinical encounters?” (Alexander, Lenahan and Pavlov, 2004:4). Similar questions might be asked in action learning. However, these questions are addressed to the viewer, to which they answer. Whereas, reflective interpretation explores these questions through the psychic operations in the material of the film clips themselves and ask questions such as: how do the film clips evoke certain responses, and approach which is useful for action learning. These approaches could be augmented by interviews etc. and have the potential to further explore the meaning of the various types of communication with participants through in-depth interviews with clients and participants following a

videoed interview as well as to further explore individual communication styles and see how persistent they are over different settings and situations.

8.9.5. Healthcare policy

Healthcare policy should recognise communication as a holistic process that cannot be broken down into separate units or specifically timed without losing the effectiveness and continuity associated with a whole consultation. It is thus suggested that patient-centred communication takes time, and probably costs money, but in the end is likely to achieve better results for the patient and service. Finally, much more research is necessary to evaluate shared and personal patient-centred video approaches in relation to NP clinical practice, its application for educational programmes and reflection.

8.10. Summary

The present study has examined the nature of videotaped recorded consultations between NPs and patients aged from 18 and 65 who attended a WiC with minor ailments. An innovative qualitative VS was developed which made use of video elicitation and a phenomenological method. This VS provided a shared interpretive approach to understanding audio and visual materials. I interpreted these consultations using a reflexive interpretation and identified mainly information focused facilitative communication. This interpretation was confirmed by a second reviewer (JC) using VT to code videos and there was evidence supporting the inter-rater reliability of this tool. The VT then has the potential to provide both practitioner and patient the opportunity to learn about shared communication in clinical practice.

Chapter 9: Conclusion

In this final chapter the present study outcomes are summarised with a discussion of some of the implications which these findings have for clinical practice.

9.1. Nurse practitioner communication in a WiC consultation

The systematic literature review in chapter three established that there were few studies that focused on primary care or nursing consultations or which had used video as a means of collecting data about nonverbal and visual or tacit cues. In particular, this research has added to the limited number of qualitative studies on primary-care advanced clinical practice consultations; and more specifically to the whole nurse-patient narrative in the primary-care consultation.

9.2. The present study findings

The aim of the present study was to interpret the nature of videotaped consultations between NPs and patients aged 18-65 years attending a WiC with a minor ailment. The findings from the present study demonstrated that in the main the video narratives were patient-centred and the conversations mainly involved information sharing between a facilitative NP and active patient. The conversations were slightly more likely to be empathic and engaged rather than an objective communication style without the realisation of an engaged and empathic action. Both kinds of conversations are task oriented and the outcomes of the present study found no fully engaged face-to-face conversations where reflective narratives are fully integrated combinations of social action.

The present study interpreted 20 video recordings of complete consultations between NPs and patients in a WiC. The videos were always interpreted as a whole narrative, and the video image demonstrated shared conversations and dynamic relationships. The interpreted consultations included examples of shared emotion, movement and knowledge conversations determined by the experience and organisation of both visual and verbal elements. Furthermore, video was a useful way of interpreting communication as it allowed the researcher time for repeated

rewind and review of the flow of various visual and verbal cues in narrative action (hence a less fragmented and more holistic accurate interpretation of data).

In total, 17 knowledge sharing, two gestural (movement) and one emotion conversation were identified. Sixteen of the communication styles were patient-centred with a relationship that was ‘in harmony’ during the consultation. The concept of patient-centred care was defined as empathic and engaged social action, in which the NP encouraged and facilitated patients to be actively involved in taking responsibility for their own health and wellbeing, whenever safe and possible. Furthermore, one of these video patient-centred relationships in harmony demonstrated two different relationships in harmony that occurred in the video narrative. At the beginning of the video communication the relationship illustrated a facilitative NP interacting with an actively involved patient and with the diagnosis of a potential emergency situation this interaction changed to a directive and passive relationship. It should be noted that both dynamic situations in this last video were empathic, engaged and in harmony. Only four consultations in the present study were in tension and were not patient-centred, with three of these consultations involving a directive practitioner, with the other dynamic as a facilitative practitioner with a passive patient in tension.

9.3. Professional artistry

The present study has focused on the insights, and priorities of professional artistry in clinical practice of the autonomous NP role. I was able to reflect and share understanding of patient-centred care using videos of these interactions, which in this method saw the patient role as one where the shared health encounter influenced the outcome. Thereby the present study has added to the literature on professional advanced nursing artistry, which the Royal College of Nursing (RCN) acknowledged as an essential part of advanced nursing alongside advanced technical competencies (Manley et al., 2005). There has been much less research on the advanced nursing styles of consultation than on the work of general practitioners (Smith, 2004), and the present study offers to add to the limited NP primary research whilst supporting the RCN finding that there was a need for further NP research (Manley et al., 2005). Moreover, most patient-centred studies in the

literature used video as a measurable quantitative study intervention rather than for qualitative interpretation (Lewin et al., 2009, Dwamena et al., 2012).

9.4. Visual sociology: a method for interpreting WiC consultations

The present study objectives included applying a visual sociology method to videos of WiC consultations; and applying a novel VS to videos of NP first contact consultations in a WiC. Visual sociology offers a method of integrating visual, verbal and nonverbal dimensions of phenomenological social action through video. Phenomenology was established as a useful method to understand subtle and tacit forms of communication in video consultations. However, the present study findings cannot be generalised to primary-care consultations. The typical situation was particular to the WiC and relates to the dynamic relationship between the NP and patient. The participant interaction always falls along a continuum of passive, active, facilitative and directive relationships where the dynamic situation is in tension or harmony depending on the combination of the types. However, with further research, the video method of interpretation of conversations has the potential to be used in other primary-care settings with primary-care practitioners.

9.5. Nurse practitioner professional artistry

A raised awareness of NP artistry in first contact nursing communication offers the potential for new understanding of communication styles in advanced nursing practice. The present study provides a template for first contact health consultation narratives that includes treatment, but also gives equal importance to the communication of health information, advice, prevention, alongside diagnosis and treatment in NP clinical practice. The findings suggest the need to develop greater flexibility in communicative approaches to first contact care and highlight the importance of the patient's role in the consultation process. For example it is difficult for the facilitative practitioner to communicate with a passive patient without developing a tense relational outcome. Video in the present study then, has the potential to be used to deepen an understanding of the shared patient-centred everyday story interpreted through reflexive temporal and spatial interrelating phenomenological social action.

9.6. Implications for practice

The VS provided an innovative method of discerning audio and visual subtle clues between the NP and patient. The present study findings provide a better understanding of communication skills in urgent primary care and the outcomes pointed to the practitioner and patient tending to communicate through an information sharing style more than emotion or gestures. Using the VT offers a way for consultation participants to review their personal communication styles with the potential to develop more inclusive approaches. This means that practitioners can use knowledge of the consultation types to develop more flexible ways of responding to patients or as a basis to reflect and learn from consultations that they feel did not go well or went particularly well. This can be undertaken using the VT developed in the present study whereby shared patient-centred communication can be interpreted. This interpretation method could also be taught to practitioners. The video can be replayed over and over again to gain a better understanding of these patient-centred video conversations and has the potential to be shared for further reflection either individually or in a group practitioner learning situation i.e. as part of practice development. Examples of consultation communication are beginning to be more readily available on the internet so there is also the potential for the NHS to share examples of best practice to better inform not only practitioners but also patients. This has the potential to develop more flexibility in the consultation conversations and relationships.

9.7. Summary

In summary, the present study has added to knowledge of the NP communication seeing and treating patients attending with a minor ailment. The present study video data was interpreted through the application of an innovative phenomenological video schema which fostered an understanding of the consultation narrative i.e. tacit and subtle audio and visual interpersonal relationships in a practitioner and patient consultation. The present study also provided a useful method for reflecting on shared communicative experience through the simultaneous interpretation of the video audio and visual materials. Furthermore, the present study provided a better understanding of NP communication in a nurse-led service and offers a

communication video tool that can be used by practitioners and researchers as it is known to have evidence of good inter-rater reliability.

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Appendix 1: Glossary of Terms

Term	*Definition*
Advanced nurse practitioner (ANP)	Experienced and educated nurses who see and treat patients and make referrals to specialists as autonomous independent practitioners.
Audiovisual materials	Non-print materials such as, video cassettes, compact discs, DVDs, and filmstrips.
Biomedical model	A medical model of illness that excludes psychological and social factors and includes only biologic factors in an attempt to understand a person's medical disease...
Biopsychosocial	The biopsychosocial model of care broadens the biomedical approach to include sociological and psychological factors and their complex interactions.
Bracketing	Bracketing is the process of recovering original awareness (perception) in phenomenology. The author chooses not to examine the real or not real existence of an object, but describes or interprets the structural qualities of personal intentional acts and objects known through lived experience.
Cochrane Reviews	Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognised.
Communication	The exchange of verbal, non-verbal and visual language in the face-to-face patient-centred videotaped interaction in a nurse-led WiC consultation. In this study the interaction studies is between a patient and an NP.
Compliance	Following instructions and treatment requirements without necessarily understanding the treatment, or being involved in the decision making, or working in partnership with the practitioner.
Concordance	Concordance is a concept concerned with listening, hearing, and supporting patients to understand and agree in partnership with the practitioner about their health status and treatment. Concordance extends the definitions of compliance to include agreement and shared decision making (SDM).
Convenience sample	A convenience sample is when a researcher uses participants that are available and able to consider participating.
Conversation Analysis (CA)	CA is a qualitative method of studying verbal and nonverbal social interaction concerned with orderliness, structure, and sequential patterns of the intersubjective interaction. Audio materials are transcribed and analysed and often supplemented with visual transcriptions
Directive	A style in which a practitioner directed the patient in their choice of treatment
Eidetic reduction	In this study is the movement, knowledge and emotion elements of conversations are essences described by Sartre in his book on the Psychology of the imagination.
Empathic	An empathic interaction is where the participants in a conversation were attentive and engaged in the conversation.
Expert Patient Programme (EPP)	Patients in this programme learning about taking care of themselves with a long term condition.
Ethnomethodology	Provides a detailed analysis of how society makes sense and orders their everyday world.
Facilitative practitioner	A facilitative approach asks open questions and encourages active shared involvement the health consultation conversation
Fully engaged reflective narrative	Fully engaged face-to-face interactions that integrate multiple combinations of perception through reflective linearity, resonances, and/or rhythm and is never objective.
Gestalt	Gestalt is used to refer to wholes, systems and complete structures combining phenomenology with psychology examining patterns in things with the understanding the psychology of the whole is more than the sum of its parts.
Harmony	Harmony is a dynamic conversation in accord. In the present study it occur with a facilitative and active dynamic or a directive and passive dynamic situation
Health consultation	The consultation is at the heart of primary health care and is the interaction that takes place between a patient and practitioner. The patient has health concerns and asks for advice and treatment from a health care practitioner.
Health practitioner	A trained clinician who works autonomously with a patient and includes general

Term	*Definition*
	practitioners, a nurse, or pharmacist seeing, treating and discharging patients in practice.
Health professional services	Include preventive, primary, secondary, and tertiary care.
Hermeneutics	The phenomenological interpretation of verbal and nonverbal or written text. In every day experience through temporal and spatial interrelating human action
Holistic care (biopsychosocial)	The practitioner focuses on the health and wellbeing of the whole person and not just biomedicine and the disease process. A holistic approach combines the biomedical, with the psychological, and the social or the biopsychosocial approach in primary consultation practice.
Holistic (patient-centred care)	Loosely defined as being patient focused in a primary-care consultation and working with the whole-person' where the practitioner is open to all of the dimensions of the patient's problems and puts the patient at the heart of the communication.
Holistic care (phenomenology)	Holistic care in this thesis is also defined through phenomenological spatial and temporal dimensions. Any event or moment is part of a bigger picture that considers relationships in terms of temporality, spatiality, intersubjectivity, embodiment and mood dimensions that are holistic and all interconnected.
Imaginative variation	The study outcomes reflect the different relationships of emotion, knowledge and movement conversations, typical situations and narrative.
Intention	Phenomenological intention in the present study is the central structure and organisation of movement, emotion and knowledge structural video materials directed toward the meaning video image and object.
Interpersonal skills	People skill relationships in practical everyday face-to-face interaction.
Intersubjective	Shared action between people understood through interrelating phenomenological horizons of consciousness. In the present study the video materials represent intersubjective shared action.
Lifeworld	Lifeworld is the world of immediate experience where the horizons of temporality, spatiality, intersubjectivity, embodiment and mood dimensions are interconnected in consciousness and is used interchangeably in the present study with lived experience.
Lived experience	Lived experience is shared or personal experience. For Schutz lived experience consists of intersubjective socially created interactions together with or constrained by pre-existing social and cultural structures .In lived experience, a phenomenological intention is naive in that it lacks the application of structured and objective ways of understanding consciousness. For example, perception occurs prior to the use of terms such as inductive or deductive thinking. In this study lived experience and lifeworld are used interchangeably.
Medical scientists	A term which denotes dentists, medial practitioner, surgeons and Includes pharmacists.
Narrative consultation	An everyday story interpreted through reflexive temporal and spatial interrelating phenomenological human action.
National Health Service First Contact Primary Care consultations	Consultations that occurred in primary care when a patient has their first contact for a particular health problem as an urgent appointment.
Nonmedical prescribers	Includes nurses, pharmacists and physiotherapists who have qualified to prescribe medicines similarly to the medical professionals.
Nurse practitioner (NP)	Experienced nurses who have developed autonomous practice skills to see and treat patients and make referrals to specialists. They have no educational qualification related to advance nursing practice.
Objective understanding	A term used by Schutz to denote social action and occurs following shared action and is individual understanding. Objective understanding has the potential to become engaged and empathic action in consultation conversations.
Objective examination	A term in SOAPier documentation in health care which stands for a physical assessment of a health condition by a clinical practitioner
Opportunistic sampling method	An inaccurate representation of a larger group or population that is used as the research cohort because the sample is taken from a group of participants that are relevant to the research question that the author has the opportunity to recruit in the

Term	*Definition*
	relevant setting.
Patient	Patient is used interchangeably for user, health consumer, client and customer The term 'patient' is used to highlight the taking care of a person who is physically ill and historically suggested a passive role. The term 'patient' is used in this study interchangeably with 'client'. The term client tends to be used in social and mental health care environments. More recently the terms 'user', 'customer' and 'consumer' have been introduced by the government encouraging a more active role by the patient in the clinical consultation encounter particularly in first contact care.
Patient-centred	Putting the patient at the centre and at the heart of the consultation through biopsychosocial and intersubjective understanding. Biopsychosocial in the present study also includes the understanding of holistic care. Holistic care in this study is phenomenological, biopsychosocial and patient-centred.
Phenomenology	Studies the structures of personal lived experience and phenomenological consciousness and interpretation. Human lived experience is always intended or directed at something. This lived experience is personal knowledge which is filled with meaning
Positivism	A philosophy of science which studies with only what can be observed with the senses and can be verified as a fact of behaviour
Convenience sampling method	Study participants are selected by convenience and accessibility.
Professional artistry	The reflexive development of , insights, and priorities in practice
Qualitative method	Studies the nature of a particular situation to describe and understand the qualities of the situation and context rather than the facts.
Reflective practice	Reflective practice includes for the purposes of this study areas of reflection such as clinical supervision, mentorship, action learning sets and expert patient programmes.
Reflexive	Reflexive awareness of the researchers influences the research process whereby personal history and experience influences the interpretation and research outcomes.
Schema	A pattern of spatial temporal experience interpreted through the video action of materials on the video image.
Shared action	Shared or social action is practical everyday face-to-face human interpersonal interaction illustrated and interpreted through video action.
Shared decision making (SDM)	SDM focused on the second half of the consultation or how treatment decisions are made, future management agreed, and shared agendas are discussed. In this thesis, shared interaction included the consultation as a whole and did not divide the clinical encounter into two parts.
'SOAP' documentation	Method of healthcare documentation used in the Walk-in centre. It included a subjective, objective assessment and plan.
Streaming in accident and emergency (A&E)	Streaming A&E patients in the present study included streaming triaged primary care patients to appropriate services such as WiC, GP, pharmacy, or other.
Symbolic interactionism	Focused on human interaction at the micro level in specific situations. Symbolic interactionism influenced ethnomethodology along with phenomenology
Technical skills	Technical knowledge skills and competencies were objectively measureable and are differentiated in this study from professional artistry which is broader than technical accountability alone. Including reflexive development of values, insights, and priorities in practice.
Tension	The result of the interaction of a facilitative practitioner and a passive patient or directive practitioner and active patient. The social interaction is conflicting and is in tension rather than in harmony
Text	Phenomenological texts are referred to as knowledge in the same sense that text are referred to in other bodies of knowledge where it is contained in books and documents. The phenomenological text differs in the manner that meaning is embedded in the text. Phenomenological knowledge-as-text has cognitive and pathic, conceptual and poetic, informative and formative dimensions (http://www.phenomenologyonline.com/inquiry/epistemology-of-practice/ accessed 30 August 2014)
Triage	The sorting of patients in A&E according to urgency, so separating patients in the first instance into majors (immediate, urgent) and minors (standard, non-urgent which

Term	*Definition*
	includes primary care).
Typical situations	Consultation outcomes that fall along a continuum of our types- passive, active, facilitative and directive. The dynamic outcome is in either tension or harmony depending on the combination of an active or passive patient interacting with a facilitating or directive practitioner.
Video	Research data of face-to-face primary-care WiC consultations interpreted in the present study. The videos include verbal and nonverbal shared healthcare interactions that illustrate clinical communication and relationships.
Video elicitation	Video materials prompt the author to reflect on clinical consultation communication. The WiC study used video elicitation to illustrate the organisation of emotion, movement and knowledge elements of consciousness into video narrative.
Video narrative	Is the video consultation narrative organised into three different kinds of text. Prefigured text is our understanding of the video text within our every day biography whereas configured text is when the video narrative is our organisation of the text in case of these WiC consultationsas a problem focused or task oriented reflexive consultations with the conversation was directed to solving a health problem and providing a solution or treatment. The refigured text is the meeting of the world of the text with the world of the reader. Although there was no example in the interpreted video consultations Abramovic (2010) provides a refigured text in her visual and non verbal conversation with Ulay.
Video Tool (VT)	A semi-structured method developed using the elements of the theoretically derived video schema that provided evidence of good video coding and the potential for good inter-rater reliability (see study video tool).
Walk-in Centres (WiC)	National Health Service Walk-in centres were introduced in 2000 to provide fast access to health advice and treatment. They provide a drop-in service, and are usually open when most other primary health services are closed. They are nurse or GP led and most of the patients are seen and treated by nurses working as independent practitioners. Walk-in centres work closely with local health services, including National Health Service Direct, ED, Social Services and local primary-care teams, as well as with voluntary organisations. Walk-in centres tend to operate on a local rather than national basis.

Appendix 2: Systematic searches

Interface		*Terms*
Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text Limiters - Publication Year from: 1990-2012 Search modes - Boolean/Phrase EBSCO host April 2013	1.	(patient* or client* or consumer* or user* or interviewee* or wom#n or m#n or adult* or person or people).ab.
	2.	(Consult* or communicat* or interact* or social action* or talk* or discuss* or encounter*).ab.
	3.	((A and E) or (accident and emergency)).ab.
	4.	(walk in Cent* or walkin cent* or walk-in cent* or A&E or A & E or emergency department* or PUC or primary urgent care cent* or Primary care or primary care or primarycare or clinic* or domiciliary or general practitioner* or physician* or internist* or clinician* or practi* or social worker* or counsellor* or counsellor* or pharmacist* or doctors or clinician* or dietician* or physiotherapist* or midwi* or nurs* or health visit* or community matron*).ab.
	5.	3 or 4
	6.	(audio-visual* or audiovisual* or audio-video* or audiovideo* or video).ab.
	7.	1 and 2 and 5 and 6
Cinahl 1,367 searched titles Endnotes 67	8.	limit 7 to (yr="1990 -Current")
Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO Psychinfo 2,242	1.	(patient* or client* or consumer* or user* or interviewee* or wom#n or m#n or adult* or person or people).ab
	2.	(Consult* or communicat* or interact* or social action* or talk* or discuss* or encounter*).ab.
	3.	((A and E) or (accident and emergency)).ab.

Interface		*Terms*
	4.	(walk in Cent* or walkin cent* or walk-in cent* or A&E or A & E or emergency department* or PUC or primary urgent care cent* or Primary care or primary care or primarycare or clinic* or domiciliary or general practitioner* or physician* or internist* or clinician* or practi* or social worker* or counsellor* or counsellor* or pharmacist* or doctors or clinician* or dietician* or physiotherapist* or midwi* or nurs* or health visit* or community matron*).ab.
	5.	3 or 4
	6.	(audio-visual* or audiovisual* or audio-video* or audiovideo* or video).ab
	7.	1 and 2 and 5 and 6
Psychinfo 2,242 Downloaded to endnote Total 107 (66)	8.	limit 7 to (yr="1990 -Current")
EBSCO Psychology and behaviour 587 Downloaded to endnote 23	1.	(patient* or client* or consumer* or user* or interviewee* or wom#n or m#n or adult* or person or people).ab.
	2.	(Consult* or communicat* or interact* or social action* or talk* or discuss* or encounter*).ab.
	3.	((A and E) or (accident and emergency)).ab.
	4.	(walk in Cent* or walkin cent* or walk-in cent* or A&E or A & E or emergency department* or PUC or primary urgent care cent* or Primary care or primary care or primarycare or clinic* or domiciliary or general practitioner* or physician* or internist* or clinician* or practi* or social worker* or counsellor* or counsellor* or pharmacist* or doctors or clinician* or dietician* or physiotherapist* or midwi* or nurs* or health visit* or community matron*).ab.
	5.	3 or 4
	6.	(audio-visual* or audiovisual* or audio-video* or audiovideo* or video).ab.
	7.	1 and 2 and 5 and 6
EBSCO Psychology and behaviour 587 Downloaded to endnote 23	8.	limit 7 to (yr="1990 -Current")
Socindex 594	1.	(patient* or client* or consumer* or user* or interviewee* or wom#n or m#n or adult* or person or people).ab.
	2.	(Consult* or communicat* or interact* or social action* or talk* or discuss* or encounter*).ab.
	3.	((A and E) or (accident and emergency)).ab.
	4.	(walk in Cent* or walkin cent* or walk-in cent* or A&E or A & E or emergency department* or PUC or primary urgent care cent* or Primary care or primary care or primarycare or clinic* or domiciliary or general practitioner* or physician* or internist* or clinician* or practi* or social worker* or counsellor* or counsellor* or pharmacist* or

Interface		*Terms*
		doctors or clinician* or dietician* or physiotherapist* or midwi* or nurs* or health visit* or community matron*).ab.
	5.	3 or 4
	6.	(audio-visual* or audiovisual* or audio-video* or audiovideo* or video).ab.
	7.	1 and 2 and 5 and 6
	8	. limit 7 to (yr="1990 -Current")
Psychinfo 2,242	1.	(patient* or client* or consumer* or user* or interviewee* or wom#n or m#n or adult* or person or people).ab.
	2.	(Consult* or communicat* or interact* or social action* or talk* or discuss* or encounter*).ab.
	3.	((A and E) or (accident and emergency)).ab.
	4.	(walk in Cent* or walkin cent* or walk-in cent* or A&E or A & E or emergency department* or PUC or primary urgent care cent* or Primary care or primary care or primarycare or clinic* or domiciliary or general practitioner* or physician* or internist* or clinician* or practi* or social worker* or counsellor* or counsellor* or pharmacist* or doctors or clinician* or dietician* or physiotherapist* or midwi* or nurs* or health visit* or community matron*).ab.
	5.	3 or 4
	6.	(audio-visual* or audiovisual* or audio-video* or audiovideo* or video).ab.
	7.	1 and 2 and 5 and 6
	8.	limit 7 to (yr="1990 -Current")
Ovid(SP) Medline April 2013 search terms	1.	(patient$ or client$ or consumer$ or user$ or interviewee$ or wom#n or m#n or adult$ or person or people).ti,ab.
	2.	(Consult$ or communicat$ or interact$ or social action$ or talk$ or discuss$ or encounter$).ti,ab.
	3.	((A and E) or (accident and emergency)).ti,ab.
	4.	(walk in Cent$ or walkin cent$ or walk-in cent$ or A&E or A & E or emergency department$ or PUC or primary urgent care cent$ or Primary care or primary care or primarycare or clinic$ or domiciliary or general practitioner$ or physician$ or internist$ or clinician$ or practi$ or social worker$ or counsellor$ or counsellor$ or pharmacist$ or doctors or clinician$ or dietician$ or physiotherapist$ or midwi$ or nurs$ or health visit$ or community matron$).ti,ab.
	5.	3 or 4
	6.	video$.mp.
	7.	(audio-visual$ or audiovisual$ or audio-video$ or audiovideo$).ti,ab
	8.	6 or 7
	9.	1 and 2 and 5 and 8
	10.	9
	9.	limit 9 to (english language and yr="1990 -Current")

Appendix 3: Table of abstracts downloaded

Abstract	Authors	Title	Abstract	Source	Date
1 abstract ✓ Fulltext Sweden Include 1	Arborelius, and Bremberg,	What does a human relationship with the doctor mean?	Previous studies have demonstrated that the human relationship with the doctor is very important. The aim of this study was to describe the specific behaviour in consultations where the patient experiences a satisfying human relationship with the family doctor. 46 consultations with 12 participating general practitioners were videotaped in four healthcare centres. Afterwards the patients and the doctors, on different occasions, commented on the recorded consultations. The comments were audio taped. Those comments of the patients, which dealt with human relationship to the doctor, were analysed. The sequences in the videotaped consultations just before these comments were transcribed and analysed. The study demonstrated that the concrete meaning of human relationship deals with simple and obvious things. The patients want the doctor to take their symptoms seriously; to listen and/or ask questions about the symptoms, and to treat the patient as a real person, not only a patient; to ask questions about other things than the disease, e.g. about the patient's family or work.	*Scandinavian Journal of Primary Health Care,* 10(3): 163-9...	(!1992)
2 abstract ✓ Full text Sweden Include 2	Arborelius and Timpka	Comparison of patients and doctors' comments on video-recorded consultations .	To compare patient and doctor views of the consultation process, 46 consultations were videotaped in four primary healthcare centres. Twelve general practitioners and 46 patients participated. Later, the patients and the doctors (on different occasions) spontaneously commented on the recorded consultations. Qualitative methods were used for the analysis. The patients seemed to have a perspective oriented towards relationships, while the doctors were more oriented towards medical tasks. There was an association of power between the parties that implies a relationship of mutual dependency. The doctors depended on the patients to obtain the information they needed about the symptoms to be able to fulfil their professional task. The patients depended on the doctor to get their important needs satisfied; everything from a particular medicine to being treated as a human being. The major differences in the comments by the patients and the doctors reflected their different roles and the asymmetry in the relationship.	*Scandinavian Journal of Primary Health Care,* 9(2): 71-7	(!1991)
3 abstract ✓ Sweden Include 3	Arborelius, Timpka, and Nyce,	Patients comment on video-recorded consultations --the "good" GP and the "bad".	The aim of this study was to describe and understand patients' positive and negative experiences of General Practitioners (GPs). Forty-six consultations were videotaped in four primary healthcare centres in Sweden. Afterwards the patients commented on the recorded consultations. The comments were categorised and analysed using an exploratory qualitative approach. An image of the 'good' GP emerged that had two major characteristics: that of being a caring human, an individual who listens, understands, and is concerned. At the same time, the good GP acts like an ordinary person and treats the patient as an equal. The personal relationship with the GP also influenced the choice and course of medical interventions. For the patient, the manner in which an intervention is seen is linked to whether the GPs treat the patient with respect or not. A typical experience of a 'bad' GP was that the GP appeared unreachable as a person. An example is the patient feeling that the GP was not taking his or her symptoms seriously. Another characteristic of the bad GP is failure to communicate to the patient his or her standpoint on issues raised during consultations.	*Scandinavian Journal of Social Medicine,* 20(4): 213-6.	(!1992)
4 abstract ✓ full text X method paper 1 exclusion UK	Bickerton., Procter Johnson and Medina	Socio-phenomenology and conversation analysis: interpreting video lifeworld healthcare interactions.	This article uses a socio-phenomenological methodology to develop knowledge and understanding of the healthcare consultation based on the concept of the lifeworld. It concentrates its attention on social action rather than strategic action and systems approach. This article argues that patient-centred care is more effective when it is informed through a lifeworld conception of human mutual shared interaction. Videos offer an opportunity for a wide audience to experience the many kinds of conversations and dynamics that take place in consultations. Visual sociology used in this article provides a method to organise video emotional, knowledge and action conversations as well as dynamic typical consultation situations. These interactions are experienced through the video materials themselves unlike conversation analysis where video materials are first transcribed and then analysed. Both approaches have the potential to support intersubjective learning but this article argues that a video lifeworld schema is more accessible to health professionals and the public. The typical interaction situations are constructed through the analysis of video materials of consultations in a London Walk-in centre. Further studies are planned in the future to extend and replicate results in other healthcare services. This method of analysis focuses on the ways in which the everyday lifeworld informs face-to-face person-centred health care and supports social action as a significant factor underpinning strategic action and a systems approach to consultation practice.	*Nursing Philosophy,* 12(4): 271-81.	(!2010)
5 abstract ✓ full text UK Include 4	Bickerton., Procter, Johnson, and Medina	A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological	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 for altering the outcome by altering behaviour during the process of interaction. The 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), narrative (to depict the stories of interactions), and a reflexive mode (to develop shared meaning through a conceptual framework for analysis). The analytic	*Human Studies,* 33(2/3): 157-171. 10.1007/s10746-010-9162-9	(*2010)

Abstract	Authors	Title	Abstract	Source	Date
		Approach.	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 WiC (Walk-in centre) 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 healthcare interactions. The videoed 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.		
6 abstract ✓ full text UK X Cancer patients 1 exclusion UK	Collins.	Explanations in consultations : the combined effectiveness of doctors and nurses' communicati on with patients.	BACKGROUND: Multidisciplinary and interprofessional working is currently a priority in healthcare policy, in caring for patients and in health professional education. Realising multidisciplinary approaches presents challenges in the context of changes in doctors and nurses' roles and the increased emphasis placed on communication with patients. In communication in consultations, explanations are employed in the service of numerous activities, including decision making, diagnosis, and physical examination, but they have been little studied. SETTING: This paper presents findings from a comparative study of doctors and nurses' communication with patients in multidisciplinary health care, focusing on diabetes in primary care. METHODS: Video- and audio-recorded consultations were subjected to conversation analysis. Output from discussion groups with patient representatives and health professionals underwent qualitative analysis. FINDINGS: Distinctive features of explanations in nurses and doctors' consultations with patients were identified. These can be understood by reference to patterns of communication. Nurses' communication was mediated by patients' contributions; doctors' communication gave an overarching direction to the consultation as a whole. While nurses' explanations began from the viewpoint of a patient's responsibility and behaviour, doctors' explanations began from the viewpoint of biomedical intervention. Their consultations lent different opportunities for patients' involvement. CONCLUSION: Nurses and doctors' communications each exhibit their own distinct features. Specification of these features, when considered in the context of a particular consultation activity such as explanations, allows both recognition of the distinct contributions each profession can offer and identification of ways of combining these to maximum effect. This has implications for policy, for practice and for interprofessional education.	*Medical Education,* 39(8): 785-96.	(!2005)
7 Abstract ✓ full text X Mental health exclusion 1	Elderkin-Thompson , Silver, and Waitskin	Narratives of somatising and non-somatising patients in a primary care setting.	Somatising patients, who comprise approximately 20 percent of the primary care population, often present physicians with recurrent but confusing combinations of symptoms without organic explanations. Illness narratives presented during initial medical encounters with primary care physicians were examined qualitatively to determine if the narrative structure, chronological development of symptoms and temporal frame differed between somatising and non-somatising patients. Following a structured interview to identify somatisation tendency and co-morbidities of depression and post-traumatic stress disorder (PTSD), 116 patients' encounters with primary care physicians were video-recorded and transcribed. Somatising demonstrated a narrative structure that was similar to that of non-somatising patients, but they used a thematic rather than a chronological development of symptoms and they did not convey a clear period. Somatising patients with a co-morbid psychological condition focused on concrete physical sensations, were unable to provide contextual history or chronological organisation, and did not develop a temporal frame. The narratives of somatising and non-somatising patients differed sufficiently to warrant further research for use as a clinical aid in the diagnosis of somatisation.	*Journal of Health Psychology,* 3(3): 407-428. 10.1177/135910539800300309	(*1998)
8 ✓ full text Include 5 USA	Henry, Stephen Forman, and Fetters.	'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	RATIONALE AND OBJECTIVES: Theory suggests that tacit clues inform clinical judgements, but the prevalence and role of tacit clues during clinical interactions is unknown. This study explored whether doctors and patients identify information likely to be tacit clues or judgements based on tacit clues during health maintenance examinations. METHODS: Qualitative analysis of video elicitation interview transcripts involving 18 community-based primary care doctors and 36 patients. Outcomes were description and analysis of tacit clues and judgements based on tacit clues mentioned by participants. RESULTS: 57 references to tacit clues and 53 references to judgements based on tacit clues were identified from patient and doctor transcripts. Non-verbal behaviours comprised the most common category of tacit clues (53 percent of doctor comments; 42 percent of patient comments). Patients mostly discussed judgements based on tacit clues that related to the doctor-patient relationship. Doctors discussed actively using non-verbal behaviours to provide patients with tacit clues about the doctor-patient relationship. They also mentioned tacit clues that informed medical judgements and decision making. Gestalt judgements based on tacit clues were common (33 percent of doctor comments). Several participants identified instances in which they had difficulty articulating their rationale for specific judgements. Doctors varied widely in how frequently they mentioned tacit clues. CONCLUSION: During video elicitation interviews, patients and doctors identified tacit	Journal of Evaluation in Clinical Practice	2011 FT article Downlo aded

Abstract	Authors	Title	Abstract	Source	Date
			clues and judgements based on these clues playing a role during health maintenance examinations. Future research should further elucidate the role of tacit clues in medical judgements and doctor-patient relationships.		
9 Abstract ✓ full text X quantitative exclusion	Makoul	Perpetuating passivity: reliance and reciprocal determinism in physician-patient interaction.	This study introduces, profiles, and tests the explanatory value of reliance, a construct that emerged from, and is expected to illuminate, consideration of perceived control in medical encounters. The investigation also links communication science with the truly interactive perspective of reciprocal determinism, highlighting the impact of personal relations and the significance of perceived control. Data from 271 encounters between general practitioners and patients in Oxford (England) were collected by means of videotapes, patient questionnaires, medical record reviews, and physician questionnaires. The analysis indicates that physician-reliant patients (i.e., those who rely on physicians to make decisions for them) tend to be older and from a more working-class background than were self-reliant patients (i.e., those more interested in participating in choices about their health care). The physician-reliant patients also had more externally oriented outcome expectations and tended to see physicians more often than did their self-reliant counterparts. In addition to defining reliance at the conceptual and operational levels, this study provides preliminary evidence that reciprocal determinism is operating in medical encounters. Despite their preference for patients who feel in control of their health, physicians tended to adapt to patients' reliance orientation, sharing decisions with self-reliant patients and making decisions for physician-reliant patients. Accommodating the passive orientation of physician-reliant patients is likely to diminish patients' chances for maintaining control in the medical encounter, which has implications for health outcomes, cost, and compliance.	*Journal of Health Communication* 3 (3): 233-59.	(!1998)
10 Abstract ✓ full text X method paper	Nessa, and Malterud,	Discourse analysis in general practice: a sociolinguistic approach	It is a simple but important fact that as general practitioners we talk to our patients. The quality of the conversation is of vital importance for the outcome of the consultation. The purpose of this article is to discuss a methodological tool borrowed from sociolinguistics--discourse analysis. To assess the suitability of this method for analysis of general practice consultations, the authors have performed a discourse analysis of one single consultation. Our experiences are presented here.	*Family Practice,* 7(2): 77-83.	(!1990)
(!2003)	Robinson	An interactional structure of medical activities during acute visits and implications for patients' participation.	Within the context of primary care, physician-patient visits, authors have documented both patients' low levels of communicative participation (e.g., question asking) and the advantages of such participation to healthcare (e.g., improved physical health and satisfaction). Prior research has offered a variety of partial, non-exclusive explanations for patients' low levels of participation. This article investigates one underdeveloped source of explanation: the organisation of interaction itself. This article argues that the establishment of new medical problems in acute visits makes relevant an organised structure of social action that is composed of an ordered series of medical activities: establishing the reason for the visit, physicians gathering additional information (i.e., history taking and physical examination), physicians delivering diagnoses, and physicians providing treatment recommendations. This "project" of medical activity shapes physicians' and patients' understanding and production of communicative behavior. Using the method of conversation analysis, and analysing transcribed audio- and videotape data of actual acute visits, this article describes and grounds this project and discusses its implications for research, theory, and improvement on patient participation.	*Health Communication,* 15(1): 27-57.	
12 Abstract ✓ Fulltext X quantitative exclusion	Street.	Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics.	Informing the patient is arguably the physician's most important communicative responsibility. Recognising these authors have long been interested in the question of why some patients receive more information from physicians than do others. In this paper, it is argued that the amount of information physicians provide patients during medical consultations may be influenced by two sets of factors, patients' personal characteristics (age, sex, education, and anxiety) and patients' communicative styles (question-asking, opinion-giving, and expression of concern). The analysis of audiovisual recordings of 41 physician-patient consultations in a family practice clinic revealed several notable findings: (a) information regarding diagnosis and health matters was primarily related to the patient's anxiety, education, and question-asking, (b) information regarding treatment was primarily a function of the patient's question-asking and expression of concerns, and (c) patients' assertiveness and expressiveness were strongly influenced by physicians' use of 'partnership-building' utterances that solicited the patient's questions, concerns, and opinions. The data suggest that, when attempting to explicate factors affecting physicians' informativeness, authors must take into account features of the patients' communicative styles as well as physicians' perceptions of certain groups of patients.	*Social Science & Medicine,* 32(5): 541-8	(!1991)
Total 12 We agree with discussion below	7 (8) included in SLR				
13 abstract J✓ R x ++ full text	Arborelius. and Timpka.	In what way may videotapes be used to get significant information	The aim of this study is to describe a two-step video method, where patients and physicians (on different occasions) comment on the recorded consultations, and to evaluate the method regarding the kind of information received and the influence of the video-camera on patients and physicians' behaviour. We chose to depart from a phenomenological method introduced by Frankel and Beckman. Their method was modified with regard to the review procedure; the instructions, for example, were changed. Forty-six consultations were videotaped in four primary healthcare centres. Twelve general	*Medical Teacher,* 12(2): 197-208	(!1990)

Abstract	Authors	Title	Abstract	Source	Date
X method paper Sweden		about the patient-physician relationship?	practitioners and 46 patients participated. Only a few patients (4) commented without any substantial content or in a completely neutral way. The remaining patients, and all the physicians, gave nuanced descriptions of their experiences during the consultations. Few (1/5) comments dealt with the videotaping itself; e.g. explanations to the research personnel and other irrelevant issues. The influence of the video-camera seemed to be stronger for the physicians than for the patients, but the effects were only marginal. The conclusion is that by this modified video-method the ability to obtain knowledge to help to understand/interpret the patient-physician relationship was increased. Nowadays video-recording is an established method in behavioural science. In a study about the patient-physician relationship, we plan to use a two-step method of video-recording as the basis for analysing the key factors in the communication. Thus, it is important first to study the possibilities of obtaining valid and reliable information with the method, and then to make a decision about advantages and disadvantages.		
14 ✓ abstract J✓ R x ++ Include 6 full text UK	Ariss.	Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	Asymmetry of knowledge does not simply relate to knowing or not knowing. Participants in consultations also display normative entitlements to knowledge, which are related to their identities in the interaction. Claims of entitlement to knowledge are oriented to by the other participant as either straightforwardly acceptable or problematic. Thus research has shown that asymmetry in doctor-patient interactions is collaboratively achieved. Whilst the asymmetry of medical consultations has long been recognised, understanding asymmetry in the context of patient participation is becoming an increasingly important priority. This paper is not concerned with potential benefits or the feasibility of increasing patient participation in general practice (GP) consultations. Rather it seeks to describe specific limitations and opportunities for the participation of patients regarding the discussion of their problems, treatments, and management of illness. Using Conversation Analysis this paper investigates GP consultations with frequently attending patients in the UK. It describes how the moral dimensions of epistemic authority constrain the different conversational resources available to GPs and patients. Findings suggest that in maintaining asymmetrical claims to knowledge debate is foregone in favour of efficient progression through the phases of the interaction. Thus, interactions militate against the discussion of areas where alignment of perspectives might be lacking and participants do not pursue actions, which might lead towards claiming a greater understanding of each other's point of view. However, there are aspects of consultations with frequently attending patients, which display reduced asymmetry with regard to participants' claims to epistemic authority.	*Social Science & Medicine,* 69(6): 908-19.	(!2009)
15 ✓abstract J✓ R x ++ Fulltext X quantitative exclusion	Campbell, Mauksch, Neikirk, and Hosokawa	Collaborative practice and provider styles of delivering health care	The delivery of primary health care involves complex interactive communication between the provider and patient. Describing the manner or style of this communication is important to understand the delivery of primary health care. The purpose of this study was to examine provider's style of interaction with the patient and to compare the styles of nurse practitioners and physicians in joint practice. 412 provider/patient clinic visits including 276 with physicians and 136 with nurse practitioners were videotaped and analysed using a content-based interactive analysis system. Five provider style indices were constructed including affiliation, control, somatic, psychosocial, and information indices. The results of this study show that the development of a content-based interactional analysis system, which focuses on clinician activities, can be useful in describing important aspects of the provider/patient encounter. Overall, there was little difference between nurse practitioner and physician style of interaction. Nurse practitioners, however, exhibited significantly more concern with psychosocial issues than physicians did. Type of visit and visit history were also factors associated with provider style. Using the style dimension indices constructed for this study a typology of provider styles was developed.	*Social Science & Medicine,* 30(12): 1359-65.	(!1990)
16. abstract ✓ J✓ R x ++ full text X quantitative exclusion	Campion, Butler, and Cox.	Principle agendas of doctors and patients in general practice consultations	Seventy-three general practice interviews were analysed according to the method described by Butler et al. Results for the three principal agenda types (physical, emotional and social) are presented in terms of the control exerted by either doctor or patient in determining the content of the interview. Both doctor and patient address physical agendas to a similar high degree. In contrast, patients present emotional agendas to a far greater extent than doctors address these concerns. The findings for social agendas are intermediate between those for physical and those for emotional agendas. It is argued that doctors can facilitate the expression of emotional and social agendas by giving explicit or implicit permission for their presence in the interview.	*Family Practice,* 9(2): 181-90.	(!1992)
17 abstract J✓ R x ++ full text X quantitative exclusion	Ford, Schofield,. and Hope.	Observing decision-making in the general practice consultation: who makes which decisions?	OBJECTIVE: To investigate opportunities for, and types of decision making in the general practice (primary care) consultation, and examine differences in skills of those doctors who are successful at meeting their patients' preferences and those who are less successful. DESIGN: Observation study of doctor-patient consultations in general practice. PARTICIPANTS: Patients attending for routine appointments in 12 general practice surgeries across Oxfordshire. METHODS: 212 doctor-patient consultations were video-recorded. The patients involved completed a questionnaire to elicit their perceptions of how decisions were made. The video-taped recordings were coded with a new instrument, the Evidence Based Patient Choice Instrument (EBPCI), to classify the number and type of decision-making opportunities arising during each consultation. 149 recordings were coded using the Oxbridge Rating Scale to assess the doctors' consultation styles. RESULTS: There was a range of decision-making opportunities in addition to those	*Health Expectations,* 9(2): 130-7.	(!2006)

Abstract	Authors	Title	Abstract	Source	Date
			involving medical treatment. With the exception of 'fitness for work', decisions were generally 'doctor led'. There was only moderate agreement between patient perceptions of their level of involvement in decision making and the objective ratings using the EBPCI. There was wide variation in the ability of doctors to meet their patients' preferences for involvement. CONCLUSIONS: There are many decisions made in primary care consultations, in addition to those about medical treatments, in which patients could be involved more than they currently are. Some doctors are significantly better than others are at meeting different patients' preferences for their decision-making role. Patients' perceptions of shared decision making appear to be influenced by the doctors' general consultation skills.		
18 abstract ✓ R✓ Jx ++ full text Include 7 UK	Hargie, Morrow. and Woodman .	Pharmacists' evaluation of key communication skills in practice.	This paper reports the results of a major research initiative into the identification of key communication skills in community pharmacist-patient consultations. It is now widely accepted that the quality of practitioner-patient communication is fundamental to effective health care. However, an analysis of the literature pertaining to the communication issues facing health professionals in general and pharmacists in particular emphasised the need for more empirical research, to chart what pharmacists themselves deemed to be the nature and range of skills, which contribute to effective communication performance in community pharmacy practice. The main aim of this research investigation was, therefore, to identify what constituted effective communicative performance by community pharmacists. This paper provides full details of the repertoire of skills and sub-skills identified as being the core communicative elements of practice. The results of this research will have relevance for health professionals and behavioural scientists, and will contribute to the assurance of quality within the field of community pharmacy practice.	Patient Education & Counseling	(**2000)
19 abs**tract** J✓ R x ++ full text X quantitative exclusion	Haskard, DiMatteo,. and Heritage	Affective and instrumental communication in primary care interactions: predicting the satisfaction of nursing staff and patients.	Verbal and nonverbal communication between nursing staff and patients has received scant research attention. This study examined patients' and nursing staff members' global affective and instrumental communication, mutual influence, and relationship to positive satisfaction. This study employed ratings of videotaped primary care visits of 81 nursing staff members with 235 patients, and assessed communication in 2 channels: nonverbal visual and speech including vocal tone. Communication channel differences and prediction of patient satisfaction were examined. The visual and vocal communication of nursing staff members and patients robustly predicted each other's satisfaction and reflected their own satisfaction with the dyadic visit. Affect was communicated more clearly through the speech with vocal tone channel, whereas instrumental communication was stronger in visual nonverbal behavior. Patients' and nursing staff members' behaviors of pleasantness and involvement frequently co-occurred.	*Health Communication,* 24(1): 21-32	. (!2009)
Total 12+ 7`(19)	1(2) +9(10) =10 (12)				
After NESSA not included by RB	JB double checked her entries	Has questions about 6 studies below			
20. abs**tract** ✓ JB ✓ RB x full text Include 8 Sweden	Olsson and Jansson	Patterns in midwives and expectant/new parents ways of relating to each other in ante- and postnatal consultations .	Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal midwifery consultations were described by means of qualitative content analysis of 58 video-recorded consultations in a Swedish primary care setting. The midwives appeared to steer the consultations by adopting a basic pattern and occasionally including other patterns. Of the five patterns disclosed, three were revealed as basic and named 'the respectful gardener and her developing plants', 'the propagandist teacher, and her ignorant pupils' and 'the steering inspector and the representatives of the population at disposal'. The midwives related in individually oriented ways in the first pattern while the latter two indicated generalised ways of relating. The expectant/new mothers were more active in the two additional patterns 'the mediating counsellor and the discreet seekers of guidance' and 'the personal women-friends'. The expectant/new fathers mostly had a minor role, only appearing actively involved within the 'gardener' pattern. Midwives need to reflect over their ways of relating as this influence how expectant/new parents deal with the information given and their satisfaction with the care.	Scandinavian Journal of Caring Sciences, 15(2): 113-22	(**2001)
21 abs**tract** ? JB Keep in RB x ++ full text X quantitative exclusion JB	Osterlund, Klang, Larsson, Ehrenberg and Fossum,	Communication and self-management education at nurse-led COPD clinics in primary health care.	OBJECTIVE: The aim of the study was to explore the structure, content in communication and self-management education in patients' first consultations at nurse-led chronic obstructive pulmonary disease (COPD) clinics in primary healthcare. METHOD: Thirty consultations performed by seven registered nurses were videotaped; structure and content in the consultation was analysed using Pendleton's Consultation Map. Nurses' self-management education was assessed from the content of the conversation: whether important and relevant information and self-management education was given, and how investigations were performed. RESULTS: Each consultation lasted for a mean time of 37.53 min. Communication about reasons for consultations concerned mainly medical and physical problems and to a certain extent patients' perceptions. Teaching about self-management and smoking cessation was of an informative nature. Two consultations ended with shared understanding, and none of the patients received an individual treatment-plan. CONCLUSION: Nurses rarely planned the consultations on an individual basis and rarely used motivational dialogue in self-management education and in smoking cessation.	Patient Education & Counseling, 77(2): 209-17.	(***2009)

Abstract	Authors	Title	Abstract	Source	Date
			PRACTICE IMPLICATIONS: The findings could be used to help nurses to reflect on how to improve the structure of the visit, self-management education, smoking cessation and patient communication.		
22 abstract JB leave in RB x X Spanish speaking exclusion JB	Saba, Wong, Schillinger, Fernandes, Somkin, Wilson, and Grumbach.	Shared decision making and the experience of partnership in primary care	PURPOSE: Communication has been researched either as a set of behaviors or as a facet of the patient-physician relationship, often leading to conflicting results. To determine the relationship between these perspectives, we examined shared decision making (SDM) and the subjective experience of partnership for patients and physicians in primary care. METHODS: From a convenience sample of experienced primary care physicians in 3 clinics, we recruited a stratified sample of 18 English- or Spanish-speaking patients. Direct observation of visits was followed by videotape-triggered stimulated recall sessions with patients and physicians. We coded decision moments for objective evidence of SDM, using a structured instrument. We classified patients and physicians' subjective experience of partnership as positive or negative by a consensus analysis of stimulated recall sessions. We combined results from these 2 analyses to generate 4 archetypes of engagements and used grounded theory to identify themes associated with each archetype. RESULTS: The 18 visits yielded 125 decisions, 62 (50 percent) of which demonstrated SDM. Eighty-two decisions were discussed in stimulated recall and available for combined analysis, resulting in 4 archetypes of engagement in decision making: full engagement (SDM present, subjective experience positive)--22 percent; simulated engagement (SDM present, subjective experience negative)--38 percent; assumed engagement (SDM absent, subjective experience positive)--21 percent; and non engagement (SDM absent, subjective experience negative)--19 percent. Thematic analysis revealed that both relationship factors (e.g., trust, power) and communication behavior influenced subjective experience of partnership. CONCLUSIONS: Combining direct observation and assessment of the subjective experience of partnership suggests that communication behavior does not ensure an experience of collaboration, and a positive subjective experience of partnership does not reflect full communication. Attempts to enhance patient-physician partnership must attend to both effective communication style and affective relationship dynamics.	Annals of Family Medicine, 4(1): 54-62.	(**2006)
23 abstract ?psychological JB? RB x full text X quantitative exclusion	Toehold, van den Brink-Muinen and Maaroos,	Patient expectations from consultation with family physician	AIM: To assess patient expectations from a consultation with a family physician and determine the level and area of patient involvement in the communication process. METHOD: We videotaped 403 consecutive patient-physician consultations in the offices of 27 Estonian family physicians. All videotaped patients completed a questionnaire about their expectations before and after the consultation. Patient assessment of expected and obtained psychosocial support and biomedical information during the consultation with physician were compared. Two authors independently assessed patient involvement in the consultation process on the basis of videotaped consultations, using a 5-point scale. RESULTS: Receiving an explanation of biomedical information and discussing psychosocial aspects was assessed as important by 57.4-66.8 percent and 17.8-36.1 percent patients, respectively. The physicians did not meet patient expectations in the case of three biomedical aspects of consultation: cause of symptoms, severity of symptoms, and test results. Younger patients evaluated the importance of discussing psychological problems higher than older patients. The involvement of the patients was high in the problem defining process, in the physicians' overall responsiveness to the patients, and in their picking up of the patient's cues. The patients were involved less in the decision making process. CONCLUSION: Discussing biomedical issues was more important for the patients than discussing psychological issues. The patients wanted to hear more about the cause and seriousness of their symptoms and about test results. The family physicians provided more psychosocial care than the patients had expected. Considering high patient involvement in the consultation process and the overall responsiveness of the family physicians to the patients during the consultation, Estonian physicians provide patient-centered consultations.	Croatian Medical Journal, 47(1): 148-54.	. (***2006)
24 ✓ Abstract ? JB leave in mental health ?diagnosis or awareness RBx full text X Mental health exclusion	Tai-Seale, Stults, Shang, and Shumway.	Expressing uncertainty in clinical interactions between physicians and older patients: what matters?	OBJECTIVE: Uncertainty is one key factor influencing physician and patient behavior. We examined the propensity to express uncertainty on mental health versus biomedical issues by elderly patients (>65 years) and physicians during primary care visits. METHODS: 385 videotaped visits were coded according to "topics", which are issues raised by any participant during the visit. This approach allowed us to examine if uncertainty was expressed in biomedical, mental health or other topics, and the factors associated with expressions of uncertainty. RESULTS: We found that patients expressed uncertainty in 20.21 percent of topics compared to physicians expressing uncertainty in 11.73 percent of topics discussed in all visits. Patients expressed uncertainty in 22 percent of biomedical and 46.5 percent ($p<0.01$) of mental health topics. Similar statistics were found in physicians' expression of uncertainty with more uncertainty being expressed with mental health topics (23.9 percent) than biomedical topics (12.56 percent, $p<0.05$). CONCLUSION: Patients expressed more uncertainties than physicians during visits. Patients and physicians both expressed more uncertainties on mental health topics suggesting that patients and primary care physicians felt less knowledgeable or less confident about dealing with mental health issues. PRACTICE IMPLICATIONS: Understanding the inherent uncertainties in medicine can help physicians and patients engage in more productive discussion about both biomedical as	Patient Education & Counseling, 86(3): 322-8.	. (***2012)

Abstract	*Authors*	*Title*	*Abstract*	*Source*	*Date*
			well as mental health topics.		
25. No Abs**tract** ✓ Full text ?JB article RBx full text X Mental health exclusion	van Dulmen, and van den Brink-Muinen.	Patients' preferences and experiences in handling emotions: a study on communicati on sequences in primary care medical visits.	No abstract available	Patient Education & Counseling, 55(1): 149-52.	(**2004)
19 + 5 (24) included	10(12) + 1 (3)= 11(15) included in SLR				
24 accepted with abstracts					

Appendix 4: Data extraction-Greenhalgh (1997)

Question1:	Does the paper describe an important clinical problem addressed via a clearly formulated question?	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	The aim of the study was, by using a qualitative method, to compare the patients' and the doctors' comments on video-recorded consultations in order to increase our understanding of the shortcomings in the patient-doctor relationship.	Arborelius and Timpka, 1991
What does the human relationship with the doctor mean?	Comparison of doctor and patient communication in primary care consultations	Arborelius, E. And Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	What is a satisfying relationship with a doctor?	Arborelius, E., Timpka, T and Nyce,1992
Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	To describe potential barriers to patient participation in frequent attendees which are grounded in asymmetries of epistemic authority	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Social action focused on outcomes understanding rather than in consultation communication	Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010
6 Pharmacists' evaluation of key communication skills in practice	What constituted effective communicative performance by community pharmacists	Hargie, O. D., Morrow, N. C. and Woodman, C,2000
7, 'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	Do doctors and patients identify information likely to be tacit clues or judgements based on tacit clues during health maintenance examinations?	Henry et al., 2011
8 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Ways of relating between midwives' & parents' in ante- and postnatal midwifery consultations	Olsson, P.and Jansson, L.,2001

Question 2	Was a qualitative approach appropriate?	Authors
1. Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	An inductive analysis was completed starting from concrete content to identify patterns, themes, and categories of they emerge out of the A qualitative approach was appropriate because these patterns and categories were discovered rather than imposed prior to data collection and analysis They found the influence of the TV-camera was marginal for the patients as well as for the doctors	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	Qualitative	Arborelius, E. And Bremberg, 1992
3 Patients comment on video-recorded consultations—the “good” GP and the “bad”	Qualitative	Arborelius, E., Timpka, T and Nyce,1992
4 Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	CA was applied to transcribed 13 video consultations randomly chosen. Collections of various recurrent features were made from these transcripts, for instance: symptom assessments, topic changes, and responses to problem presentations. In addition, the features were then applied to the remaining data.	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Qualitative	Bickerton, J., Procter, S., Johnson, B. and Medina, A., 2010
6 Pharmacists' evaluation of key communication skills in practice	Qualitative	.Hargie, O. D., Morrow, N. C. and Woodman, C,2000
7. 'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	The primary unit of analysis for this study was the transcripts from participants’ elicitation interviews using a taxonomy of non-verbal behaviours from a major textbook on this topic and a further four categories were added that were tacit clues	Henry et al., 2011
8 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Qualitative	Olsson, P.and Jansson, L.,2001

Question 3	How were (a) the setting and (b) the subjects selected?	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	Forty-six consultations were video-recorded in four healthcare centres. About one week after the consultation, the patients and the doctors observed and commented on the video-tape. All comments were audio-taped. The patients: A sample of patients, stratified with respect to sex, age, first or second visit, was studied to obtain as broad a variation as possible of different types of consultations. The patients comprised 23 males and 23 females, aged between 20 and 97 years. The patients received written and verbal information about the study. Ninety-one percent participated. All patients who participated also completed the study. One patient, however, asked later to have "his" video-tape erased. The doctors: Twelve general practitioners (six males and six females) participated. The average age was 40 (range 35-50). On average, the doctors had practised for 13 years (range 9-27). They were all registered practitioners.	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	Primary care Sweden 46 pts/videos 12 GPs 4 HCs	Arborelius, E. And Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	Primary care Sweden 46 patients & 12 GPs at 4 HCs	Arborelius, E., Timpka, T and Nyce,1992
4 Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	Twenty-three consultations with frequently attending patients involving four GPs in northern England were videoed Between November 2001 and November 2002 of frequent attendees: patients visiting the GP 10+ times in the past twelve months. Participating patients were twenty three to eighty five years with the mean age of fifty two.	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Primary care UK Walk-in centre 28 patients /nurses ,NPs &GPs	Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010
6 Pharmacists' evaluation of key communication skills in practice	Primary care UK 15 Pharmacies 15 and 20 consultations per pharmacist	.Hargie, O. D., Morrow, N. C. and Woodman, C,2000
7 'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	Data from 72 video elicitation interviews was collected involving 18 doctors and 36 patients (two per doctor). Doctor & participants were recruited from six different practices. Sites were chosen to include urban, suburban and rural community-based primary care practices; university-affiliated and private practices; and internal medicine and family doctor practices in south-eastern CA.	Henry et al., 2011
88 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Primary care Sweden , Midwifery, 5 postnatal parents and 5 midwives at different centres and a total of 58 video consultations.	Olsson, P.and Jansson, L.,2001

Question 4	What was the author's perspective and had this been taken into account?	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	Qualitative reflexive analysis of concrete content from of the comments were organised into topics, patterns and themes. Doctors and patients comments were selected if they reflected difficulties in interaction by the authors of the article.	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	Reflexivity	Arborelius, E. And Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	Reflexivity	Arborelius, E., Timpka, T and Nyce,1992
Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	Videos were transcribed and collections of various recurrent features were identified such as symptom assessments, topic changes, and responses to problem presentations. The transcripts were reflexively analysed where the participant has demonstrated orientations towards claims of knowledge regarding the patient's problem, treatment, or management were identified for further analysis.	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Reflexivity	Bickerton, J., Procter, S., Johnson, B. and Medina, A., 2010
6 Pharmacists' evaluation of key communication skills in practice	Reflexivity	.Hargie, O. D., Morrow, N. C. and Woodman, C,2000
'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	Using a reflexive approach and a coding scheme for tacit clues (i.e. non-verbal behaviours) and judgements based on tacit clues (i.e. gestalt judgements and judgements for which participants had difficulty or were unable to articulate their underlying reasoning). A text book taxonomy of non-verbal behaviours of 33 coding categories. Transcripts were reflexively reviewed and coded by the primary author and independently reviewed by the second author. Codes were modified through a constant comparative approach and four new codes added. Disagreements were reconciled through discussion and consensus as well as adjudication by the third author when necessary.	Henry et al., 2011
88 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Reflexivity	Olsson, P.and Jansson, L.,2001

Question 5	What methods did the author use for collecting data and are these described in enough detail?	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	Use of Frankel and Beckman method means that after the videotaped consultations the recording is shown to the doctor and the patient - at separate occasions. The patient/doctor is instructed to stop the videotape as many times as he wants to comment. All comments are audio-taped and the time is recorded. These are later analysed.	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	Videoed consultations of participants were reviewed and stopped for comments.	Arborelius, E. and Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	Video elicitation patient comments transcribed and analysed	Arborelius, E.,Timpka, T and Nyce,1992
Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	The data included consultations with frequently attending patients as 10 + in previous twelve months. There were 23 video recorded consultations of patients involving four GPs, in northern England, between November 2001 and November 2002. Patient age range was 23 to 85 with mean of fifty two. 5 were m & 18 female. The method was discussed in detail.	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Videoed consultations of WiC practitioner and consumers conversations , typical situations and dynamics interpreted directly through visual and audio content.	Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010
6 Pharmacists' evaluation of key communication skills in practice	Videos obtained of pharmacy consultations.	Hargie, O. D., Morrow, N. C. and Woodman, C ,2000
'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	A modified snowball sampling technique was used to identify practices in Michigan in the USA. Interested participating Doctor eligibility criteria were being a community-based general internist or family doctor; willingness to allow one's patients to be recruited; and willingness to be interviewed and audio-as well as video-recorded.	Henry et al., 2011
88 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Videos Descriptions and interpretations of transcribed text along with viewing original video.	Olsson, P.and Jansson, L.,2001

Question 6	What methods did the author use to analyse the data and what quality control measures were implemented?	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	The concrete content of the comments was the starting-point in an inductive analysis (patterns, themes, and categories) followed by more comprehensive categories which appeared to elucidate interesting similarities and differences between the comments. All three authors were involved with the reflexive analysis	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	Sequential analysis of transcribed audio tape	Arborelius, E. And Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	Grounded theory themes and qualitative abstractions	Arborelius, E., Timpka, T and Nyce,1992
4 Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	13 of these consultations were randomly chosen to be fully transcribed using CA until at least half of the consultations from each GP were transcribed. The four GPs provided 10, 2, 5, and 6 consultation recordings, and respectively 6, 1, 3, and 3 of these were fully transcribed. Various recurrent features were identified from transcripts, for instance: symptom assessments, topic changes, and responses to problem presentations.	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Phenomenology used to understand communication in Walk-in centre videos	Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010
6 Pharmacists' evaluation of key communication skills in practice	Videos analysed individually by the pharmacist concerned; and then groups of 3 pharmacists shared expertise.	Hargie, O. D., Morrow, N. C. and Woodman, C,2000
7 'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	The primary unit of analysis for this study was the transcripts from participants' elicitation interviews and were coded using published and additional codes. Interviews from doctors and patients were evaluated separately. The study was IRB approved. Interviews from doctors and patients were evaluated separately using a template analysis approach	Henry et al., 2011
88 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Video transcription of audio and qualitative content analysis to – identify patterns of relating	Olsson, P.and Jansson, L.,2001

Question 7	Are the results credible and if so, are they clinically important	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	Patients seemed to have a perspective oriented towards relationships, while the doctors were more oriented towards medical tasks. The results indicate that the influence of the video-recording is mostly marginal both for the patients and for the doctors. The results were credible.	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	Concrete meaning of human relationship deals with simple and obvious things	Arborelius, E. And Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	Relationship with GP influenced course & choice of intervention	Arborelius, E., Timpka, T and Nyce,1992
Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	Typical orientations to roles overwhelmingly recognised in discussions of asymmetry in medical consultations are collaboratively achieved by the participants during the course of the interaction and the results were credible	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Videos interpretations knowledge based interactions between active consumers and facilitative practitioners,	Bickerton, J., Procter, S., Johnson, B. and Medina, A., 2010
6 Pharmacists' evaluation of key communication skills in practice	11 core skills and 45 related sub-categories provide a cartographic representation of skills employed by community pharmacists.	Hargie, O. D., Morrow, N. C. and Woodman, C,2000
'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	Participants' comments fell into two broad categories: statements relating to the doctor–patient relationship, and statements relating to judgements informing medical decision making. They were credible	Henry et al., 2011
88 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	A variety of content themes and ways of relating were examined. Demonstrating a basic pattern of relating interposed with other patterns.	Olsson, P.and Jansson, L.,2001

Question 8	What conclusions were drawn and are they justified by the results?	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	The asymmetry in the situation The interpretation may be that the patients are exposed to the doctors' medical knowledge and, consequently, to the power connected to this knowledge.	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	The patient wants a real relationship not only as a patient, the doctor to take symptoms seriously, both verbally and non-verbally. It does not seem to be a question of time but rather a question of awareness of these needs.	Arborelius, E. And Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	Acceptance of Interventions often linked to whether a GP treats the patient with respect or not	Arborelius, E., Timpka, T and Nyce,1992
Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	The maintenance of differential orientations to entitlements to knowledge allows topics to be closed and new topics opened up with little regard to the position of the co participant on these matters. The data demonstrate a style of interaction which progresses steadily, despite differences of opinion, rather than exploring potential disagreements	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Patients attending Walk-in centres are seeking information from GPs NPs & nurses and the majority of practitioners and consumers interact in harmony.	Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010
6 Pharmacists' evaluation of key communication skills in practice	Building rapport most important skill and within this confidentiality component. Challenge to link in a measurable way skilled communicative performance to actual health outcomes	Hargie, O. D., Morrow, N. C. and Woodman, C,2000
'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	Doctors have different levels of nonverbal sensitivity (measured by their ability to recognise people's emotions from video clips). Doctors sometimes had difficulty articulating how they judged whether a patient was depressed, and patients sometimes had difficulty explaining why they felt comfortable with their doctors. Neither doctors nor patients always fully appreciate how or why they make certain judgements in the examination room, and doctors vary substantially in how often they recognise the role of tacit clues during clinical interactions Some doctors and patients have more insight into the role of tacit clues than others. These methods can inform interventions	Henry et al., 2011
8 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Midwives need to reflect on ways of relating as these influences how expectant/new parents deal with information given and satisfaction with care.	Olsson, P. and Jansson, L.,2001

Question 9	Are the findings of the study transferable to other clinical settings?	Authors
Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations	To examine when and how both practitioners and patients are satisfied or dissatisfied with consultation outcomes.	Arborelius and Timpka, 1991
2. What does the human relationship with the doctor mean?	Yes	Arborelius, E. and Bremberg, 1992
3 Patients comment on video-recorded consultations—the "good" GP and the "bad"	Yes	Arborelius, E., Timpka, T and Nyce,1992
Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation	Evidence describing barriers and opportunities for achieving promote patient-centred approaches including more equal participation, shared decision making and shared understanding could usefully inform these communication models and the implementation of policies designed to change the way healthcare interactions are conducted.	Ariss, 2009
5 A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach.	Yes	Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010
6 Pharmacists' evaluation of key communication skills in practice	Yes	Hargie, O. D., Morrow, N. C. and Woodman, C,2000
'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in doctor-patient interactions	Video elicitation has the potential to improve both medical decision making and the doctor–patient relationship by providing a more complete understanding of the kinds of information – tacit and explicit, accurate and misleading – on which doctors and patients depend during clinical interactions.	Henry et al., 2011
8 8 Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations	Yes	Olsson, P and Jansson, L , 2001

Appendix 5: Ethics documents

Study Consent forms

PATIENT INFORMATION SHEET AND CONSENT FORM

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

This study is looking at videoed health care visits of minor illnesses that are seen at the [redacted] Walk-in Centre. A minor illness is a health problem, which is not serious and can often be treated without any medicine and is often resolved with good healthcare advice. If you agree to be in this study your visit with the health practitioner will be videoed and this will be one of the documents that will become material for the study. The video of your visit will be compared with up to 30 other videos taped here over a month. The study is looking at similarities and differences between different patients and practitioner videoed health visits.

You are invited to participate in this study because:

You are attending the [redacted] Walk-in Centre today asking to see a healthcare practitioner with a minor illness

You were given an advertisement about our study at our front and you agreed to participate

You are over 18 years of age and under 65

You have a minor illness that is treatable at the nurse-led Walk-in centre

You are not participating in another study or have not been a research participant in the past 28 days

You do not have any learning disabilities, mental illness, have dementia, are a prisoner, or are a young offender

You speak English as your first language or there is an interpreter available to translate for you

You are willing to be videoed and understand that you can change your mind at any time and withdraw from the study

You are willing to sign the study consent form and it has been explained to you

You understand you can decline to be part of the study at any time before, during or after the healthcare consultation

You are will to allow the video to be used for educational purposes

It is up to you to decide whether or not to take part in the study. If you do decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part, will not affect the standard of care you receive.

Everyone who visits the Walk-in Centre who fits the requirements of the study will be invited to participate.

The healthcare visit should take no less or more time than it would take if the consultation weren't videoed. The video will be turned on as you enter the consultation room and will be turned off as you leave. Our consultation times can be anywhere between 6 to 45 minutes long but the average is usually about 20 minutes. Only the healthcare practitioner and yourself will be in the room as the videoing occurs.

The videos may help understand what happens during a healthcare visit, how the video presents it, and how your taped consultation compares with other videoed consultations made at the Walk-in Centre. We are always looking at ways to improve how patients and practitioners experience these visits.

You need to do and will be asked to do nothing different from a normal visit here. We would like you to act no differently than you do normally.

There are no real benefits to you taking part in this study but we hope that the information we get from the study may help us to better understand patients and practitioners during a videoed consultation.

If you feel taking part in this research project has harmed you, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

If you consent to take part in the research your medical records from your visit along with the videoed documentation today may be inspected by the members of the research team and shared for educational purposes only. There is the possibility that students will view your consultation but your name will remain anonymous.

The results of the study may not be available for 8 years and after this time all the videoed materials will be destroyed and the results published.

Tower Hamlets Primary Care Trust and City University are supporting this study. A research study is part of the requirement for my studies at City University and reviewed by:

The East London & City Local Research Ethics Committee

Chair Mr Richard Smith Tel: 02076556622

City Senate Research Ethics Committee

Chair: Tel: 02070408010

Contact for Further Information:

For any further information please contact the Principal Investigator Jane Bickerton at [redacted] Walk-in Centre Tel: [redacted]. Please do not hesitate to contact her with any question.

Thank you again for taking part in the study You will be given a copy of this information sheet and a signed consent form to keep.

HEALTH PRACTITIONER INFORMATION SHEET AND CONSENT FORM

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

This study is looking at videoed healthcare minor ailment visits at the [redacted] Walk-in centre. The study is looking at the nature of videoed health consultations. It is looking at patterns of communication present in videoed: similarities and differences between videoed healthcare consultations to better understand the nature of videoed health consultations. The researcher will look for patterns in the videos and try to identify how these present themselves through bodily movements, gestures and verbal intonations during the video. The researcher will not assess the video against a measurable standard of care or provide any outcome measurement of your ability as a practitioner and so will not be able to say whether a videoed consultation is good or bad. The videos may help understand what happens during a healthcare visit, how video material presents the consultation, and how your taped consultation compares and is different from other videoed consultations made at the Walk-in centre.

If you agree to be in this study the consultation will be videoed and this will be one of the documents that will become material for the study along with the documentation of the consultation. The video of the consultation will be compared with up to 30 other videos taped at the Walk-in Centre over up to a three month period.

You have been invited to participate in this study because you are a healthcare practitioner who sees and treats patients at the nurse-led [redacted] Walk-in centre. You are willing to see study participants that have signed a consent form for this study and are:

attending the [redacted] Walk-in centre today asking to see a healthcare practitioner and they present with a minor ailment

These patients were given an advertisement about the study at our front desk and agreed to participate

They are Over 18 years of age and under 65

They are presenting with a minor ailment seen and is treatable at the nurse-led Walk-in centre

The patients are not participating in another study or have not been a research participant in the past 28 days

They have signed a consent form stating that they have no learning disabilities, mental illness, or dementia, are not a prisoner, or a young offender

Speak English as their first language or there is an interpreter available to translate

Are willing to be videoed and understand they can change their mind at any time and withdraw from the study

Have signed the study consent form which has been explained to them

Understand that they can decline to be part of the study at any time before, during or after the healthcare consultation

All study participants agree to the video consultation being used for educational purposes.

You as the healthcare provider may decline to be part of the study at any time before, during or after the healthcare consultation

It is up to you to decide whether or not to take part in the study. If you do decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part, will not affect the standard of care you receive.

Everyone who visits the Walk-in Centre who fits the requirements of the study will be invited to participate if consultations are being videoed unless it will make their visit much longer and they are not in agreement with this.

The healthcare visit should take no less or more time than it would take if the consultation weren't videoed. You will turn the video on as the research participant enters the consultation room and turn it off as they leave. The video camera will be focused on one area. It is fine to move out of the videos field but there will be no visual footage of that period of the consultation. Consultation times can be anywhere between 6 to 45 minutes long but the average is usually about 20 minutes. Your consultation times should not be affected by the videoing.

You need to do nothing different from what you would normally do when you complete a health consultation during this study. We would like you to act no differently than you do normally.

The one possible benefit to you taking part in this study is the possibility of looking at your consultation skills for educational purposes. It is hoped that the information obtained from the study may help to better understand patients' and practitioners' interactions during a videoed healthcare consultation.

If you feel taking part in this research project has harmed you, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

If you consent to take part in the research the medical records from the visit along with the videoed documentation may be inspected by members of the research team and shared for educational purposes only.

The results of the study may not be available for 8 years and after this time all the videoed materials will be destroyed and the results published.

Tower Hamlets Primary Care Trust and City University are supporting this study. A research study is part of the requirement for my studies at City University and reviewed by:

[redacted] Research Ethics Committee

Chair [redacted]

City Senate Research Ethics Committee

Chair: Tel: [redacted]

Contact for Further Information:

For any further information please contact the Principal Investigator Jane Bickerton at [redacted] Walk-in Centre Tel: [redacted]. Please do not hesitate to contact her with any question.

Thank you again for taking part in the study

You will be given a copy of this information sheet and a signed consent form to keep.

Ethics and Research and Development approval letters

CITY UNIVERSITY LONDON

SHS Research Ethics Committee

Project Amendments / Modifications / Request for Extension

For use in the case of all research previously approved by SHS Research Ethics Committee.

Completed forms should be returned to the Secretary to SHS Research Ethics Committee, Alison Welton (a.welton@city.ac.uk)

Note that you only have to respond to the sections relevant to you.

Details of Principal Investigator and Study	
Name	Jane Bickerton
Address	Jane E.Bickerton Lecturer Nursing Division School of Health Sciences, 1 Myddleton Street London, EC1R 1UW.
Telephone	[redacted].
Email	[redacted]
Title of study	"An examination of images in videoed healthcare consultations at a London Walk-in centre to identify a fragmented or unified image"
SREC reference number	04/Q0605/70
Study Duration	
Start Date	January 2005
End Date	
Project Amendments / Modifications	

Type of modification/s (tick as appropriate)

Research procedure/protocol (including research instruments)	
Participation group	
Information Sheet/s	
Consent form/s	
Other recruitment documents	
Sponsorship/collaborations	
Principal investigator/supervisor	
Extension to approval needed (extensions are given for one year)	
Other	x

Details of modification (give details of each of the amendments requested, state where the changes have been made and attach all amended and new documentation)

REC Project Reference Number: 04/GOW05/70 Applicant's Reference Number

APPLICANT'S CHECKLIST – v. Apr 2004

COMPLETE THIS CHECKLIST AND SEND IT WITH YOUR APPLICATION.

Indicate if the following have been enclosed by putting a circle round the correct answer. Do NOT staple documents, which will need photocopying; collate using large paperclips.

Send ONE copy of the following WITH DATES AND VERSION NUMBERS on all accompanying documentation, unless stated otherwise:

Standard NHS REC Application Form Parts A and B	Yes	No
Standard NHS REC Application Part C	Yes	No
Covering letter on headed paper	Yes	No
Research protocol (~~SIX~~ TWO COPIES)	Yes	No
A summary, synopsis or diagram (flowchart) of protocol in non-technical language	Yes	No
Investigator's brochure or summary of product characteristics data sheet for all drugs (THREE COPIES)	Yes	No
A summary C.V. for the Chief Investigator	Yes	No
A summary C.V. for the supervisor (student research only)	Yes	~~No~~ Error
Letter from sponsor (if not the funder, the applicant's employer)	Yes	No
Any relevant external peer review	Yes	No
Comments from Statistician	Yes	No
Details of any Data Monitoring Committee	Yes	No
Statement regarding compensation arrangements	Yes	No
Interview schedules or topic guides for research participants	Yes	No
Copy of Questionnaire (finalized/not yet finalized*) *delete as applicable	Yes	No
Sample diary card/patient card	Yes	No
Printed copies of advertisement material for research participants, e.g. posters, newspaper adverts, website. For video or audio cassettes, please also provide the printed script	Yes	No
Letters of invitation to research participants	Yes	No
GP/consultant information sheets or letters	Yes	No
Research participant information sheet (PIS)	Yes	No
Research participant consent form	Yes	No

SI 14 Favourable opinion following consideration of further information
Version 2, October 2004

COPY

NHS

[redacted] Local Research Ethics Committee
[redacted]

Telephone Number: [redacted]
Fax Number: [redacted]
Email Address: [redacted]

20 December 2004

Ms J.E Bickerton
City University PCPHU
St Bartholomew's School of Nursing & Midwifery
Philpot Street
London
E1 2EA

Dear Ms Bickerton,

Full title of study:	***An examination of the organisation of images in videoed health care consultations at a London Walk-in Centre to identify a fragmented or unified image***
REC reference number:	***04/Q0605/70***
Protocol number:	***N/A***

Thank you for your letter of 10 December 2004, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form. Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed that they have no objection.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application	1	10/09/2004	22/09/2004
Application - Section A23	2		10/12/2004
Investigator CV	1	10/09/2004	22/09/2004

Protocol	1	30/06/2004	22/09/2004
Letter from Sponsor	N/A	08/06/2004	22/09/2004
Peer Review	1	24/06/2004	22/09/2004
Compensation Arrangements - Tower Hamlets PCT	Provisional	19/08/2004	22/09/2004
Compensation Arrangements - City University	N/A	25/09/2003	22/09/2004
Copies of Advertisements	1	30/06/2004	22/09/2004
GP/Consultant Information Sheets	1	30/06/2004	22/09/2004
Participant Information Sheet	2	18/11/2004	10/12/2004
Participant Consent Form	1	10/09/2004	22/09/2004
Response to Request for Further Information	N/A	10/12/2004	10/12/2004
EC School of Nursing & Midwifery Ethical Committee Cover Sheet	N/A	16/07/2003	22/09/2004
Research timetable	1	30/06/2004	22/09/2004
Supervisor CV	1	10/09/2004	22/09/2004

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

04/Q0605/70	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Enclosure 1

[redacted] Local Research Ethics Committee 3

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	04/Q0605/70	**Issue number:**	1	**Date of Issue:**	20 December 2004
Chief Investigator:	Ms J.E Bickerton				
Full title of study:	An examination of the organisation of images in videoed health care consultations at a London Walk-in Centre to identify a fragmented or unified image				

This study was given a favourable ethical opinion by [redacted] Local Research Ethics Committee 3 on 13 December 2004. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Documents submitted to City University London ethics committee

This form must be completed as part of all research proposals regardless of whether the proposal is going to [redacted] or other Health Authority, City University Ethical Committee or any other ethics research approval body.

Please complete this form and return 2 copies to [redacted], Research Office, St Bartholomew School of Nursing & Midwifery [redacted]). One copy of this form will be retained in the School Research Office and the other forwarded to Ms Sarah Simpson, the Secretary to University Ethical Committee and kept as a record of the research that you are completing under the auspices of City University. In some circumstances, as deemed necessary by the School Research Office/University Ethical Committee, further information may be required.

Name of Principal Investigator(s): Jane E Bickerton

Department/Unit/Team: Public Health and Primary Care Unit

(***For Students Only***)

Name of Supervisor **Susan Procter Professor of Research**

***Course*: Mphil/Phd Student**

***Student Number*:**_____

Title of research proposal: An examination of the organisation of images in videoed healthcare consultations at a London Walk-in Centre to identify fragmented or unified image using Sartre and Bergson's theory of the image

Trust/Funding Body(s) involved: **Tower Hamlets Primary Care Trust**

As City University Ethical Committee must consider the ethical implications of all experiments, investigations and procedures involving human or animal subjects carried out in the University or under the auspices of the University, please provide a brief summary of the research involved in this proposal. This should include aims, rationale, methodology, and dissemination plans.

The aim of this research study is to test the transferability of a process of phenomenological analysis of performance video artists to the videoed healthcare consultation.

Healthcare practitioner consultations are imbued with formidable sets of assumptions about the purpose, meaning and experience of the consultation. Many of these assumptions derive from notions of efficiency and effectiveness in healthcare delivery. Consequently the embodied experience of videoed consultations has not been recognised as an important feature. In transferring the methodology described above to healthcare consultations it is anticipated that the embodied meaning of those consultations will emerge. The framework of fragmented and unified experience is particularly relevant to these consultations as ultimately the nature of the experience may determine the efficiency and effectiveness of these videoed consultations.

The study will analyse videoed consultations at the Whitechapel Walk-in-Centre taped over a three month period. They will represent a broad healthcare practitioner skill mix seeing patients with minor ailments. The practitioner will choose the consultations they wish analysed. Videoed consultations will be analysed until saturation is reached and no new interpretations can be found within the analysis of the data. At least five but no more than 30 consultations should be sufficient to demonstrate the presence of a fragmented or more unified narrative image. The method of analysis is neither patient nor health professional focused but is centred on the world of the video itself.

The results of this research will be written up and submitted to various academic journals and will be available at the Walk-in Centre. It is expected that it will take up to eight years for the results to be available for publication.

1. Are the aims and objectives of the research consistent throughout the documentation? YES

2. Does the document comply with the Data Protection Act 1998?
YES

3. Does the document contain copyright material? (This includes all published text and graphics)If not covered by the terms of licence granted to City University by the Copyright Licensing Agency please attach evidence of clearance or exemption. If

you are unsure please refer to http://www.city.ac.uk/dataprotection/dp_research.htm

NO

4. Do you consider the research to be covered by City University's insurance policy?

(If not, please contact [redacted] who will seek further advice)

YES

5. Can you confirm that the proposal will be considered by a Local or Multiple Research

Ethics Committee under NHS auspices? (If not, a full application to the University Research

Ethics Committee must be made.)

YES

I confirm that the above checks have taken place on the attached documentation and that another member of the research team has additionally checked the documentation.

Name (print) Jane E Bickerton Position MPh/PhD Student at City University/Nurse Consultant Whitechapel Walk-in Centre

Principal Researcher

Signature_____Date_____

_____

Name (print) Susan Procter PhD Position Professor of Research Public Health and Primary Care Unit at City University

Supporting Researcher/ Signature of Supervisor (required for all students)

Signature_____Date_____

_____

City University London

Senate Research Ethics Committee

This form is to be used in conjunction with form EC1. Please complete this form and return 13 copies with the completed EC1 forms to Ms Saran Simpson, Academic Registry.

If any of the checks are incomplete or supporting documents have not been received with the research proposal the Research Ethics Committee will not consider the proposal and it will be returned to you for completion.

Title:
Name of Principal Investigator(s):

Department (s) involved: (delete as appropriate)

1. Have all documents been thoroughly checked for grammatical and spelling errors?
YES

2. Has the documentation been proof read by a member of the research team other than
the principal researcher?
YES

3. Have page numbers been included in large documents?
YES

4. Have all letters and consent forms been written in plain English?
YES

5. Are the aims and objectives of the research consistent throughout the documentation? YES

6. Has all supporting documentation been included in the EC1 submission?
YES

7. Does the document contain copyright material? (This includes all published text

and graphics). If not covered by the terms of licence granted to City University by the

Copyright Licensing Agency please enclose evidence of clearance or exemption.

NO

8. Has this research proposal been reported to the departmental Ethical Committee or

its equivalent?

YES

9. Has this research proposal been reported to a Local Research Ethics Committee e.g.

LREC; MREC; ELCHA? (If YES please attach evidence of approval from such body).

YES

10. Does the document comply with the Data Protection Act 1998? Researchers must

consider the act when considering the use of data, storage of data and disposing of data.

Guidance on the principals of the act are available at:

http://www.city.ac.uk/ic/dp_research.htm YES

The Principal Investigator (s) and the relevant Head of Department should sign the following declaration. If the Principal Investigator is also the Head of Department, the signature of the Dean of the School should be sought. Please note that it is bad practice for both signatures to be the same. Applications where both signatures are the same will not be accepted. Alternative signatures could be sought from the Director of Research.

I confirm that the above checks have taken place on the attached documentation and that another member of the research team has additionally checked the documentation.

Name (print)_____
Signature_____Date_____

Principal Investigator

Name (print)_____ Signature_____
Date_____

Head of Department

Documents submitted to the [redacted] Local Research Committee

An examination of videoed healthcare consultations in a Walk-in centre

Part A

An examination of the organisation of images in videoed healthcare consultations at a London Walk-in Centre to identify fragmented or unified image using Sartre and Bergson's theory of the image

Keywords: health care, video consultations, Walk-in Centres, Sartre, Bergson, Nurse Practitioners, primary care, Out of Hours health care, minor ailments, student healthcare education, communicative theory

A7 principal research question

To test the transferability of the process of analysis derived from my master's thesis to the health practitioner consultation.

The master's thesis analysed narratives of videoed performances and the PhD thesis will apply the same methodology to videoed health practitioner consultations. Healthcare practitioner consultations are imbued with formidable sets of assumptions about the purpose, meaning and experience of the consultation. Many of these assumptions derive from notions of efficiency and effectiveness in healthcare delivery. Consequently the embodied experience of the consultations for both parties has not been recognised as an important feature. In transferring the methodology described above to healthcare consultations it is anticipated that the embodied meaning of those consultations will emerge. The framework of fragmented and unified experience is particularly relevant to these consultations as ultimately the nature of the experience may determine the efficiency and effectiveness of these consultations.

A9 Justification for the research

There is a growing interest in analysing primary care practitioner videoed consultations and in particular the patient-centred consultation. This research is presently being carried out in the area of General Practice.

This PhD will build on work I undertook for my master's thesis. In my master's thesis I further developed the methodological work of my supervisor Dr. Angel Medina who is a recognised Husserlian scholar. He has written extensively on the application of phenomenology and existentialist theories to literature, performance, video, art history and architecture.

In my master's thesis I developed a method of analysing performance video integrating the methodologies of Sartre's and Bergson's theories of the image. The thesis outlined an embodied object created through the imagination in Sartre, in Dr. Medina's words a fragmented image, and the unification of corporeal and dynamic schemas in Bergson, a unified image for Medina (1979). Through this analysis I gained experience of analysing the world of videoed performances: in these instances videos of performance video artists. The analysis in the thesis focuses on a lived embodied experience presented through the medium of a videoed performance. The analysis begins with the focus on the embodied emotional, intellectual and action process in the imagination moving to the analysis of reciprocal interaction of consciousness and world. The researcher names these videoed performances as experience which is ultimately a fragmented or unified image. The fragmented experience projects outside the world of the performer's embodied experience and projects a dissonant world. The unified experience presents through shared interaction of consciousness and world, and presents as a fully integrated and resolved biographical narrative.

This method focuses on the world of the consultation rather than the practitioner or the patient. The research will focus on an analysis of the world of the consultation, the consultation completed by the multidisciplinary healthcare team working in the [redacted] NHS Walk-in-Centre (WiC). There is considerable research on the video examination of doctors and in particular the general practitioner.

In 2002 The British Medical Journal published research by Peter Campion et al. The research analysed the data from the MRCGP video examination of doctors nearing their completion of three year postgraduate training in general practice. It found doctors showed “only limited ability to achieve patient-centred outcomes. The ability to elicit patients’ ideas, concerns, and expectations is fundamental to good consulting, but our results suggest that few doctors regularly use this ability, even in a highly selective set of consultations. Likewise the checking of understanding and the involving of patients in decision making-both likely to improve concordance are rarely demonstrated.”

In extracting this research Campion examined videoed consultations. In order to pass the MRCGP video examination the doctors are assessed over five areas of performance and the analysis of the videoed consultations is hierarchical. The five areas for consideration are: the reason for the patient’s attendance, exploring the problem(s), tackling the problem(s), explaining the problem and making effective use of the consultation.

Other healthcare professionals have had far less access to the videoed consultation as a learning tool. My research will provide a novel approach to the analysis of the videoed consultation and will include a multidisciplinary group of healthcare professionals.

The WiC provides primary health care to patients who have no easy access to primary care. It is a paperless healthcare centre and the staff includes nurse practitioners, nurses, general practitioners, and Bengali bilingual receptionists. All these practitioners will be offered the opportunity to participate in the research.

My research will be neither practitioner nor patient focused and will be non hierarchical. It will be expected that many of the consultations such as a task oriented consultation will present as a unit of meaning appropriate for the intention of a fragmented consultation. My thesis is not claiming that the unifying experience of the world of a consultation is better or worse than a fragmented image. I will argue that it is merely different.

A10.

Methodology:

I will analyse videoed consultations at the [redacted] Walk-in-Centre. They will represent a broad healthcare practitioner skill mix seeing patients with minor ailments.

I will gain ethical approval for the study from the Tower Hamlets Primary Care Trust and obtain the patient's and practitioner's consent.

Video consultations will be collected from each practitioner until saturation is reached and no new interpretations can be found within the analysis of the data. I will expect to find various units of meaning in the task directed consultation and this may be the resultant image rather than the more complex fragmentary or unified image. At least five or more consultations should be sufficient to achieve the aim written above and will provide enough data to satisfy a sceptical audience and enable the possibility of fragmented and a unified image to be demonstrated.

Patients will be offered the opportunity to withdraw their consent, as with the practitioner, if the material which emerges out of the consultation is seen as too sensitive and the video will be destroyed.

The consultations analysed will be those which gave the practitioner the greatest satisfaction. The method of analysis is neither patient nor health professional focused but is centred on the world of the video itself.

Sources of data to be used:

I will analyse at least five videoed health consultations from the skill mix of practitioners seeing patients at the WiC. They will include at least five from each practitioner: including a nurse, a first contact practitioner (a physiotherapist, occupational therapist, medical social worker, pharmacist, etc), a general practitioner, and a bilingual front line receptionist.

The [redacted] Walk-in Centre was opened in December 2001. During the following year the nurses were videoed on several occasions during their healthcare consultations for learning purposes. Both patients and nurses gave written consent for a video camera to video from one point of view the healthcare consultation. There was no one else present in the room. The nurses viewed their consultations individually and if they wished their videoed consultations were discussed in a group in order to share and gain a better understanding of a healthcare consultation. Primary care nurses at the WiC found the experience helpful and are asking to repeat the project. The participation in this research study will be voluntary both for the client and for the healthcare worker.

The consultation will be videoed at the Whitechapel Walk-in-Centre in a similar way to the original project; however, the video consultation will be analysed using the methodology in my thesis. However, the healthcare worker will be able to keep the video for learning purposes alone if the patient and healthcare worker both agree. The WiC was opened in 2000 to provide unscheduled primary care access to a culturally diverse patient population in the socio-economically deprived borough of Tower Hamlets. Patients are treated for minor ailments.

The patient will be asked if they are willing to participate in the study and will be required to sign a consent form which will be explained to them in detail. The procedure will be covered in the consent form. The practitioner will choose the consultations they wish have analysed.

A11

The video camera can be stopped at any point during the consultation if the client/patient or practitioner wishes. Both will be made aware of this possibility during the consenting process.

As a qualified nursing professional, if during my analysis of the videoed consultation I have questions about the healthcare offered, it will be my responsibility to discuss it with the practitioner and ultimately the client themselves.

A14

If embarrassing, sensitive, or upsetting information arises during the consultation which the patient or practitioner are conscious of during the videoing the camera can be stopped by either of them and the material erased. There will be an agreement made between the client and practitioner during the consenting process. If criminal or other disclosures requiring action are brought to the researchers attention during the analysis of the videoed consultation the researcher will take the required action outlined in her nursing professional code of conduct.

A15

The client and practitioner will participate in the videoed consultation and the video will be destroyed within 8 years of the consultation which is the number of years that my PhD research my take until completion.

A16

That the client or practitioner do not feel comfortable stopping the videoing during the consultation. There will be exclusion criteria included prior to the procedure which will exclude known sensitive material. A referral can be made to another healthcare professional to help resolve the potential adverse effect.

A17

The practitioner has the potential to change their consultation technique. In the event that the client or practitioner suffers discomfort an appropriate healthcare referral will be made.

A18.

The practitioner will learn from viewing their consultation technique

A19

The research might observe a healthcare consultation which provides inappropriate care. The researcher will then be required to act on the situation according to her professional code of conduct.

A20

The study participants will be clients/patients that visit the nurse-led [redacted] Walk-in Centre for healthcare advice and treatment. There will be pamphlets at the front desk where the clients sign in and the front line staff will invite them to take a leaflet and consider being videotaped during their health consultation. A member of staff will offer to give them more information about the research study and the videoing process. They will be asked questions which will identify if they fulfil the inclusion criteria or will be excluded from the study because they meet one of the exclusion criteria. This interview will take no less than 15 minutes. If they think they might be willing to consider being videoed during the consultation they will taken in an interviewing room where the video procedure will be outlined and if they are still willing to consider being videoed the research assistant will show them the consent form and ask them if they can go through it with them. Following the outlining of the consent form the client will be recruited into the study. They will be informed that they can decline to part of the study at any time. They can ask for the video recorder to be turned off at any time and if it is they can request to have the tape recorded over while they are in the room. The client will also be informed that the health practitioner can request the videoing to be stopped at any time too. The consent form will contain a simply explained version of all the steps of the protocol and will include that the video tape will be kept in a locked place for up to 8 years.

A21

The research participant will be recruited through an advertisement at the front desk in the Walk-in-Centre. The front line staff will highlight the pamphlets when the clients sign into be seen at the WiC. There will be no pressure to participate as a research participant.

A22

The research participant is over 18 years of age.

The research participant wants to participate.

The client is presenting with one of the health conditions that are treated at the nurse led walk-in centre.

The client is not participating in another study or has not been a research participant in the past 28 days

The client is not part of any of the groups outlined in A24

There is an interpreter available to be with the client if they do not speak English

They client is willing to be videoed and understands what this means

The client is willing to sign and understands the consent form

The client understands they can decline to be part of the study at any time.

A23

The client does not fulfil all the criteria above

A28

The client may have up to 2 hours to decide if they would like to participate in the study

A 29

There will be an interpreter present or an interpretation service will be used

A35

The client will be covered under the THPCT indemnity and/or compensation policy

A40

Clients are given a number when they come to the WiC and this will be the identification used for the study. It will be hard to anonymise the videotaping but the client is at liberty to request the video at any time until the video tape is destroyed.

The client will be given a telephone number to contact should they require any details. The video will be locked at all times.

A41

The analysis of the data will take place at the WiC or City University or at my home and it will be carried out by Jane Bickerton the MPhil/PhD student carrying out the research. Other professionals may be included in the analysis where appropriate.

A43

A44 Up to 8 years

A 47

Literature review looking at research on Nurse Practitioners and videoed healthcare consultations

A48

The primary outcome measure will be:

Video consultations will be collected from each practitioner until saturation is reached and no new interpretations can be found within the analysis of the data. I will expect to find various units of meaning in the task directed consultation and this may be the resultant image rather than the more complex fragmentary or unified image. At least five or more consultations should be sufficient to achieve the aim written above and will provide enough data to satisfy a sceptical audience and enable the possibility of fragmented and a unified image to be demonstrated.

A53 For qualitative analysis what is the methodology called for analysing data until saturation is met.

A57

Jane Bickerton was appointed as a lecturer in Primary Care and Public Health Nursing in January 2003, and is teaching on the BSc Nurse Practitioner course. She

holds a joint post with Tower Hamlets Primary Care Trust working at the [redacted] Walk-in-Centre as a Nurse Consultant.

She is a Bart's trained nurse and qualified as a Health Visitor through North London Polytechnic while working in Hackney. She has worked as a Housing Adviser at Shelter Housing Aid Centre and in Guatemala as a healthcare volunteer.

In the late seventies she moved to the States where she worked as a registered nurse for the Feminist Women's Health Center. In the nineties she worked as a research study coordinator at Emory University in the School of Medicine and was involved with reproductive health and lipids research. She worked for the Department of Psychology on research into learning in uteri. In 1997 she qualified as a Women's Health Nurse Practitioner through Emory University's Regional Training Centre, and is licensed as a Nurse Practitioner in the State of Georgia.

She is passionate about the art of communication and taught World Cultures in the undergraduate programme at the Atlanta College of Art. She completed a BA in psychology at Oglethorpe University in 1980 and an MA in philosophy at Georgia State University in 1991. Her Master's thesis, using a communicative hermeneutical and existential theory, examines the organisation of aesthetic images in performance videos. This communicative theory will be used as the foundation for research towards a Doctorate in Health from City University. This research will examine the organisation of documentary images in patient-practitioner consultation videos.

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Appendix 6: Data extraction and thematic descriptions

Articles in SLR	*Different forms of communication*	*Complexity of communication in healthcare consultations*	*Interpersonal interaction dynamics*	*Satisfaction with the consultation outcome*
1. Comparison of Patients' and Doctors' Comments on Video-Recorded Consultations Arborelius and Timpka, 1991	Patients comment on difficulties in giving correct information. Drs have difficulties understanding the patient and are frustrated It's difficult to express what I want to say; it's difficult to find the right words 'I don't know, but I have the feeling that she belittles my problem.'	Empathic, engaged, open, personable. Opposite is objective distanced.	Asymmetry dynamic. Comments that have no correspondence. The patients comment on the importance of the doctor having the patient as the starting point The doctors comment on events when they have experienced the patient's behaviour as disturbing.	Patients commented on the effect of the relationship itself, whether it was positive or negative, whereas doctors tended to share a patient's ability to provide adequate information.
2. What does the human relationship with the doctor mean? Arborelius, E. and Bremberg, 1992	Verbal and non-verbal: Patient expresses both by her words and by her intonation, that she is sad and irritated because she has not been healthy yet. A non-verbal characteristic of these consultations is that the doctor's eye-contact with the patient is rather limited. The doctor's body is also sometimes turned away from the patient.	the doctor does not receive and answer emotional messages if they occur The doctor asks questions about the patient's symptom but he does not reply with explorative, affective and/or listening responses to the patient.	Sequences which precede positive comments about the relationship with the doctor: - doctor either asks questions very precisely and/or that he carefully listens to the symptoms the patient tells him about. Sequences in the consultation which precede negative comments about the relationship with the doctor. The doctor does not listen carefully can be noticed by a non-empathic intonation and by the fact that "confirming" answers such as "yes", "no", "hmm" are expressed in a routine way that indicate non-presence, as in this case:	The patient's experience of a satisfying human relationship with the doctor corresponded to specific behaviour such as explorative, listening, and/or emotional responses from the doctor. When reciprocal eye contact was present. The patient's comments seemed to express a satisfaction with something more than the doctor's mere listening to his medical symptoms. A probable interpretation was that the doctor had understood and responded to the patient, e.g. by active and empathic listening.
3 Patients comment on video-recorded consultations—the "good" GP and the "bad" Arborelius, E., Timpka, T and Nyce,1992	GP treats the patient with respect or not. A bad GP is when the patient feels that the GP was not taking his or her symptoms seriously.	The "good" GP emerged that had two major characteristics: that of being a caring human; an individual who listens, understands, and is concerned. A typical experience of a "bad" GP was that the GP appeared	The good GP acts like an ordinary person and treat the patient as an equal. The personal relationship with the GP also influenced the choice and course of medical interventions. For the patient, the manner in which an intervention is seen is linked to whether the GPs treat the patient with respect or not... The bad GP is failure to communicate to the patient his or her standpoint on issues raised during consultations.	GP support through ways of caring

Articles in SLR	*Different forms of communication*	*Complexity of communication in healthcare consultations*	*Interpersonal interaction dynamics*	*Satisfaction with the consultation outcome*
		unreachable as a person.		
4. Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation Ariss, 2009.	Focussed on knowledge and authority of knowledge in conversations. GPs' responses to patients' claims of epistemic authority on matters of diagnosis, illness management or treatment.	GPs might resist patients' talk by withholding responses Maintains an orientation to the asymmetry of rights to the knowledge Four types of GP responses (agreement, elaboration, lack of engagement and disagreement)	How the typical orientations to roles overwhelmingly recognised in discussions of asymmetry in medical consultations are collaboratively achieved by the participants during the course of the interaction. Style of interaction which progresses steadily, despite differences of opinion, rather than exploring potential disagreements.	Patient satisfaction is described through the specific limitations and opportunities for the participation of patients regarding the discussion of their problems, treatments and management of illness.
5. A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach. Bickerton, J., Procter, S., Johnson, B. and Medina, A.,2010.	Patients attending Walk-in centres are seeking information from GPs NPs & nurses. Limited understanding leads to communication shared through hand and body gestures (movement) rather than words (knowledge) and the movement of the participants at times mirror's each other	There are empathic and engaged conversations, and objective and unengaged conversations.	The majority of practitioners and consumers interact in harmony but there are examples of interactions in tension lacking SDM and concordance.	The facultative practitioner and the active patient in harmony
6. Pharmacists' evaluation of key communication skills in practice. Hargie, O. D., Morrow, N. C. and Woodman, C,2000	Ranked key communication skills included building rapport, nonverbal communication, building rapport, explaining, questioning, listening, non-verbal communication, suggesting/advising, opening, closing, assertiveness, disclosing personal information and persuading.	Objective and engaged rapport building.	Building rapport most important skill and within this confidentiality component.	Effective communication was closely connected to patient satisfaction.
7. 'How do you know what Aunt Martha looks like?' A video elicitation study exploring tacit clues in	Nonverbal sensitivity : tacit clues during clinical interactions ability to recognise	Empathic and engaged: 'I'll use my body a lot, I mean, I'm	Patients' comments all concerned the doctor–patient relationship. Doctors' comments dealt with	The patient experienced the doctor as having time for them and not be impatient

Articles in SLR	*Different forms of communication*	*Complexity of communication in healthcare consultations*	*Interpersonal interaction dynamics*	*Satisfaction with the consultation outcome*
doctor-patient interactions. Henry et al., 2011	people's emotions/comfort/ judgements/insight Verbal and nonverbal behaviours.	pretty focused about it' and 'you're also going to see ability to steer the conversation. I mean you can do it non-verbally'. Comments suggested that this doctor had given the role of non-verbal behaviour in doctor– patient interactions considerable thought.	both the doctor–patient relationship and medical decision making. Most doctor comments about the doctor–patient relationship involved actively considering nonverbal behaviour to develop and maintain good rapport: I have to assess what I have to do differently to establish a good rapport.	
8. Patterns in midwives' and expectant/new parents' ways of relating to each other in ante- and postnatal consultations. Olsson, P.and Jansson, L.,2001	topics are introduced in a personal way/ the instructor tells how the pregnancy should be.	Connected and engaged listening and caring for the parents. Disconnected, distanced and disinterested Promotes biomedical and not psychosocial aspects of pregnancy within certain pre-identified limits. Instructs/directs and does not share.	5 ways of relating influences how expectant/new parents deal with information given and satisfaction with care.	A facilitative and open approach to the consultation was the most satisfactory names the 'Respectful gardener and her developing plants'.

Appendix 7: Study data template

Video number http://www.youtube.com/watch?v=7VGSk4sDKSk [accessed 18/07/2013] Patient information: age and sex Practitioner information: General Practitioner	'SOAP' Summary documentation	[redacted]
Subjective (patient tells their story about the presenting complaint including their health history).	Presenting complaint History of presenting complaint Past Medical history Medications & Allergies Family History Social History	[redacted]
	Review of Systems	[redacted]
Objective(physical assessment of the patient complaint)	Appearance Mental health Head Eyes Ears Nose & Throat (HEENT) Neurological/reflexes	[redacted]
Assessment (The results from the combining of the patient personal health history and the practitioner's physical assessment)	Differential diagnoses Primary diagnoses Diagnoses secondary to primary diagnoses Diagnosis of presenting complaint	[redacted]
Plan (the decision about how the participants are going to plan treatment)	Investigations such as blood work Treatments including prescriptions Referrals and teamwork includes carers and family etc. Safety netting Safeguarding Relevant guidelines etc.	[redacted]
Video schema	Video interpretation Summary	

Shared connection	The analysis attentive and centred on a shared intersubjective video image.	
Conversation:	Knowledge interaction focuses most on sharing information Movement interaction experienced through non-verbal elements such as gestures Emotional interaction experienced through feeling elements. Overarching conversation.	Attentive and objective or engaged communication.
Attentive, empathic and engaged	Engaged conversations is an empathetic interaction where participants are attentive to each other. Objective conversations is disengaged and not engaged.	
Typical situation	There is an overarching typical situation depicted in the video Typical situations are an accumulation of conversations There is a continuum of one of four typical situations that include active/passive, facilitative/directive The typical situation is in tension or harmony.	
Text and narrative	Texts present a typical situation that is objective or engaged. Narrative situation are fully engaged face-to-face interactions that integrate multiple combinations of perception through linearity, resonances, and/or rhythm and is never objective.	

Appendix 8: Examples of communicating visually and non-verbally

Wordless (mostly visual) cues between people such as gestural body language	Pointing, shrugging shoulders, leaning forward	Body language reflects the importance of what is said by leaning forward, opening your eyes wider, and using appropriate hand gestures	Mirrored movements. So for example the patient leant forward and the practitioner moved either backwards or forwards	Patient could be interpreted as anxious or frustrated when they gesticulated moving their hands and arms to try and be understood	Include visual and wordless kinaesthetic movements in social action perhaps to enhance the meaning of words	Configuration or pattern of visual/ nonverbal or verbal video data that gathers patterns, categories and themes of patient-centred and shared-care interpersonal narrative
Communication through gestures and touch, body language or posture or physical distance	Hand on someone's shoulder touching oneself	Participants had their legs crossed towards or in opposition to each other Using appropriate hand gestures.	Hand and foot gestures supporting each other. Reinforcing with gestures what is said by leaning forward.	Moving foot up and down or rocking forwards and backwards	To shake hands when meeting for the consultation	Whole or emergent structure as opposed to
Communication through facial expression	Smile, expression of surprise	Opening your eyes wider while talking.	Reading thoughts by watching facial expressions	Frowning or grimacing	Smiling or welcoming each other on meeting and or saying goodbye	Essential structures in the individual consciousness as opposed to culture in Barthes and post structuralism
Communicating through eye contact	Mutual gaze, looking at person vs. looking at floor	Reinforcing with eye contact (excessive eye contact can be a sign of disrespect in some cultures).	Eye contact to read for signs of confusion, disagreement, disbelief, resistance or understanding	Eyes watering or reddening or wild	Direct eye contact on greeting or parting depending on cultural expectations	Essence or shape of an entity's complete form

Appendix 9: Video Tool (version 1)

Note that the yellow shaded areas were added following the analysis of the videos

'SOAP' Summary	
Subjective	
Objective	
Assessment	
Plan	
Shared connection Summary	
Conversation	
Emotion/knowledge/ movement	
objective or empathic engaged	
Typical Situation	

and including consensus data from figure 7.4

The coding form

Typical Situation				
Practitioner		Patient/Client		Harmony/tension
Facilitative		Active		Harmony
		Passive		Tension
Directive		Active		Tension
		Passive		Harmony
General comments				
Reflection Narrative, configured or reconfigured text				

The process guide

<table>
<tr><td colspan="3">The process guide</td></tr>
<tr><td colspan="3">Step 1: Shared action in the video story
Focus on video elements rather than the individual participants. The whole communication process involves visual (non-verbal) and audio (verbal, sounds, words). Similarly to meditation practice focus your mind on experiencing a combination of sounds and the visual elements without becoming engaged with the consultation content. Your mind is clear, relaxed, and inwardly focused. You are fully awake and alert, but your mind is not focused on the representations of the consultation taking place in the video. The video materials are the material acts of inner consciousness where your mind is calm and tranquil. Where the practitioner left the room the video data is not included because of its potential to have an effect on the overall outcome.
Suggestion: Focus on stilling your mind.</td></tr>
<tr><td colspan="3">Step 2: Psychology of perception, conception and imagination
Focus on shared action across the video image as components of three different kinds of conversations. Focus again on the combination of audiovisual video elements and try to identify how emotion or knowledge or movement elements are experienced within the image. Look, watch, listen and hear linear movements, different colours and hues of emotion and listen to the meaning in the words. In verbal communication consider the type of questions (open, directed, affirming for example). Communication skills include building rapport, nonverbal communication, explaining, questioning, listening, suggesting/advising, opening, closing, assertiveness, disclosing personal information and persuading. Pay attention to understanding emotion, knowledge and movement as separate elements across the video image without separating the elements from the participants in the video. These particular elements are combined into conversation types.
Suggested questions:
What elements of conversation content hold your attention?
What is it about these phrases that you find interesting in the video narrative?
How do you understand the meaning of these phrases?</td></tr>
<tr><td colspan="3">Step 3: Elements of conversation
Focus on the predominant element of the conversations under ‘emotion’ ‘movement’ and ‘knowledge’ which lead you to identification of an overarching conversation that is named either knowledge/movement/emotion across the audio and visual narrative. Distinguish between emotion, knowledge and movement elements in the conversation and include not only words but also aural, verbal and visual elements such as gestures and visual expressions. Visual cues include facial expressions, gestural movements, and audio cues such as laughing out loud or conversations. All conversations have the potential to develop into an empathic engaged conversation i.e. to be with that person, rather than seeking to act upon them. Be aware that the placement of chairs and tables represents aspects of personal boundaries and space.
Suggested questions:
How are the different elements of the communication conversation separate and shared?
What feelings or emotional response do you have to the video story?
If sign language was being used to impart knowledge what type of conversation might you have?
What makes you choose one of the conversations over the others described below (emotion/knowledge/movement)
Are the participants in the video engaged in conversation and empathically listening to each other?</td></tr>
<tr><td>Predominant Emotion conversation
Emerges from a combination of all three elements where the emotional content is supported by movement and knowledge elements. So, for example, words express emotion more than information or knowledge and gestures also support the emotion more than the emotion supporting the gestures.</td><td>Predominant Knowledge conversation
Emerges from a combination of all three elements where visual and verbal information and knowledge is supported by gestures and emotional sharing. So, for example, a verbal sound may be expressed that supports understanding or an emotional nod or verbal sound that acknowledges and supports facts in a knowledge conversation.</td><td>Predominant Movement conversation
Emerges from a combination of all three elements and is realised through the movement conversation which can involve gestures and hand movement, for example, as movement delineating personal space and boundaries. The space is not named but rather articulated through space as the hands express an emotional concern.</td></tr>
<tr><td colspan="3">Step 4: Social interaction between the participants
Focus on the social action between the participants. How are they interacting? Interpret these interactions through an accumulation of various interaction approaches that are 1) active or 2) passive, 3) facilitative or 4) directive. These approaches organise along a continuum of four typical situations which are either in harmony or in tension. The patient may be active or passive and the practitioner facilitative or directive. An active patient interacting with a facilitative practitioner and a passive patient interacting with a directive practitioner realises a consultation outcome in harmony. An active patient interacting with directive practitioner and a passive patient interacting with facilitative practitioner realise consultation outcomes in tension. Communication has the potential to change and adapt and so the final outcome may be the result of various typical communications that fall along a continuum and may be difficult to differentiate.
Suggested questions:</td></tr>
</table>

How does the overall communication between a practitioner and patient lead to a harmonious outcome?
How does the overall communication between a practitioner and patient lead to a tense outcome?
Are there barriers to communication?
What are the barriers to shared partnership working?
Can you identify any transparent moments of sharing?
Can you identify any transparent moments of sharing?
How does the patient speak for themselves?
Does the practitioner listen, understand, and care?
Is the practitioner an unreachable person?
Is the practitioner open and receptive to the patient?

Step 5: Kind of video story

There are three kinds of video story that are the narrative, the configured text and the refigured text.
The narrative is where the focus is on describing the video story as a document in a similar manner to transcribing an audiovisual document through close reading.
The configured text is making associations with your own experience of communicating as a healthcare consultation and configuring a text?
The reconfigured text is when communication in the consultation creates moments where understanding the video text is reconfigured and entangled with your life experiences in such a manner that the video consultation takes on an existential form that changes your personal understanding of healthcare communication?

Suggested questions:

Can you give an example of how the video participants are paying attention?-
Are the participants really listening to what is being asked and said?
Can you determine the outcome for each typical situation? i.e. active, passive etc. outlined in step 5.
Are there examples of typical situations where the patient-practitioner tension exists
Does tension matter to the outcome?
Does the practitioner who is most in harmony with the patient have the fewest “inconclusive” outcomes?
Is the practitioner most able to switch from being directive to facilitating on a case-by-case basis the most effective?

The process requires further checking by another reviewer

The coding guide

The coding guide	
Emotional conversation	
Definition	**Communication through feelings and emotions through verbal or non-verbal actions.**
Indicators	**Pay attention to a consensus of shared actions that lean towards different forms of emotion supported by knowledge and movement. The communication content tends to settle towards a type and a consensus although it is not easy to identify how these different elements are building towards a particular overarching conversation.** Look, watch, listen and hear emotion clues and expressed feelings. Visual cues may present that are suggestive of emotion such as smiles and frowns. **Body movements such as withdrawal or moving forwards.** Sound elements such as sighs, tonal qualities, level of voices. Word statements such as 'I feel sad' or 'I feel happy'. **Eye contact suggestive of confusion, disagreement, disbelief, resistance or understanding can be identifiable through acoustic clues such as pitch, amplitude and spectrum cues**
Differentiation	**NB emotional, knowledge and movement elements or actions are defined as parts of a whole organised in varying amounts. e.g. these can be visualised as three different segments of a cake, if having difficulty distinguishing the contributions of the three actions try drawing it to see if a visual representation of a cake divided into emotional, knowledge and movement slices and see if this helps you decide which action predominates.** **Visual and verbal actions have multiple meanings and are understood differently.** Understanding can vary because of cultural, gender, economic, political, and individual patient's physiological situation. **A deaf personal may communicate through visual sign language; the mother tongue may be different from English meaning that some nuances in the spoken language may be lost.** **Social interaction takes place in a geographical space which is where the participants get close maintaining psychological distance.**
Examples: Emotion	**In video (National Health Service, 2013) the participants discussed symptoms arising from cancer. The listening and visual skills involved emotion, movement and knowledge. In this particular video, there were edited images. Fixed and edited shots were used that demonstrated the emotion conversation. The emotional elements were not only associated with visual expressions, but also through the verbal tone of the conversation and gestural movements. All three elements (emotion, knowledge and movement) of the conversation were recognised but both the knowledge and gestural elements emphasised emotional expression that provided the overarching conversation.**
Movement conversation	
Definition	**Communication through movement, gestures or use of space.**
Indicators	**Pay attention to communication through gestures and touch, body language or posture or physical distance e.g. hand on someone's shoulder, touching oneself, participants with their legs crossed towards or in opposition to each other. Using appropriate hand gestures. Hand and foot gestures supporting each other. Reinforcing with gestures what is said by leaning forward. Moving foot up and down or rocking forwards and backwards. To shake hands when meeting for the consultation. Including visual and wordless kinaesthetic movements in social action perhaps to enhance the meaning of words.** **Look, watch, listen and hear for these different elements in the conversation. There is usually a tendency for the use of a particular conversation. It is not always easy to ascertain but the more readily available element in the video becomes the overarching conversation. A spoken sentence is experienced through audio as well as visual expression. The words may be spoken in a loud authoritative manner where the finger is pointed and shaken to emphasise their importance. The understanding of these words is shared through knowledge, emotion and movement**
Differentiation	**NB emotional, knowledge and movement elements or actions are defined as parts of a whole organised in varying amounts. E.g. these can be visualised as three different segments of a cake, if having difficulty distinguishing the contributions of the three actions try drawing it to see if a visual representation of a cake divided into emotional, knowledge and movement slices and see if this helps you decide which action predominates.** **There are many visual and verbal actions that are understood differently.**

	Understanding can vary because of cultural, gender, economic, political, and individual patient's physiological situation. **A deaf personal may communicate through visual sign language; the mother tongue may be different from English meaning that some nuances in the spoken language may be lost.** **Social interaction takes place in a geographical space which is where the participants get close maintaining psychological distance.** **Where a participant is deaf the audio materials play a lesser role in the video consultation.**
Examples: Movement	**A presenting complaint of facial pain demonstrated a movement conversation that involved kinaesthetic movements (CSA, 2013c). These nonverbal movements included hand and arm gestures used to enhance the meaning of verbal and knowledge elements. Movements of the participants mirrored each other: as the patient leant forward, the practitioner moved backward or forward empowering the patient to share information as he listened. Another example was that participants crossed their legs towards each other or away from each other. These visual gestures were interpreted as movement elements. For example the patient gestured with her hands and nodded her head emphasising gestural movement as she verbally expressed emotional concern.**
Knowledge conversation	
Definition	**A communication predominately in which information is shared or gathered.**
Indicators	**Pay attention to knowledge non-verbal information sharing which occurs through pointing, eye contact or shrugging shoulders. Audible vocal cues such as change in voice volume can also occur. Reading thoughts by watching facial expressions. Practitioners may use their medical knowledge authority on matters of diagnosis, illness management or treatment rather than sharing and explaining.** **Look, watch, listen and hear for these different elements in the conversation. There is usually a tendency for the use of a particular conversation. It is not always easy to ascertain but the more readily available element in the video becomes the overarching conversation. A spoken sentence is experienced through audio as well as visual expression. The words may be spoken in a loud authoritative manner where the finger is pointed and shaken to emphasise their importance. The understanding of these words is shared through knowledge, emotion and movement**
Differentiation	**NB emotional, knowledge and movement elements or actions are defined as parts of a whole organised in varying amounts. E.g. these can be visualised as three different segments of a cake, if having difficulty distinguishing the contributions of the three actions try drawing it to see if a visual representation of a cake divided into emotional, knowledge and movement slices and see if this helps you decide which action predominates. There are many visual and verbal actions that are understood differently.** **Understanding can vary because of cultural, gender, economic, political, and individual patient's physiological situation.** A deaf personal may communicate through visual sign language; the mother tongue may be different from English meaning that some nuances in the spoken language may be lost. **Social interaction takes place in a geographical space which is where the participants get close maintaining psychological distance.** Where a participant is deaf the audio materials play a lesser role in the video consultation.
Examples: Knowledge	**The participants visually and verbally addressed the issue and there was a clear verbal communication exchange(CSA, 2013e). The practitioner asked many questions and the patient responded. There were both emotion and movement elements, but these were less apparent. The conversation was succinct and knowledge-based. This is common in WiC consultations where patients share information about their complaint and the practitioners share information about minor ailments. These questions have a verbal and a nonverbal and visual element and viewing the video images directly the practitioner looks directly at the patient, smiling and encouraging (movement and emotion) the patient to share more information about the history of the presenting complaint.**
Objective conversation	
Definition	The participants take part in a conversation where the focus of the conversation is the facts of the presenting complaint and the purpose of the conversation is to resolve and treat the illness.
Indicators	**Look, watch, listen and hear the conversation attentively, pragmatically and objectively**

	addressing the health consultation. The consultation follows the SOAPier approach making it possible to stay on track acting upon the patient seeing them as object of health care rather than as a person. The patient may see the practitioner as only a healthcare practitioner rather than a person. The participants are may not able to be fully open to what each other are saying.
Differentiation	**Look for a connection in which the patient and/or practitioner have a person-detached viewpoint, this conversation is transactional but there can also be different levels of involvement present or involvement based on different perspectives.** Focus on the participant and their own communication in the video narrative. **Separate and experience the participants as individuals.**
Examples of objective conversations	**The relationship between the practitioner and patients is task-oriented communication. The participants are in a shared interpersonal relationship and there remains an objective distance between them.**
Empathic conversation	
Definition	**The participants' conversation is shared and attentive; the conversation is more people focussed than presenting complaint focused.**
Indicators	**Look, watch, listen and hear the conversation attentively, the participants should be able to be fully open to what each other are saying.**
Differentiation	**Look for a shared and reciprocal relationship, in which the participants have reciprocal levels of intimacy, intensity, directness for example. This may be because the practitioner is engaged and works on equalising the relationship.** Focus on the participant communication in the video narrative. Separate and experience the participants as individuals **Discover whether the participants are engaged and empathic to each other , remember that the practitioner is taught to empathise with the patient**
Examples: empathic conversations	**The participants chatted and shared experiences. There was mirroring of gestural movements and the participants were in natural dialogue.**

Typical situation 1- facilitative practitioner, active patient (in harmony)	
Definition	**A facilitative practitioner is attentive the patient and an active patient responds by actively engaging in the conversation. This situation is in harmony as both participants are appropriately responding to each other.**
Indicators	**The patient's voice is an essential part of the consultation process. whole-person' practice, where the practitioner was open to all of the dimensions of the patient's problems. The concordant approach involves practitioners listening, hearing and supporting patients to understand and agree in partnership about their health status and treatment. Using patient-centred interaction approach, involves understanding the patient's unique illness experience, exploring their Ideas, concerns, expectations, feelings, thought, and the effects of the illness on the patient. Their consultation styles respond to the styles of patient self-presentation with the aim of maximising patient satisfaction and adapt their consultation styles to help resolve tensions. The practitioner aids the patient through information sharing in an appropriate format and the practitioner has an understanding of the kind of involvement needed for decision making, such as responding to patient's concerns. Look, watch, listen and hear for how the tension or harmony emerges along a continuum in the social interaction. The patient and practitioner have corresponding specific behaviour to explorative, listening, and emotional behaviour such as reciprocal eye contact. The practitioner having the patient as the starting point. The practitioner communicates through ways for caring. The patient asks questions in an atmosphere conducive to dialogue, openness, sharing and curiosity.**
Differentiation: Facilitative in tension	A harmonious situation will have a facilitative practitioner and an active patient. **A tension situation would be a passive patient with a facilitative practitioner (no one in the driving seat).**
Example:	**A facilitative practitioner is able to share information with a patient through active listening and empathic responses. The practitioner invited information and listened to patient cues of wellness following up with questions related to the present complaint of chest pain. (CSA, 2013e). All the questions were related to subjective history in the 'SOAP' documentation. The facilitative practitioner and the active patient participant were attentive and engaged and there was shared understanding of the disease process and personal illness.**
Typical situation 2- Directive practitioner, passive patient (in harmony)	
Definition:	The directive practitioner and passive patient in harmony **In the past a directive practitioner and the passive patient in harmony was the expected typical situation, and this video demonstrates such communication. The practitioner directs the consultation in a professional manner. More recently patients have been encouraged to take a lead in their health care and practitioners have been trained to be more facilitative and less directive in a patient centred approached. However, there are situations such as a very ill patient or emergency situation where a more directive approach is appropriate.**
Indicators: Directive in harmony	**Look, watch, listen and hear the conversation attentively, pragmatically and objectively addressing health consultation. The practitioner is directive and the patient is patient in this typical situation. There can be adverse consequences with the lack of patient participation. There are many reasons why the patient may be passive. The practitioner may be very directive and the patient does not feel comfortable participating actively. Most patients want to participate in their consultation but are not sure that are allowed to and often don't know how to. In a consultation where the patient has an emergency condition patients prefer a more directive approach from a practitioner. Where a health condition has long term consequences patients usually like to be involved in shared decision making. Reasons for a more passive and directive patient may include whether the practitioner is more interested in developing their own line of thought or that of the patient's.**
Differentiation: Directive in tension	A harmonious situation will have a directive practitioner and a passive patient. **A tension situation would be an active patient with a directive practitioner (two people in the driving seat).**
Examples:	**The older patient often feels more comfortable with the practitioner taking the lead. However, in a television programme Embarrassing Illnesses on Channel 4, there is an example of a directive practitioner and passive patient in harmony (Channel Four, 2013). The consultation**

	takes place between a young woman with an ear complaint and a young practitioner. Both provide an excellent example of this directive situation on a programme developed specifically to educate TV watchers on health care.
Typical situation 3- Facilitative practitioner, passive patient (in tension)	
Definition:	A facilitative practitioner is attempting to share the conversation with the patient, however the patient is not sharing in the dialogue (maybe they feel this is inappropriately culturally or the patient is too unwell)
Indicators:	Look, watch, listen and hear how practitioner uses their facilitation skills with a patient who does not actively engage with the consultation process and realises a tense situation. The practitioner attempts to share the conversation with the patient and involve them in their health care. They encourage the patient to share their understanding of their illness whilst considering both the disease process and the patients' illness experience. These positions are challenging because the patient may not feel able to participate or that they can say nothing and are not in a position to negotiate. The facilitative practitioner and the directive patient in tension may occur due to many factors including social, political, ethnic, cultural and or educational background.
Differentiation: Facilitative practitioner, passive patient (in tension)	A facilitative practitioner and passive patient are in tension as 'no one is in the driving seat' and the shared goal of the conversation will not be attained. To achieve an harmonious outcome the practitioner may change tack and become more directive
Examples:	The participants raised tone and quality of both their voices expressed frustration. The participants returned repeatedly to their earlier questions and statements in attempts to improve communication. The conversation dynamic moved between an active and passive patient and a directive and facilitative practitioner in tension as the participants tried to find a solution to the problem.
Typical situation 4- Directive practitioner, active patient (in tension)	
Definition:	There is no shared partnership and the practitioner is directive and an active patient finds themselves in a tense situation where a practitioner cannot listen or hear their attempt to share their story The practitioner may want to direct the patients' health care but the patient wants to be actively involved. The practitioner is not listening to the patients wish. The practitioner does not see or hear the patient and maintains control of the content of the narrative. These practitioners think they know what the patient wants and do not realise that patients are different and that they don't automatically understand the disease process and can separate it from their personal illness process.
Indicators:	Look, watch, listen and hear the conversation attentively, pragmatically and objectively addressing health consultation. Complex and dynamic interaction between practitioners and patients involves social, cultural, and ethical considerations. The practitioner does not provide the patient with choice and has strong opinions, they may be unaware of the patient's social space or empowerment needs. The patient's social status, age, ethnic group and gender may conflict with the practitioner. A knowledgeable patient about their condition may threaten the dynamics of a hierarchical relationship The patient may speak actively and loudly, make strong movements to try and force the practitioner to pay attention to them. The practitioner may use direct eye contact to maintain control.
Differentiation- Directive practitioner, active patient (in tension)	**This situation is in tension because 'two people are in the driving seat'.** If the practitioner becomes more facilitative then the situation will become more harmonious
Example: The directive practitioner and active patient in tension	**. The audio and visual conversation included elements of movement, knowledge, and emotion that illustrated some flexibility in the social interaction as the practitioner moved from directive to a more facilitative stance as the patient moved from being in shocked active stance to slightly more active conciliatory stance. The interaction was in tension throughout the consultation as the GP denied his blunder in a directive manner but finally attempted to change the outcome to a more harmonious situation which did nothing to improve the patient experience.**

Type of text	
Narrative text	
Definition:	**A narrative text is one which the reader/viewer/observer understands the elements of the story/consultation but it not integrated into the experience or learning of the reader/viewer/observer.**
Indicators:	**This approach takes place as you follow the communication in the video of a primary-care consultation story. The video narrative illustrates an everyday understanding of the story where the reader and viewer accepts what the video tells and has not reflected on how associations between the different video materials configure to demonstrate shared conversations and dynamic typical situations. Often in the beginning when we are becoming familiar with a consultation we see the narrative as a document, and we do not reflect on the video or make associations between our own, emotion movement and knowledge experiences and the video constructed narrative.**
Differentiation:	At the configuration stage we start to interpret and find meaning/associations within the data **At reconfiguration we start to use the conversation to raise awareness of our current actions and plan to make these different in future.**
Examples:	A viewer understands the elements of the consultation but does not see the experience as anything more than understanding a narrative (or story).
Configured text	
Definition:	A configured text emerges where associations are made between the different social actions and the consultation dynamic. Historically and socially understanding is moulded and formed by personal experiences and are associated and connected by what we have previously learned
Indicators:	**Look and listen while reading and viewing the video without reflecting on the narrative. Are you able to find associations between actions and outcomes?**
Differentiation:	A narrative text lacks associations and deeper understanding **A reconfigured text gives inspiration, insight, recognition, or comprehension that changes our world view of consultation communication for us in our future.**
Example:	**The video stories in this thesis were all configured texts in that the author was able to find meaning and association between the various elements of the conversations/consultations.**
Reconfigured text	
Definition:	**Reconfigured textual consultations demonstrate grounded interactions where sharing experience is reconsidered. The video/consultation materials evoke perceptive, imaginative and conceptual images that evoke combinations of movement such as schematic linearity, emotion through colour and gestures through rhythms and resonances. Knowledge combinations of words and verbal social action such as giggles and smiles express comfort or embarrassment. In this way the video story the text is refigured through an existential and biographical turn.**
Indicators:	**Look, watch, listen and hear the conversation attentively, pragmatically and objectively addressing health consultation. Does the consultation give your insight, understanding or inspiration for your own practice? The reconfigured text has the quality of being understood through our own personal situation in an 'ah ha moment' of sudden realisation, inspiration, insight, recognition, or comprehension that changes our view of consultation communication for us in our future.**
Differentiation: Reconfigured text	**A narrative text has a storyline but we are unable to make connections and associations with that story.** **A configured text makes connections and associations within that story but does not change our own world view.**
Examples:	If you understand the components of the conversations and how they relate to each other and you have thought through how to apply this as new knowledge to practice then you have successfully reconfigured the text.

Appendix 11: A video Lifeworld Approach to Consultation Practice

Bickerton, J., Procter, S., Johnson, B. and Medina, A. (2010) A Video Lifeworld Approach to Consultation Practice: The Relevance of a Socio-Phenomenological Approach. Human Studies, 33(2/3): 157-171.

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RESEARCH PAPER

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

Jane Bickerton · Sue Procter · Barbara Johnson · Angel Medina

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Abstract This article discusses the [development and] use of a video life-world 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 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), narrative (to depict the stories of interactions) and a reflexive mode (to develop shared meaning through a conceptual framework for analysis). The analytic framework is derived from a life-world 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 videoed 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

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Appendix 12: Unscheduled Care

Bickerton, J., Procter, S., Johnson, B. and Medina, A. (2010) Unscheduled care: learning from video-recorded consultations. Emergency nurse : the journal of the RCN Accident and Emergency Nursing Association, 18(5): 20-23

Feature

Unscheduled care: learning from video-recorded consultations

Jane Bickerton and colleagues explain what the conversations and interactions between service users and practitioners reveal about the quality of patient-centred care

Summary

One aspect of the implementation of patient-centred care is the improvement of consultations between service users and practitioners, and this can be done through 'communicative action'. This article explains how observing video recordings of consultations in a walk-in centre can help service users and practitioners better understand each other's conversations and interactions.

Keywords
Communicative action, healthcare consultations

TO IMPLEMENT patient-centred care, clinicians must increase public participation in, and knowledge of, decisions about their care (Department of Health (DH) 2005).

One way to achieve this is through 'communicative action', in which individuals interact and co-ordinate their actions according to agreed interpretations of given situations (Habermas 1986). This can support better understanding of social relations between practitioners and service users.

As Schickler (2005) points out: 'The only way to find what a person thinks, believes and feels about health and illness is to ask them, to have a conversation as one might in everyday life.'

The communicative actions discussed in this article is illustrated in video recordings of consultations between service users and practitioners in an NHS walk-in centre in London.

Analysis of the consultative practice makes use of a recognised body of theoretical writing concerning communicative action (Sartre 1969, Berger and Luckmann 1979, Schutz and Luckmann 1989).

The study of such videos can help consultation participants, for example, develop their awareness of the conversations in, and the dynamics of, their consultations and so enable them to change their behaviours and improve outcomes.

The first NHS nurse-led walk-in centres were opened in 2000 to provide treatment and advice for service users with a wide range of non-urgent, primary care complaints (Coleman *et al* 2001, Salisbury *et al* 2002, Salisbury and Munro 2003). They tend to serve younger or middle aged women and men, who rarely present with chronic health conditions.

Such service users are generally low users of general practice, perhaps because their GPs are difficult to access (Salisbury *et al* 2002).

Procter *et al* (2008) found that more than 40 per cent of GP-registered walk-in centre users had been seen by their doctors but still thought that their health problems were emergencies. Almost the same proportion attended for reassurance and advice.

For the purposes of the author's study, service users and practitioners at the walk-in centre consented to their consultations being video recorded. The author viewed all of the videos and chose two to discuss, with the relevant case studies, in this article.

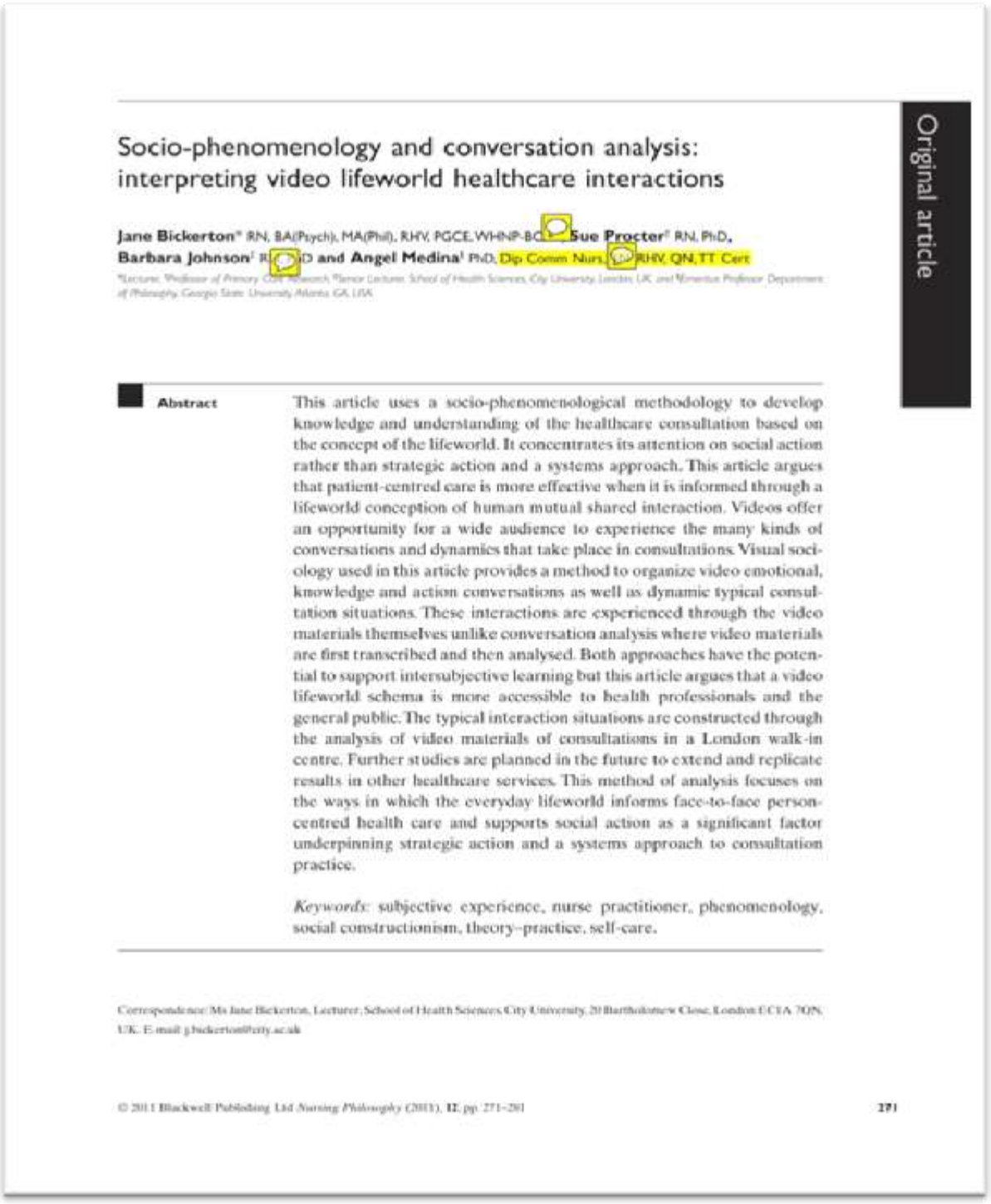
Anyone who views videoed consultations can study how the participants move and express emotion, and try to understand the underlying meaning of what they say. Viewers can then identify which of the three elements of movement, emotion or meaning is dominant in each of the conversations.

Each video should be viewed at least three times so that viewers can:

- Have a sense of the conversation as a whole, without differentiating between the participants' interactions.

Appendix 13: Socio-phenomenology and conversation analysis:

Bickerton, J., Procter, S., Johnson, B. and Medina, A. (2011) Socio-phenomenology and conversation analysis: interpreting video lifeworld healthcare interactions. Nursing Philosophy, 12(4): 271-281.



Original article

Socio-phenomenology and conversation analysis: interpreting video lifeworld healthcare interactions

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Abstract

This article uses a socio-phenomenological methodology to develop knowledge and understanding of the healthcare consultation based on the concept of the lifeworld. It concentrates its attention on social action rather than strategic action and a systems approach. This article argues that patient-centred care is more effective when it is informed through a lifeworld conception of human mutual shared interaction. Videos offer an opportunity for a wide audience to experience the many kinds of conversations and dynamics that take place in consultations. Visual sociology used in this article provides a method to organize video emotional, knowledge and action conversations as well as dynamic typical consultation situations. These interactions are experienced through the video materials themselves unlike conversation analysis where video materials are first transcribed and then analysed. Both approaches have the potential to support intersubjective learning but this article argues that a video lifeworld schema is more accessible to health professionals and the general public. The typical interaction situations are constructed through the analysis of video materials of consultations in a London walk-in centre. Further studies are planned in the future to extend and replicate results in other healthcare services. This method of analysis focuses on the ways in which the everyday lifeworld informs face-to-face person-centred health care and supports social action as a significant factor underpinning strategic action and a systems approach to consultation practice.

Keywords: subjective experience, nurse practitioner, phenomenology, social constructionism, theory–practice, self-care.

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Appendix 14: Streaming primary urgent care: a prospective approach.

Bickerton,J., Davies, J.,Davies, H.,Apau, D.& Procter, S.(2012) Streaming primary urgent care: a prospective approach. Primary Health Care Research & Development, 13 (2): 142-152

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RESEARCH

Streaming primary urgent care: a prospective approach

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Aim: To identify the appropriate service provider attendees of emergency departments (EDs) and walk-in centres (WICs) in North East London and to match this to local service provision and patient choice. **Design:** An anonymous patient survey and a retrospective analysis of a random sample of patient records were performed. A nurse consultant, general practitioner (GP) and pharmacist used the presenting complaints in the patients' records to independently stream the patient to primary care services, non-National Health Services or ED. Statistical analysis of level of agreement was undertaken. A stakeholder focus group reviewed the results. **Subjects and setting:** Adult health consumers attending ED and urgent care services in North East London. **Results:** The health user survey identified younger rather than older users (mean age of 35.6 years – SD 15.5), where 50% had not seen a health professional about their concern, with over 40% unable to obtain a convenient or emergency appointment with their GP. Over a third of the attendees were already receiving treatment and over 40% of these saw their complaint as an emergency. Over half of respondents expected to see a doctor, one-quarter expected to see a nurse and only 1% expected to see a pharmacist across both services, although WICs are nurse-led services. More respondents expected a prescription from a visit to a WIC, whereas in the ED a third of respondents sought health advice or reassurance. **Conclusion:** A number of unscheduled care strategies are, or have just been, developed with the emphasis on moving demand into community-based services. Plurality of services provides service users with a range of alternative access points but can cause duplication of services and repeat attendance. Managing continued increase in emergency and unscheduled care is a challenge. The uncertainties in prospective decision making could be used to inform service development and delivery.

Key words: general practitioner; nurse practitioner; pharmacist; streaming to emergency and urgent primary care; unscheduled care service development and delivery

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Introduction

Increasing demand for urgent care services continues to challenge western health-care provision (Lega and Mengoni, 2008; Scott *et al.*, 2009; Hughes *et al.*, 2011). In the United Kingdom, it is commonly assumed that up to 60% of patients attending emergency departments (EDs) are non-urgent (Audit Commission, 2001; Ya'ish *et al.*, 2007); more recent figures using a standardised definition indicate that between 10% and 30% of cases could be classified as primary care (Carson *et al.*, 2010). In response, the United Kingdom has seen an expansion of unscheduled local care services including the introduction of general practitioner (GP)-led polyclinics/primary care resource centre (Department of Health, 2007a; 2007b), extended GP hours and implementation of urgent care centres (Department of Health, 2008; NHS, 2010;). Recent research indicates that two-thirds of EDs in England have

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Appendix 15: Walk-in-Centre Nursing: The unique nature of walk-in-centre nursing

Bickerton, J. (2010) Walk-in-Centre Nursing: The unique nature of walk-in-centre nursing In Cox, C. and Hill, M. (Eds.) Developing Expertise: Professional Issues in Practice and Walk in Centre Nursing. Wiley & Blackwell.

Part 2: Walk-in Centre Nursing: The unique nature of Walk-in centre nursing

(Jane Bickerton).

The aim of this chapter is to explore the nature of nursing in a NHS Walk-in Centre (WiC) and its relation to first contact primary urgent care nursing in the United Kingdom (UK). The chapter will explore the main areas of responsibilities of the WiC practitioner, as well as the role of management in a nurse-led service. WiCs over the past decade have offered a unique opportunity for experienced nurses to develop clinical skills for the completion of a complete episode of patient care, including diagnosis and treatment. In the primary care setting this opportunity was previously associated with General Practitioners (GPs). A nurse-led setting also provides an opportunity to develop leadership skills along with clinical skills in corporate management. The educational and training needs of nurses in this context will be discussed and, after an overview of the WiC nurse alongside the first contact practitioner in the urgent care, the chapter will consider if these services are meeting goals set by an NHS patient-led service.

The learning outcomes of this chapter include the following points:

- To identify and examine the role of the WiC nurse
- To critically explore and evaluate how the role of the WiC nurse is being influenced by the changing primary urgent care environment
- To examine educational and training needs for WiC nurses developing autonomous primary care practitioners skills in practice
- To explore professional issues concerning corporate leadership and management in a nurse-led service
- To consider patient-led NHS consumers and their evaluations of health care in the nurse-led WiC setting.

Introduction and Background

NHS WiCs were set up as nurse-led primary care health services at the beginning of the millennium to complement GP primary care services. Nearly a decade on there has been a rapid expansion of WiCs that have become part of a growing variety of primary care and first contact services for health care that are an alternative form of care from the GP general practice. A single WiC provides more than 36,000 consultations each year (DH, 2006)

When WiCs first opened in 2000, the aim was to provide primary care to health consumers whose lifestyles prevented them from easy access to a GP near their home.

Appendix 16: Walk-in Centre Nursing: The use of theory and research to inform practice

Bickerton, J. (2010) Walk-in Centre Nursing: The use of theory and research to inform practice In Cox, C. and Hill, M. (Eds.) Developing Expertise: Professional Issues in Practice and Walk in Centre Nursing. Wiley & Blackwell.

DOMAIN FIVE: THE PROFESSIONAL ROLE
CHAPTER 10 USE OF THEORY AND RESEARCH EVIDENCE TO INFORM PRACTICE

The aim of this chapter is to explore the effective use of evidence-based practice (EBP) and identify the kinds of activities and approaches that could encourage the active use of this process by nurse clinicians in clinical practice, such as Practice Nurses (PN) and Walk-in-Centre (WiC) nurses. The new autonomous practitioner expanded roles sitting between nursing and medicine are being shaped by the dominant managerial, professional and medical discourses (Aranda and Jones, 2008). These approaches may undermine the ontological and epistemological nursing approaches to caring and are likely to be task driven and emphasise a standardised approach to healthcare (Malone, 2003). The application of theory and evidence-based practice to direct care can challenge this practice. Acquiring evidence allows the WiC nurse and PN to develop and implement the advanced nursing professional role as well as provide examples of evidence of the professional domains of practice that meet the Knowledge and Skills Framework (KSF) (DH, 2004). The information and knowledge dimensions of evidence in particular require the practitioner to have the knowledge and skills to acquire, organise, provide and use knowledge and information. The practitioners provide examples of application in practice to meet the domains of practice and one such example might be qualitative and quantitative research (NMC, 2006; RCN, 2008).

The learning outcomes of this chapter are:

- To understand the professional role of first contact nurse in a WiC and the PN as it relates to EBP;
- To assess how qualitative and quantitative theory and research are used to support evidence based practice;
- To consider the role of research and audit on the care of patients accessing first contact and long term condition health care;
- To identify evidence based research and theory and its use in the WiC and general practice setting;
- To consider the role of EBP in a patient-centred and patient-led health service.

Introduction and background

"Health care that is evidence-based and conducted in a caring context leads to better clinical decisions and patient outcomes." (Fineout-Overholt et al; 2005:335)

EBP is concerned with changing clinical practice to improve patient care. It is a flexible, dynamic and a non-linear approach to health care practice (Levin and Feldman, 2006). EBP evolved out of Evidence Based Medicine (EBM) introduced by Dr Archie Cochrane in 1972 and was further developed through the Cochrane Collaboration in 1993 (Cody, 2006). In order to provide best evidence based practice it requires the following elements: