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HOW DOES THAT MAKE YOU FEEL?:
AN EXPLORATION OF WINDOWS OF OPPORTUNITY DURING THE
PRIMARY CARE VISIT

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the
Graduate School of The Ohio State University

By

Thirzie Leola McClure, B.S., M.Ed.

*****

The Ohio State University
2001

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ABSTRACT

The physician-patient relationship has been described as one of the most complex interpersonal relationships. It is within the medical consultation that information is exchanged and decisions regarding treatment are negotiated between physician and patient. Effective communication about illness and treatment contributes to patients' feelings of being cared for as people and enhances their perceptions of affective care. The inclusion of affective behaviors in the medical consultation may not only offer a healing potential for the patient, but it may also lead to the reduced consumption of medical resources. Evidence suggests that a patient's willingness to adhere to medical recommendations might be increased if the physician is sensitive to the patient's needs as a person, communicates caring, and develops rapport with the patient.
Additionally, the way in which the physician communicates relationally has implications for issues such as trust, loyalty, and respect within the physician-patient relationship.

Patients express negative affect during the medical visit and create windows of opportunity for physicians to respond to these expressions. There exists within this discourse context a limited opportunity for the physician to respond to the patient's expression of emotion. The manner in which the physician responds to the patient's initiation is crucial to how the remainder of the interaction will proceed.

This study focused on patients' expression of negative affect during the medical visits as well as physician response to these expressions. Participants included 150 primary care patients and 25 physicians at nine different medical facilities in and around a large Midwestern metropolitan area. Each physician was audiotaped with six patients.

The results indicate that patients were explicit in their expressions of negative affect. Patients often used preparatory remarks to signal that a window of opportunity was being presented. Contrary to reports in the literature that physicians
responded to negative expressions regarding medical topics. Physicians in the sample were less responsive to expressions about psychosocial issues. Physicians most often provided information in their responses.
Dedicated to my mother, my friend
ACKNOWLEDGMENTS

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Chapter 1

INTRODUCTION

The physician-patient relationship has been described as one of the most complex interpersonal relationships (Chaitchik, Kreitler, Shaked, Schwartz, & Rosin, 1992; Ong, De Haes, Hoos, & Lammes, 1995). Roter, Hall, and Katz (1987) assert that the medical consultation affords the physician a "powerful, sensitive, and versatile instrument for patient assessment and treatment" (p. 399). Studies have shown that the interpersonal communication between physicians and patients plays an important role in the delivery of quality health care (Beisecker, 1990; Greenfield, Kaplan, & Ware, 1985; Hall, Roter, & Katz, 1988; Korsch, 1989; Roter, Hall, & Katz, 1988; Thompson, 1984; Waitzkin, 1985).
It is within the medical consultation that information is exchanged and decisions regarding treatment are negotiated between physician and patient (Street, 1992). The ability to communicate effectively with patients resulting in a good interpersonal relationship can be regarded as a prerequisite for optimal medical care (Ong, DeHaes, Hoos, & Lammes, 1995); however, it is a skill that many physicians lack (Ford, Fallowfield, & Lewis, 1996).

The quality of the interpersonal relationship between physicians and patients has implications for other aspects of the medical environment. Patients' perceptions of the physician-patient relationship are important antecedents to their commitment to the physician, their decision to turn to nonmedical healers, and even their willingness to institute malpractice litigation against physicians (Bartlett, et al., 1984; Beckman, et al., 1994; Buller & Buller, 1987; Buller & Street, 1991; DiMatteo & Hayes, 1980; Hall & Dornan, 1988). Additionally, Joos, Hickman, and Borders (1993) assert that patients who are more satisfied with their care are also more likely to comply with treatment recommendations.
Instrumental Versus Affective Behaviors

Researchers in physician-patient communication make an important distinction between two types of behaviors exhibited during the medical consultation (Bensing, 1991; Ben-Sira, 1976, 1984, 1985; Bloom, 1963; Cegala, Coleman, & Turner, 1998; DiMatteo & Hayes, 1980; Ong, et al., 1995; Roter, Hall, & Katz, 1987; 1988). In 1963, Bloom labeled these two domains of behavior the "instrumental dimension," which emphasizes the technical aspects of the physician's treatment of the patient, and the "expressive dimension," which emphasizes the affective or socioemotional aspects of the physician-patient interaction. The instrumental domain belongs to the cognitive, while the socioemotional belongs to the emotional domain of the human psyche (Hall, Roter, & Katz, 1987).

Ong and colleagues (1995) describe the instrumental and the affective domains of the physician-patient relationship as "cure-oriented" and "care-oriented," respectively. The cure-oriented behaviors are included in the instrumental or task-focused domain,
while care-oriented behaviors fit into the affective or socioemotional domain. These domains reflect the patients' need for both cure and care during the medical consultation. The patient has the need to know and understand (cure) as well as the need to feel known and understood by the physician (care). The feeling of being understood by another person is intrinsically therapeutic in that it establishes a sense of connectedness that patients need to feel whole (Suchman, Markakis, Beckman, & Frankel, 1997). Both instrumental and affective behaviors are recognized as essential in physician-patient communication and correspond to the two main communicative purposes of the medical consultation: information exchange and relational development (Bensing, 1991; Cegala, 1997; Cegala, McGee, & McNeilis, 1996).

**Instrumental Dimension**

There is a general consensus in the literature regarding the conceptualization of what has been termed the instrumental or task-focused domain. Instrumental behaviors include giving information, asking questions, counseling, giving directions (Hall, Roter, & Katz,
perceptions of technical competence (DiMatteo & Hayes, 1980; Roter, 1989); data-gathering and proficiency (Roter, Hall, & Katz, 1987); quality and efficacy of treatment (Ben-Sira, 1980; 1985); discussing test results, identifying future treatments or tests, discussing side effects of current treatments or tests, discussing prognosis (Blanchard, et al., 1983); and explaining reasons for treatment or nontreatment (Siminoff, Fetting, & Abeloff, 1989).

**Affective Dimension**

While there is reasonable agreement among researchers regarding the components of the instrumental domain of the physician-patient relationship, affective behaviors, on the other hand, have not been so systematically conceptualized or measured. Buller and Buller (1987) describe the affective domain as including behaviors that are designed to establish and maintain a positive relationship between the physician and the patient. These behaviors include those which communicate "interest, friendliness, empathy, warmth, genuineness, candor, honesty, compassion, a desire to help,
devotion, sympathy, authenticity, a nonjudgmental attitude, humor, and a social orientation" (p. 376). Other researchers have conceptualized affect as behaviors by the physician that view the patient as a person rather than a case (Ben-Sira, 1976, 1980, 1985; DiMatteo & Hayes, 1980). This behavior involves showing interest in the patient's personal, family, and social issues and concerns as well as being tolerant of his or her behavior as an anxiety-laden individual and not simply as a detached instrumental object (Ben-Sira, 1985). Similarly, DiMatteo (1979) defines affective communication as a kindness and concern that communicates to the patient the he or she is cared for as a person. DiMatteo characterizes the physician's ability to satisfy the patient's socioemotional needs as physician "rapport."

Blanchard and colleagues (1983) conceptualize affective behavior as the physician's bedside manner or interpersonal skills, which Ford, Fallowfield, and Lewis (1996) believe involves showing concern and giving reassurances. A similar conceptualization
describes physicians' behavior that demonstrates a willingness to listen to the patients' concern (Wolfe, Putnam, James, & Stiles, 1978).

Roter, Hall, & Katz, perhaps the most prolific researchers in the area of physician and patient communication of affect, define affective behaviors differently than most other researchers. These investigators believe affect can be communicated in various ways during the medical consultation (Hall, Roter, & Katz, 1987, 1988; Hall, Roter, & Rand, 1981; Roter, 1984, 1989; Roter & Hall, 1989; Roter, Hall, & Katz, 1987). First, certain verbal categories can be considered intrinsically affective. *Intrinsic* affect refers to verbal statements that have positive socioemotional content. These may include personal remarks, statements of agreement or approval, and laughing and joking. Second, *conveyed* affect refers to emotion carried through the manner of expression. Voice quality and other nonverbal cues can convey affect. Finally, the *interpreted*, or attributed level of affect reflects the total impression the receiver takes from the interaction. At this level, the sheer fact of engaging
in certain activities can, because of the patient’s interpretation, carry affective significance that the activities do not intrinsically possess or that is conveyed through the manner of expression.

In addition to the numerous behavioral components of the affective domain, a variety of terms have been used to refer to this aspect of physician-patient communication including humanistic, relational, socioemotional, and psychosocial. While these terms carry distinctions in definition, they are all used to describe that part of physician-patient communication not attributed to technical or medical discourse, but rather to the affective aspects of the relationship.

A review of the literature demonstrates that much of the research focus in physician-patient communication has been in the instrumental or task-oriented domain, especially the information exchange behaviors of physicians and patients (Ong, et al., 1995). The affective or socioemotional domain is less developed and needs additional research (Bensing, 1991; Ong, et al., 1995).
The focus of the current research is within the affective domain of the physician-patient relationship. The study examines patients' expression of negative affect during the medical consultation. Negative affect is defined as the expression of worry, concern, anger, tension, or anxiety. The study also investigates physicians' response to such expressions. There is evidence that affective behaviors influence patient illness and disease recovery (Bensing, 1991; Ben-Sira, 1984; White, 1988). How the physician responds to patient expressions of negative affect during the visit may help or hinder that recovery. To more fully address this issue, researchers must determine the extent to which expressions of negative affect are present in the medical consultation as well as the types of responses offered by the physician. Physician response could then be examined to determine which types of responses are most appropriate to achieve the highest quality patient health outcomes. This study is a first step toward that goal.

Chapter Two contains a literature review of the models of physician-patient interaction with particular emphasis on contrasting the biomedical and biopsychosocial perspectives of
medial care. Following these comparisons, there is a discussion of psychosocial behaviors within the medical consultation. The chapter also accents the importance of interactivity when studying human behavior and points out the lack of this focus in previous studies about physician-patient communication. The concept of windows of opportunity within the medical visit is introduced and explicated. Finally, the research questions with accompanying rationales are presented.

Chapter Three contains an explanation of the methods used in the study, while chapter Four contains the results of the data analysis.

Chapter Five provides a summary of the major results as well as conceptual and practical implications of the findings. It also discusses the limitations of the study. The chapter concludes by offering future direction for continued study examining the affective behaviors of physicians and patients.
Chapter 2

RATIONALE AND RESEARCH QUESTIONS

Models of Physician-Patient Interaction

Numerous models of communication have been developed in an attempt to explain the dynamic involved in the physician-patient relationship. Emanuel and Emanuel (1992) present four models of the physician-patient relationship including the paternalistic, informative, interpretive, and deliberative. The models were developed not to describe any particular physician-patient interaction but rather to highlight "different visions of the essential characteristics of the physician-patient interaction" (p.2221). The four models encompass many of the concepts proposed by previous
authors (Balint, 1957; Becker, 1976; Becker, et al., 1979; Engel, 1957; Parsons, 1951; Perry, 1993; & Szaaz and Hollender, 1987) and serve as a good summary of this work.

The paternalistic model is sometimes referred to as the authoritarian, parental, or priestly model. In this model, the physician first determines the patient's medical condition and stage in the disease process, then identifies the medical tests and treatments most likely to restore the patient's health. At the extreme, the physician authoritatively informs the patient what medical treatment will be administered and when it will begin. In the paternalistic model, the physician behaves as a guardian to the patient, articulating and implementing what he or she deems is best for the patient.

In the informative model, the physician provides the patient with all relevant information for the patient to select the medical interventions he or she wants and the physician then provides the selected treatments. At the extreme, patients could come to know all the medical information relevant to their disease and available interventions and select the one that they feel is best. In the
informative model, the physician furnishes the technical expertise, providing the patient with the means to exercise control over treatment.

The physician-patient interaction within the interpretive model has as its goal to make clear the patient’s values and what he or she wants. The physician helps the patient select an intervention that is within the patient’s values. According to the model, the patient’s values are not always fixed or known to the patient. Therefore, the physician facilitates the explication of those values and what treatments best realize the specified values. In the interpretive model, the physician acts as a counselor who supplies relevant information and helps to translate values. Only then does the physician suggest what medical interventions might be appropriate.

In the deliberative model, the physician and patient work together to determine the best health-related values that can be realized in the clinical situation. The physician’s objectives include suggesting why certain health-related values are more worthy and
should be pursued. In the deliberative model, the physician acts as a teacher or friend, encouraging the patient to talk about what treatment would be best.

Using these models as a guide, Roter and colleagues (1997) analyzed 537 physician-patient interactions and found that the most common pattern of communication was the narrowly biomedical pattern type, which is akin to Emanuel and Emanuel's paternalistic model. These behaviors occurred in approximately one-third of the visits. Biopsychosocial (interpretive) communication patterns were present in 20% of visits, while psychosocial (deliberative) and consumerist (informative) patterns were used the least, accounting for less than 10% of the visits each.¹

The researchers also found an additional communication model which they termed expanded biomedical. This pattern is similar to the narrowly biomedical pattern in terms of the high occurrence of physician question-asking behavior. However, there

¹It should be noted that the data used for this analysis was gathered in the mid-1980's and as such may not be representative of today's medical environment.
are more moderate levels of biomedical and psychosocial behaviors for both patients and physicians. The expanded biomedical pattern was present in about one-third of the physician-patient encounters.

There has been little consensus about the superiority of any one model of the physician-patient interaction (Roter, et al., 1997). Much of the debate has surrounded the paradigm shift from a more paternalistic view toward one in which both physician and patient participate in the interaction (Roter, et al., 1997; Perry, 1993; Smith, 1989). Perry (1993) suggests that rather than view the models as specific alternatives existing in pure form, they should be seen as points on a continuum.

The last three decades have witnessed a shift in research focus from the biomedical view of health care to a more patient-centered, biopsychosocial perspective (Ong, et al., 1995). Derived from molecular biology, the biomedical approach assumes that disease can be fully accounted for by deviations from norms of measurable biological processes (Novack, 1981; Silverman, et al., 1983). The biomedical approach thus views health simply as the absence of disease (Shannon, 1989). This approach excludes the importance of
subjective information which patients can provide regarding their illness on the basis that this detail is not measurable or objective (Engel, 1997).

Recognizing that there is more to the experience of illness than is explained by the manifestation of disease, Engel (1977) proposed the biopsychosocial perspective which provides a conceptual framework conducive to accommodating the human domain. Explicit attention to humanness makes the biopsychosocial view of the patient more complete and inclusive than the biomedical approach (Engel, 1997). Based on general systems theory, the biopsychosocial perspective allows the physician to consider the possible relationships between illness and the various levels of the systems hierarchy (cell, tissue, organ, individual, family, group, community, society). Therefore, this perspective incorporates the subjective as well as the objective aspects of illness (Perry, 1993). That is, the biopsychosocial perspective is seen as an interplay between environment, physical, behavioral, psychological, and social factors (Shannon, 1989).
Medical professionals have typically relied upon the biomedical approach to shape interactions between physicians and patients. The dominance of the biomedical approach in medical practice causes the physician to view the patient's emotional state as an outcome of the disease, which will naturally be alleviated upon recovery from the illness (Silverman, et al., 1983). While the biomedical approach emphasizes the physical symptoms of illness, it rejects the therapeutic importance of the physician's attention to the patient's psychosocial issues (Ben-Sira, 1985).

It is generally accepted by researchers and physicians alike that the biomedical approach's exclusive focus on the patient's somatic condition is too narrow (Forde, 1996). Primary care physicians are often confronted with complex illnesses that require them to go beyond a biomedical view of the patient (Like & Reeb, 1984). However, research suggests that the biomedical approach continues to dominate medical practice (Roter, et al., 1997). This dominance and the need for a more biopsychosocial perspective is witnessed in patient complaints about medical care (Engel, 1978). Patients complain that physicians don't communicate well, that they
don't listen, that they seem insensitive to personal needs, and that they neglect the person in the pursuit of diagnosis and treatment. These criticisms could be addressed through the physician's attention to patients' affective concerns during the medical encounter.

Kosa and Robertson (1969) argue that since medical treatment rarely gives immediate relief of the physical disturbance, physicians' activities should be accompanied by affective behaviors aimed at reducing the patient's anxiety. Ideally, good medical practice would follow a biopsychosocial perspective where there is attention to a patient's social and emotional problems as well as to the physical ailments (MacWhinney, 1989).

While the biomedical approach may be appropriate for many acute conditions, it is inadequate for the treatment of chronic illnesses that are naturally accompanied by social, family, and behavioral stressors. With the aging of America, the treatment of chronic illness is increasingly becoming more prominent in medical care. This increase echoes the need to incorporate the biopsychosocial perspective into everyday medical practice.
Affective Behaviors

Ben-Sira (1976) argued that the manifest goal of the patient to have his/her illness problem solved is most often accompanied by a latent goal of having his/her anxiety problem solved. Studies indicate that as many as 50 percent of all visits to primary care providers involve affective behaviors (Campbell, Neikirk, & Hosokawa, 1990; Katon, Williamson, & Ries, 1981; Novack, 1981; Verhaak & Wennick, 1990; Von Korff, et al., 1987); however, these matters are often ignored and little research has examined the effects of affective discourse on patient health outcomes. Roter and colleagues (1995) report that between 30 and 40 percent of primary care patients screen positive for significant levels of emotional distress. Despite the high prevalence of emotional distress, these aspects often go unrecognized during routine office visits with primary care physicians, especially if the reason for the visit is a physical complaint (Bridges & Goldberg, 1985).
Affective behaviors have been described as the receptiveness for and treatment of non-somatic aspects of the patients' health (Arborelius & Osterberg, 1995; Bensing, 1991). Levinson and Roter (1995) define affective discourse as including discussion about the feelings and emotions and social relations of the patient. This definition parallels Ben-Sira's (1985) description of affect in which the physician shows interest in the patient's personal, family, and social concerns.

There is growing insight that affective behaviors influence the development and severity of almost every disease as well as the recovery and even survival of many patients (Bensing, 1991; Ben-Sira, 1984; White, 1988). However, the implications from knowledge gained through research in this area are rarely translated into everyday medical practice (Bensing, 1991). According to Novack (1981), most physicians completing a medicine residency possess superior knowledge and skills in physical and laboratory diagnosis; however, these physicians are ill equipped to handle the affective components of the patient's illness. Like and Reeb (1984) suggest that medical students should be exposed to the
biopsychosocial perspective early in their training so that they will be better able to incorporate this type of communication into their interactions with patients.

**Importance of Physician Attention to Affective Behaviors**

Early research in physician-patient communication demonstrated that the outcome of the medical consultation was positively influenced by whether the physician was friendly and engaged in general conversation that was non-medical (Freeman, Negrete, Davis, & Korsch, 1971). It has been shown that effective communication about illness and treatment contributes to patients' feelings of being cared for as people and enhances their perceptions of affective and socioemotional care (Bloom, 1963).

The inclusion of affective behaviors in the medical consultation may not only offer a healing potential for the patient, but it may also lead to the reduced consumption of medical resources (Forde, 1996). Evidence suggests that a patient's willingness to adhere to medical recommendations might be increased if the physician is sensitive to the patient's needs as a
person, communicates caring, and develops rapport with the patient (Rodin & Janis, 1979). Additionally, the way in which the physician communicates relationally has implications for issues such as trust, loyalty, and respect within the physician-patient relationship (Cegala, McGee, & McNeilis, 1996).

The physician's attitude toward affective expressions during the visit also influences the patient's satisfaction with care (Bertakis, 1991; DiMatteo, Taranta, Friedman, & Prince, 1980; Stiles, Putnam, Wolfe, & James, 1979). Bertakis and colleagues (1991) found that when the discussions in the medical consultation included affective issues, patients reported being more satisfied with the visit than when the conversation was strictly about biomedical topics. In a meta-analysis of 106 studies, Hall and Dornan (1988) report that of the 11 aspects of satisfaction with medical care examined, patients were least satisfied with the physicians' attention to affective expressions. Even when the resolution of a technical aspect of the physician-patient encounter might appear to be the most important decision to the end result of medical care (e.g. treatment X instead of treatment Y), effective communication within the affective
domain may still be an important component of the perceived success of the interaction from both participants' perspectives (Inui & Carter, 1985). In studying affective behaviors, researchers can gain insight into the influence of this communicative domain on patient behavior and patient health outcomes (Roter & Hall, 1992).

Expression of Negative Affect

Parsons (1951) argued that illness is invariably accompanied by strain and emotional disturbance due to the patient's suffering, inability to cope with the situation, and uncertainty with regard to the outcome. The General Health Questionnaire defines emotional problems as anxiety, depression, mood changes, nerves, stress, tension, problematic living arrangements, work, family problems, family health, death in family, and need for support or reassurance (Roter, et al., 1995). Patients express these emotional problems through their affective behaviors during the medical consultation.

Behaviors within the affective domain have been defined in various ways by different researchers. Some researchers make distinctions between positive and negative affect. Positive affective
has been defined as the demonstration of caring and concern, warmth, and positive feelings (DiMatteo, Prince, & Taranta, 1979); giving assurances, agreements, approval, and compliments (Ford, Fallowfield, & Lewis, 1996); sympathy, friendly rapport, and encouragement (Roter & Hall, 1989). Negative affect has been defined as anxiety and frustration (Dungal, 1978); disagreements and criticisms (Ford, Fallowfield, & Lewis, 1996); anger, irritation, and tension (Roter & Hall, 1989).

As early as Hippocrates' time it was recognized that the physician's ability to detect and to respond to a patient's expressed needs and anxieties could significantly impact the course of the patient's recovery (DiMatteo, 1979). Additionally, tension has been shown to negatively affect patient compliance (Heszen-Klemens & Lapinska, 1984). For these reasons it is important to examine how physicians respond to patients' expressions of negative affect during the medical visit.
Communication as Interactional

Most studies that have examined affective behaviors during the medical consultation have focused exclusively on one participant, usually the physician (Ben-Sira, 1985; Blanchard, et al., 1983; Hall, Roter, & Katz, 1987, 1988; Hauck, Zyzanski, Alemango, & Medalize, 1990; Levinson & Roter, 1995). Other studies have focused on the patients' perceptions of the physicians' affect (Ben-Sira, 1976; 1980; DiMatteo & Hayes, 1980). Some studies have based their findings on the perceptions of the participants rather than actual recordings of the physician-patient interaction (Ben-Sira, 1976, 1980, 1985; Blanchard, et al., 1983; DiMatteo & Hayes, 1980; Dungal, 1978). At other times, decisions regarding affect were made exclusively by third party raters and coders (Bensing, 1991; Blanchard, et al., 1983; Ford, Fallowfield, & Lewis, 1996; Hall, Roter, & Rand, 1981; Levinson & Roter, 1995; Roter, 1984). Only one study examined both the physicians' and the patients' affective behavior (Hall, Roter, & Rand, 1981). Although the affective domain was explored for both participants, the analyses of their
behavior were performed independently. That is, the physician and patient were treated not as interactants in the medical consultation, but rather as individuals acting independently of one another.

Although there appear to be numerous variations in both the conceptualization and operationalization of affective behavior during the medical consultation, what is of greater concern is that attention has been paid to only one participant in the encounter. Analyses that focus only on one participant neglect one half of the communicative contributions to that exchange. Additionally, analyses of this nature ignore the influence of one participant's expressions upon the other participant's subsequent talk. If communication is viewed as interactional, it is critical that studies be conducted that examine the discourse between physician and patient with this communicative interactivity as a central thrust of the analysis. In this manner, we would examine not only what the patient says, but also how the physician responds to what is said and how this response impacts or influences the remainder of the encounter.
Studies indicate that physicians and patients agree that the responsibility for relational maintenance is assumed to lie with the physician (Cegala, McGee, & McNeilis, 1996). What appears to be most important within this interaction is the ability of the physician to identify which statements of patient affect should be more fully discussed and explored to give the patient an overall feeling of being cared for as an individual.

Windows of Opportunity

"It is our duty (as physicians) to remember at all times and anew that medicine is not only a science, but also the art of letting our own individuality interact with the individuality of the patient" (A. Schweitzer in Strauss, 1968, p. 361). Studies have shown that patients want to talk about social, emotional, and family issues in addition to the biomedical topics during the medical consultation (Bertakis, 1991; Bloom, 1963; Campbell, Neikirk, & Hosokawa, 1990; Katon, Williamson, & Ries, 1981; Verhaak & Wennick, 1990; Von Korff, et al., 1987). Some patients will introduce these topics
explicitly into the conversation. Other patients will indirectly make reference to a psychosocial issue in hopes that the physician will realize the patient's desire to discuss the emotion further. In either case, there exists within this discourse context a limited opportunity for the physician to respond to the patient's expression of emotion. If the physician does not take advantage of the opportunity afforded by the patient, the opportunity may often be lost, never to be revisited. Therefore, the manner in which the physician responds to the patient's initiation is crucial to how the remainder of the interaction will proceed (Dungal, 1978).

Branch and Malik (1993) analyzed videotapes of five seasoned clinicians to examine how these professionals reacted to and dealt with patients' expressions of emotion during the medical encounter. Since instances in which patients discussed their psychosocial concerns stood out from the rest of the consultation, the authors termed these interactions "windows of opportunity." The researchers observed that by paying attention to these windows, the
experienced clinicians were able to address the patients' expression of emotion in a brief manner. Additionally, the patients seemed satisfied that they were able to adequately express themselves.

Building on the work of Branch and Malik, Suchman and colleagues (1997) undertook a descriptive, qualitative examination of verbal exchanges during medical visits with primary care providers. The goal was to identify patients' direct and indirect expressions of affect and to examine the physician's level of empathic response to the patient. The authors define empathy as comprising two essential components: cognitive and behavioral. These components encompass the "accurate understanding of the patient's feelings by the clinician and the effective communication of that understanding back to the patient so that the patient feels understood" (p. 678). This definition of empathy parallels the description of the patient's need for both cure and care during the medical encounter (Ong, et al., 1995).

The authors used an iterative, consensus-based review process to evaluate 11 transcripts and 12 videotapes of primary care medical encounters. The result of this procedure was a descriptive
classification of patient initiation of and physician response to affect in the medical consultation. The authors first identified within the physician and patient's conversation an empathic opportunity or potential empathic opportunity. An *empathic opportunity* is described as an explicit expression of emotion by the patient. This is in contrast to instances where the patient brings up an emotion indirectly and the physician must infer underlying emotions from the patient's statement. This indirect expression of emotion is labeled a *potential empathic opportunity* because the potential for exploration of the emotions exists only if the physician recognizes the patient's covert initiation.

Once an empathic or potential empathic opportunity had been identified, the researchers examined the physician's response to the patient. At this point in the consultation, the physician must decide how to respond to the opportunity. The physician could explicitly acknowledge the patient's emotion. This action was labeled an *empathic response* to show that the physician had in fact responded to the patient's demonstration of emotion. The physician
could also chose to ignore the patient's direct statement of emotion. The authors classified this reaction as a *missed empathic opportunity* to show that the emotion went unacknowledged.

When faced with an indirect display of emotion, the physician could ask the patient to elaborate using a continuer such as "I see" or "go on." This invitation for elaboration of the emotion is classified as a *potential empathic opportunity continuer*. Finally, with either explicitly or implicitly expressed emotions, the physician can ignore the patient's statement and redirect the conversation back to biomedical topics. These instances were classified as *empathic opportunity terminators* and *potential empathic opportunity terminators*.

Applying these concepts and subsequent analysis, the authors found that physicians frequently did not acknowledge the opportunities to discuss emotions initiated by patients' explicit or implicit expressions. Rather, the physicians returned the discussion to the preceding topic which most often in this study was the diagnostic exploration of symptoms.
The authors assert that when affective expressions go unrecognized and unexplored, both the patient and the physician lose. The patient feels as if the physician is uncaring because he or she does not take the time to discuss issues that are not within the biomedical framework. The physician feels unappreciated for doing what he or she was trained to do (i.e., pursue diagnostic assessment and treatment). In this situation, both the physician and patient are victimized by a model of medical practice that is too narrowly focused on the biology of the disease rather than on the experience of illness (Suchman, et al., 1997).

Through their classification of patient expressions, Suchman and colleagues (1997) added needed systematic analysis to the research on affect. However, there are limitations of the authors' assessment of physicians' behavior using this analysis of empathic communication. First, although the study examines instances where the patient express affect, the authors do not identify the topic of the expression. The question still remains as to what particular types of emotions patients want to explore. While researchers assert that patients want to discuss affective issues (Campbell,
Neikirk, & Hosokawa, 1990; Katon, Williamson, & Ries, 1981; Novack, 1981; Roter, et al., 1995; Verhaak & Wennick, 1990; Von Korff, et al., 1987), there has been no systematic categorization of these topics.

A second limitation of this study is the description of physician response. The researchers identify whether the physician responds to the patient's expression of emotion; however, they do not indicate the type of response given. While it is important to know whether physicians respond or terminate expressions, it is also necessary to know what types of responses are provided the patient. For example, does the physician respond by offering understanding, reassurance, or information? This type of information may have implications for physician communication skills training.
Research Questions

This study investigates patient demonstration of negative affect during the medical consultation. The goal is to classify patient initiation of and physician response to windows of opportunity to explore expressions of negative affect (hereafter referred to as windows of opportunity). The study examines research questions in the following areas: (1) patient initiation and (2) physician response.

Patient Initiation

Studies report that as many as 50% of all medical visits involve affective behaviors (Campbell, Neikirk, & Hosokawa, 1990; Katon, Williamson, & Ries, 1981; Novack, 1981; Verhaak & Wennick, 1990; Von Korff, et al., 1987). It is unclear, however, what specific criteria were utilized for identifying physician-patient interactions as reported in these findings. The windows of opportunity included in this analysis may be tied to the patient's medical condition. However, the expression of negative affect goes beyond the physical
aspects to how the patient deals with the problem or how the condition influences the patient's work, family, or social life. Additionally, the current study laid out specific criteria for dyads to be included in the analysis. First, the windows of opportunity must be initiated by the patient. In some medical visits, physicians rather than patients are the ones who introduce conversations about the patients' emotions or emotional state. These instances are not examined in this analysis. The second criterion is that the expression of negative affect within the window must be current. That is, the patient is presently experiencing the emotion. Dyads in which the patient is recounting an instance of having been concerned, worried, or anxious about a previous matter are not included in the analysis. Finally, the reason for the visit cannot be affective in nature. The physician cannot be anticipating that the patient will want to discuss certain issues due to the stated or written reason for the encounter. With these criteria in place, the first research question examines the frequency and characteristics of windows of opportunity within the sample of 150 physician-patient medical consultations.
RQ1: To what extent do physician-patient dyads evidence window of opportunity discourse?

Physician Response

When patients initiate a window of opportunity during the medical consultation, physicians can either respond to or ignore the expression. The physician response to the patient's window can impact the remainder of the interaction. For this reason, it is important to examine whether physicians respond to patient's explicit and implicit expressions of negative affect. Additionally, it needs to be determined to what types of windows physicians respond. For example, do physicians respond more often to expressions about family concerns, behavioral issues, or work matters? Finally, studies must explore the types of responses physicians offer their patients who have initiated windows during the visit. The following research questions were formulated to examine these areas of the physician response to patients' windows of opportunity during the medical consultation:
RQ2: To what extent do physicians respond to patients' windows of opportunity during the medical consultation?

RQ3: Does physician response vary according to the directness of the patient?

RQ4: To what types of expressions of negative affect do physicians respond?

RQ5: What are the circumstances under which patients initiate subsequent windows of opportunity?

RQ6: Does the inclusion of patient preparatory comments make a difference in securing a physician response?

RQ7: What types of responses do physicians offer their patients?
Chapter 3

METHOD

The current study is part of a larger investigation of physician-patient communication funded by The Agency for Health Care Policy and Research. The purpose of the larger study was to test the effectiveness of a training booklet designed to enhance patients' communication skills. The data were collected from July 1997 to November 1997. This chapter describes the study design as well as the discourse coding system.

Participants

Participants for the study included 25 family practice physicians and 150 patients. Among the physicians, 17 were males, 8 were females. Physicians and patients were recruited from nine
different medical facilities in and around a large metropolitan area in central Ohio. Sixteen of the participating physicians practiced in private offices, while nine of the physicians practiced in a university-supported clinic. Twenty-two physicians were White, three were African-American. Physicians in the sample averaged 11 years post-residency (range = 1 month to 36 years). Appendix A contains demographic information relevant to the patient sample.

Design and Procedures

Each physician was audiotaped with six different patients, two in each of the following three intervention conditions. The trained group (N=50) received a training booklet in the U.S. mail 2-3 days prior to their scheduled appointment. The informed group (N=49) received a brief written summary of the major points of the training booklet while in the waiting room prior to seeing the physician. The untrained, or control, group (N=51) did not receive any intervention prior to their scheduled appointment. Data collection was completed at one site before moving to another location.
Patient Selection and Assignment

Each patient listed on the appointment records for a given day was assigned a number. Patients were randomly selected from the list and telephoned to determine their interest in participating in the study. Patients were told that their physician had agreed to participate in a study of physician-patient communication and that they were being contacted to determine if they had an interest in participating in the study as a patient. Of those patients contacted, 84% agreed to participate. Patients who agreed to participate were randomly assigned to one of three conditions (i.e. trained, informed, untrained).

Physician Selection

Physicians agreed to participate in the study prior to data collection. They were told they would be audiotaped with six different patients. Physicians were informed that a portion of their patients would receive an educational intervention, but they were not made aware of the specific objectives or content of the intervention. In an effort to further mask the intervention
condition, patients in the untrained group were given a copy of the consent form with a cover exactly like the cover of the training booklet and brief summary given to the trained and informed patients. While there was no visual access to the patient and thus nonverbal displays could not be observed, audio channels provided access to what was said. Patients made explicit reference to the study materials during the interview in only two instances. Additionally, physicians typically were not aware of which interviews were being taped because they had no way of knowing if the microphone in the examination room was operational or not. Taping was usually done over the course of several hours during which physicians saw a mixture of patients, some of whom were participants in the study and others who were not a part of the study.

Training Booklet

The 14 page training booklet was based on previous work in physician-patient communication (Cegala, 1997; Cegala, Colemena, & Warisse, 1998; Cegala, Drummond, McCartney, & Marinelli, 1997;
Cegala, McNeilis, Socha McGee, & Jonas, 1995; Cegala, Socha McGee, & McNeilis, 1996; Socha McGee & Cegala, 1998) and results of an assessment of earlier versions of the training materials (Cegala, et al., 1997). The booklet was designed to instruct patients in information provision, seeking, and verifying. It was formatted like a workbook with examples and space for notes. The booklet was analyzed for readability using the Flesch Reading Ease and Flesch-Kincaid Grade Level indices. The reading ease score was 68.96, which falls within the range for standard reading difficulty. The Flesch-Kincaid score was at the fifth grade level.

An evaluation form was mailed with the booklet, which trained patients were asked to complete after using the booklet to prepare for their appointment. The evaluation form was developed for and used in previous research which pilot tested an earlier version of the training booklet (Cegala, et al., 1997). Overall, the booklet was evaluated as useful and informative.
**Compliance Measure**

A self-report measure of compliance was used because it was most appropriate for assessing the varied forms of treatment characteristic of a primary care setting. Although self-reports of compliance are not problem-free, there appear to be key factors that improve their validity. Researchers suggest that patients' self-reports are more valid if they are asked about their compliance to treatment in a non-threatening manner (Hays & DiMatteo, 1987; Sackett, 1979). Additionally, studies indicate that patients' self-reports of compliance are likely to be more accurate when data are gathered by someone not connected with the medical establishment (Hays & DiMatteo, 1987; Thompson, 1984). The data gathering procedure used in this study met both of these conditions.

Compliance was assessed with respect to:

(a) prescribed medication(s),

(b) behavioral recommendations (e.g., diet, exercise, smoking cessation),

(c) follow-up appointments, and

(d) referrals to another physician(s).
A distinction was made between noncompliance due to the patient's intent not to follow treatment recommendations and noncompliance resulting from factors other than the patient's intent (e.g., forgetfulness or lack of understanding about treatment procedures and/or their rationale). Unintentional noncompliance was assessed with two sets of items. Patients were first asked a series of questions designed to assess their recall of treatment recommendations regarding medications, behavioral changes, follow-up appointments, and referrals. Patients' responses to these questions were assessed against transcripts of the interviews to determine the accuracy of the patients' recall of treatment information. The logic of this procedure was based on the assumption that if a patient could not correctly recall treatment information, he or she was not likely to have followed the recommendation, or at minimum did not follow the treatment as prescribed. In either instance, it is assumed that lack of recall about treatment information was indicative of unintentional noncompliance. Second, patients responded to two unintentional noncompliance items based on previous work (Brooks, et al., 1994;
DiMatteo, et al., 1992). Finally, intentional noncompliance was assessed with 12 items based on work by Becker and Maiman (1980) and Donovan and Blake (1992).

Administration of Materials

All patients were met in the waiting room by one of the researchers or a research assistant. They were given a pre-interview questionnaire to complete and were asked to sign an Institutional Review Board consent form.

Trained patients were asked if they experienced any difficulties in using the training booklet. The booklet was briefly examined for evidence of usage (e.g., written notes, underlining). Informed patients were given a brief summary of the major points of the training booklet and encouraged to read the summary before seeing the physician. Untrained patients were simply told that they would soon be taken to the examination room to await the physician.
Two examination rooms were equipped with wireless microphones. Recording equipment was housed in a separate room not visible to participants. Recording began when the physician entered the room and continued until the end of the medical visit. The length of the interview was recorded using a stopwatch.

The entire interview was monitored as it was recorded. As soon as the interview ended, patients were taken to the waiting room and given two post-interview questionnaires to complete. When they completed the questionnaires they were paid according to their assigned intervention condition: $20 for informed and untrained patients; $30 for trained patients who were asked for a larger time commitment. All patients were given a copy of the training booklet. They were encouraged to use it for their next appointment or to consider sharing it with family or friends.
Telephone Survey

Approximately two weeks after the taped medical visit patients were telephoned and engaged in an interview designed to assess their compliance with medical recommendations made during the taped visit. At this time, a measure of delayed recall of information was also collected.

Discourse Coding

Coding System

The choice of an interaction analysis system is crucial to the nature of the research findings; however, often the decision to use a particular analysis system is made based upon its availability and/or its proven high reliability, but without much further thought (Ong, et al., 1995).

The coding system utilized to categorize physician-patient discourse in this study is an extension of the Suchman, et al., (1997) classification of affect. Specifically, the current study classified patient demonstration of negative affect during the medical
consultation. By expressing negative affect, patients in the sample provided windows of opportunity for the physicians to explore these emotions. Negative affect is defined as the expression of worry, concern, anger, tension, or anxiety. These windows may be related to medical topics; however, the discourse goes beyond a description of symptoms to how the condition affects the patient's life.

The coding scheme focuses on the patient's expression of current emotions only. The physician is not expected to explore or to allow the patient to explore past emotions. However, if the emotion has occurred in the past and the patient brings the negative affect to the current encounter, a window of opportunity has occurred. Additionally, if it was determined that the reason for the visit was to discuss affective issues, the dyad was not included in the analysis.

The first step in the coding process was to identify when a window of opportunity has occurred. Once a window was identified, each participant's relevant discourse was unitized. A discourse unit consists of a participant's uninterrupted word or string of words.
This series of words is analogous to what is termed in written communication as a sentence. It is equivalent to a thought unit or t-unit as defined by Hunt (1964; 1965). Essentially, each unit contains a complete thought, usually incorporating a subject and predicate.

The code assigned to each discourse unit consists of eight characters. The patient codes consist of six meaningful codes and two placeholders at the end. Within physician codes, these placeholder positions are used to identify physician response and type of response. The use of placeholders allowed the researcher to maintain a consistent number of codes per unit among patients and physicians. The codes assigned to physicians' and patients' discourse units are described in detail in the following pages. The entire code manual is included in Appendix B.

The basic assumption of this coding system for physician-patient discourse is that the window of opportunity must be introduced by the patient. Some patients in the sample initiated more than one window. For this reason, each window received a number corresponding to the initiation attempt for that patient.
This same window number was carried over to the physician response codes so that distinctions could be made regarding which windows received a physician response and which were terminated.

A patient may introduce a window directly into the conversation or the patient may take a more indirect approach. An explicit window is defined as an instance that is flagged linguistically. That is, the patient explicitly states that he or she is worried or concerned about something or the discourse is such that it is obvious that negative affect has been expressed. Some examples of such explicit statements are listed below:

"I feel as if everything is crowding in on me."

"It was one of those things, like where does it end? You know, without the pills my blood is thinner and stuff anyway, but of all the things right now that adds up getting into this, I've been working for that guy that gave me the hypertension to begin with for the last three weeks. He's been paying me again and working on that stuff, so . . ."

"It's like everything's falling apart right now."

"While I'm here, I read like five or six articles about chlamydia. How it's symptomless and it made me, I really don't think I'm going to rest, but I may be totally paranoid."
"I guess I, I mean I work, I'm you know, anti-depressants, what you mean by anti-depressants, I mean is that something that I can take while I'm working? I mean, I'm working on patients. I mean, I don't want to be like falling asleep at the chair when I'm working on them."

Implicit windows are defined as those instances in which the patient does not directly state the emotion, but the emotion can be inferred by word choice or by vocal qualities. Since negative affect is not only verbal, but can also be expressed through tone of voice, audiotapes of the consultations were used during the unitizing and coding of transcripts. Examples of implicit windows follow:

"I work in human resources. But I work for a printing company; exposed to some chemicals."

"I don't know if it'd be my stomach's caused by the nerves or if it's caused by the ulcer still, or . . . "

"They took my blood, you know, like they, like they're supposed to, you know in their pre-admission, you know. I don't know how many tubes or anything. I didn't look. And anyhow, when I had that done, my fingertips and my palms started turning black, blue. You know, not bruised colored, but black and blue, real ugly looking."
"So you're saying this probably won't happen again, but it could. I mean, you're saying most likely not, but not for sure. I mean you're not going to..."

"But sometimes I feel like when I'm driving in the darkness. Maybe I'm just so tired. You know, everybody has problems."

Patients sometimes make several utterances before the eventual expression of negative affect, while others are very direct with their initiations. Likewise, some physicians invite patients to continue to express and explore the emotion before responding. For this reason, the coding scheme takes into account where in the progression of the expression each utterance occurs. That is, the discourse may consist of introductory or preparatory remarks before the patient formulates the window. There is the actual window of opportunity in which the patient actually expresses the negative affect. Finally, after the physician responds, the patient may give additional explanation of the issue or concern. The manual developed for the coding system presents these concepts as follows:
Speaker

The speaker of each utterance is assigned a code identifying which participant spoke the utterance.

P Utterances spoken by the patient.

D Utterances spoken by the physician.

Window Number

1 = 1st Window
2 = 2nd Window
3 = 3rd Window
4 = 4th Window

Directness of Initiation

E Explicit Window
Explicit expressions are those instances that are linguistically flagged. The patient explicitly states the concern or the discourse is such that it is obvious that an emotion has been expressed.

I Implicit Window
Implicit expressions are those instances in which the patient does not directly state the emotion, but the emotion can be inferred by the word choice or by vocal qualities.
Progression of the Expression

P Preparatory
Preparatory remarks involve patient comments leading to a window of opportunity.

W Window
The window of the expression is content-based; therefore, the window begins when the patient expresses negative affect. Once the window is opened, all utterances are coded "W" until the physician speaks.

X Explanatory
The explanatory code is used only after the physician has responded to a window. That is, after the physician acknowledges the expression, all subsequent patient utterances are coded as explanatory. In this manner, we can see how much the physician allows the patient to explore the emotion.

Once a window of opportunity is identified and the appropriate progression of expression coded, the topic of the window is assessed and an appropriate code assigned. This code identifies the general topic of the utterance (e.g., what the emotion is about). The purposes for coding the topic of the window are: (1) to determine if certain issues are introduced more frequently than
others within the medical consultation and (2) to examine the
physician's response to various types of emotions expressed by the
patient.

The topical categories in the coding system include the
following:

**F Family**
Emotions related to a patient's family and home
life, including pressures associated with children, spouse, and relatives.

**S Social**
Emotions related to the patient's social life or
feelings toward society in general. Included in this
category is a general feeling of anxiety.

**W Work**
Emotions related to the patient's work environment
including pressures from the position and
responsibilities or the people with whom the
patient works.

**B Behavior**
Emotions related to the patient's behavior
including smoking, drinking, diet, sleeping habits, etc.

**D Diagnosis**
Emotions related to a diagnosis of the patient's
medical condition. This may be in response to a
physician's current diagnosis or a self-diagnosis by
the patient.
Procedures/Tests
Emotions related to procedures or tests including details about the procedure or test as well as results from procedures or tests.

Symptoms
Emotions related to symptoms associated with the patient's medical condition; how symptoms impact the patient's life. This differs from a simple accounting for or description of symptoms.

Treatment
Emotions related to a patient's treatment for a medical condition. Included in this category are such matters as medications, physical therapy, and referrals to other medical professionals.

Prognosis
Emotions related to the long-term aspects of a medical condition. Included in this category are concerns about how long the condition will last, whether or not a full recovery can be expected, etc.

Procedural
Emotions related to health care benefits, plans, etc. to pay for treatment including paperwork, third party-provider, and disability benefit.

Speech Disfluencies
Statements within the expression of negative affect that carry no contextual contribution to the conversation. These include incomplete statements, redundancies, and repetitions in speech.
0 Other
Utterances that do not fit into one of the previous categories but that are classified as affective in nature.

Some window topics were broken into subcategories to further explicate the reasons for the patients' expression of negative affect. The following subcategories were initially coded; however, they were subsequently collapsed during the analysis due to the small frequencies within each subcategory. All other topics received placeholders as data points for this code.

Family

1 Children
Emotions related to a patient's child(ren)

2 Spouse
Emotions related to a patient's spouse

3 Relatives
Emotions related to a patient's relatives other than children or spouse including siblings, parents, in-laws, etc.

4 Other
Emotions related to a patient's family that do not fit into one of the above categories.
| **Social** | **1** General Anxiety/Stress  
Statements that indicate a general sense of anxiety including being stressed out. |
| **Social** | **2** Social Life/Relationships  
Statements about a patient's social life or interpersonal relationships including intimate relations. |
| **Social** | **3** Emotional State  
Statements regarding a patient's current emotional state such as feeling upset or being angry. |
| **Social** | **4** Other  
Statements about a patient's social circumstances that do not fit into one of the above categories. |
| **Work** | **1** Dangers  
Emotions related to dangers at the patient's place of business such as the threat of disease or exposure to other harms. |
| **Work** | **2** Too much work/stress  
Statements expressing the amount of work, number of hours worked, or stress that the patient experiences while at work or as a result of work. |
| **Work** | **3** Co-workers  
Statements related to co-workers and/or other employees at the patient's place of business. |
4 Other
Statements related to a patient's work that do not fit into one of the above categories.

Behavior 1 Eating/Exercise
Emotions related to a patient's diet or eating habits or about a patient's level of activity

2 Smoking/Alcohol
Emotions related to a patient's smoking habits or alcohol consumption

3 Sexual Behavior
Emotions related to a patient's sexual behavior including partners, practices, disease, etc.

4 Other
Emotions related to a patient's behavior that do not fit into one of the above categories.

The next step in coding windows of opportunity was to determine how the physician responded to the patient. The physician could respond by offering a direct, functional response or by providing a continuer. Examples of continuers include phrases such as "go on," "I see," and "OK." These phrases allow the patient to further explore the emotion. A physician may also terminate the discussion of the negative affect. This behavior was
coded as a *terminator* in that the physician directed attention away from the affective topic, usually by ignoring the demonstration of affect. A final manner in which a physician could respond is through offering a *delayed response*. A physician's delayed response does not immediately follow the initiation of a window, but rather comes at some later point within the consultation. A delayed response may be given in addition to an immediate response. A delayed response may also be provided for a window that had previously been terminated. Examples of responses, delayed responses, and terminators are included in Appendix C. The following categories further define the types of possible physician response:

**R Response**
A physician's immediate response to the patient's expression of emotion.

**C Continuer**
A physician's statement following an expression of emotion that allows the patient to further explore the emotion. This could be as simple as "uh-huh," "OK," or "go on." The physician could repeat the patient's expression in part or full in a manner that seeks to have the patient continue with
explanation. A continuer does not provide information, but rather invites the patient to elaborate and to explore the expression.

T Terminator
A physician's statement following the patient's expression of emotion that ignores the demonstration of affect.

L Delayed Response
A physician's delayed response to a patient's expression of emotion. Discourse is only considered a delayed response if the physician voluntarily comes back to the topic. If the patient has to bring up the issue again, this is counted as another expression and assigned the next corresponding number of expression.

While it is important to recognize the physician's response to a patient's window of opportunity, it is equally important to identify the type of response provided. The physician may respond in various manners including provide information, show compassion, and offer assurance. The next step in the coding process involved distinguishing the specific type of physician response. The categories of physician response used for the coding scheme include the following:
I Information
The physician responds by providing additional information about the topic or issue.

U Understanding or Compassion
The physician responds by showing compassion and understanding toward the patient. One way to do this is that the physician will "name" the emotion. For example, the physician might say, "it sounds to me like you are upset," or "you feel guilty." Another way to show compassion is that the physician might demonstrate some sort of confirmation. For example, the physician might say, "You know, if that happened to me, I'd be upset too."

Q Question to Gather More Information or Check For Understanding
The physician asks question(s) of the patient in an attempt to further his or her understanding of the situation and to better prepare a response. This could take the form of a direct or indirect question.

A Reassurance
The physician responds by offering assurance to the patient regarding the concern. These are statements that are designed to allay the patient's concerns. Examples might include assurances that the patient will not die from a procedure, that the patient's feelings are normal, or that the patient will be OK.

D Redundancy
Physician utterances consisting of repeated information or statements that do not provide additional information or content.
Other
A physician's response to a patient's demonstration of emotion that does not fit into one of the previous categories.

Unitizing and Coding

The researcher reviewed audiotapes along with transcripts of all 150 physician-patient dyads to determine which interactions contained windows of opportunity. The 48 transcripts that were identified as having windows were examined a second time. During this time, the researcher unitized all relevant window discourse. A third time through the transcripts involved the actual coding of each discourse unit using the coding system described above.

Another person not associated with the study unitized and coded a sample of 15 randomly selected transcripts. The selection of transcripts included some that had been identified as containing windows as well as some that did not involve windows of opportunity. The coder was made aware that some of the transcripts did not contain window discourse; however the particular transcripts were not specified. Of the 15 transcripts selected for the other coder, 10 contained windows and 5 did not.
Fifteen transcripts is 10% of the original 150 physician-patient dyads, while the 10 transcripts containing windows is approximately 20% of the sample of transcripts analyzed for this study. This is an acceptable number for reliability coding.

The coder received training over the course of three training sessions. The first session was designed to introduce the coder to the coding system. At this time, the codebook was distributed and explained. Three practice transcripts, along with audiotapes of the interactions, were provided to the coder with instructions to both unitize and code the transcripts. The coder was made aware that the practice transcripts all contained window discourse thereby affording the opportunity to practice application of the coding system. A second training session was held to determine the extent of agreement on the practice transcripts. As a high level of agreement was achieved, the coder was encouraged to continue with the remainder of the practice transcripts. The third session was held primarily to discuss any last minute questions and to provide the transcripts used in the reliability coding.
Holsti's (1969) method of agreement was used to determine reliability estimates. This method involves a proportion with the numerator being the number of codes multiplied by the number of coding agreements and the denominator being the sum of the coding decisions made by the first coder and the second coder. Three reliabilities were assessed: 1) identification of a window of opportunity; 2) unitizing of the window discourse; and 3) content coding. The reliability score for window identification was .75 and unitizing of the window discourse was .96. The reliability for content coding was assessed in terms of the directness of the patient, the topic of the window, the subtopic, if applicable, and the physician response. Reliabilities were as follows: directness, .75; topic, .88; subtopic, .86; and response, .82.

Data Analysis

The method of data analysis for this study involved a combination of quantitative and interpretive techniques. Due to the exploratory nature of the investigation, descriptive statistics were
analyzed to examine the frequency and composition of patient-initiated windows of opportunity. Frequencies and percentages were used to explore the research questions designed to investigate physician response and discourse provided for windows.
Chapter 4

RESULTS AND DISCUSSION

Although limited research has been conducted within the affective domain of physician-patient communication, there is still no clear sense of how often windows of opportunity occur during the medical consultation. Additional information is needed to provide a description of the windows as well as to determine the content of the expressions. The first research question (see page 36) was designed to address these omissions in the literature and to lay the groundwork for additional analyses.

Results for RQ1

Of the 150 physician-patient dyads in the sample, only about one-third (N=48) contained expressions of negative affect that created a window of opportunity for the physician to explore. All
dyads included in the analysis had at least one window (range, 1-4). Twenty of the patients engaged in a second initiation of a window, while third and fourth initiations were attempted by 7 and 3 patients, respectively. As will be reported shortly, there are varying circumstances accounting for subsequent window attempts. A total of 78 windows were introduced by patients, making the average number of windows per patient just over one and one-half (M=1.63).

Patients vary in the manner in which they initiate windows. Some patients use introductory comments to signal that a window of opportunity is being presented. Other patients simply express the emotion without preparatory discourse. Over half of the patients in the sample (N=27) utilized preparatory remarks to signal that a window of opportunity was opening. Some patients used preparatory discourse during more than one window attempt (see Table 4.1). Overall, 41% of all windows of opportunity contained preparatory statements.
Patients provided explanatory remarks only after the window had been acknowledged by the physician. Of the 78 windows created by patients, almost half (N=37) included explanatory comments following a response from the physician. Sixty-five percent (31/48) of patients in the sample uttered explanatory statements.

<table>
<thead>
<tr>
<th></th>
<th>Preparatory</th>
<th>Window</th>
<th>Explanatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occurrence</td>
<td>32</td>
<td>78</td>
<td>37</td>
</tr>
<tr>
<td>Average Number</td>
<td>1.78</td>
<td>3.14</td>
<td>9.89</td>
</tr>
<tr>
<td>of Discourse Units</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Patients</td>
<td>27</td>
<td>48</td>
<td>31</td>
</tr>
</tbody>
</table>

Table 4.1: Descriptive information of patient preparatory, window, and explanatory attempts.
The average amount of discourse varied according to the type of patient comment. Preparatory remarks averaged less than two discourse units in length (M=1.78)^2 while window statements consisted of about three units (M=3.14) per occurrence. Explanatory comments were the longest type of patient statement averaging just under 10 discourse units per explanation (M=9.89). Discourse within the window made up about one-third of patient discourse units. Patient explanatory units made up the largest proportion of total discourse units, indicating that, given a physician response, patients tend to elaborate on affective issues. This suggests their desire to talk about such matters.

An examination of discourse units showed that of the 6,591 total patient discourse units in the sample containing windows, 668 units were identified as windows of opportunity. This is only 10% of the total patient discourse units. Accordingly, even within the sample of 48 dyads containing windows, affective discourse occurred infrequently in relation to overall patient discourse.

^ The average discourse unit is approximately 7 words in length.
As evidenced by the distribution of patient discourse units displayed in Table 4.2, when windows did occur, patients most often expressed negative affect explicitly rather than implicitly. Eighty-one percent (46/57) of preparatory, 89% (217/245) of window, and 92% (337/366) of explanatory discourse units were explicit. Overall, 90% (N=600) of all patient affective discourse units were explicit statements.

<table>
<thead>
<tr>
<th></th>
<th>Explicit N (%)</th>
<th>Implicit N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparatory</td>
<td>46 (8)</td>
<td>11 (16)</td>
<td>57 (8.5)</td>
</tr>
<tr>
<td>Window</td>
<td>217 (36)</td>
<td>28 (41)</td>
<td>245 (36.7)</td>
</tr>
<tr>
<td>Explanatory</td>
<td>337 (56)</td>
<td>29 (43)</td>
<td>366 (54.8)</td>
</tr>
<tr>
<td>Totals</td>
<td>600</td>
<td>68</td>
<td>668</td>
</tr>
</tbody>
</table>

* Percentages are computed within columns using column totals.

Table 4.2: Frequencies and percentages of patients' explicit and implicit discourse units.
As noted earlier, the number of patient windows in the sample ranged from one to four. It was of interest to discover at what point during the medical visit patients initiated windows of opportunity (see Table 4.3). Over half (N=25) of all first window attempts were made during the beginning of the medical encounter. One might expect a pattern whereby the percentage of windows introduced would increase as the number of the attempt and time elapsed increases. However, patient second attempts were quite evenly spread across the encounter with a slightly higher percentage of windows being initiated during the beginning of the consultation. The majority of patients (57.1%) initiating a third window did so during the middle portion of the visit, while two-thirds (N=2) of patients with fourth attempts presented them during the end.

Summary. Windows of opportunity occur infrequently within the medical consultation. Only about one-third of physician-patient dyads in the sample of 150 dyads contained window discourse. Of those, over half (56.3%) of the patients used preparatory remarks.
Window Attempt Number (N) | Beginning* % (N) | Middle % (N) | End % (N)
--- | --- | --- | ---
1 (48) | 52.1 (25) | 31.3 (15) | 16.7 (8)
2 (20) | 40.0 (8) | 30.0 (6) | 30.0 (6)
3 (7) | 14.3 (1) | 57.1 (4) | 28.6 (2)
4 (3) | 0 (0) | 33.3 (1) | 66.7 (2)

Totals 78 34 26 18

*The length of the visit was established by using the total number of typed, double-spaced pages of discourse. The page number on which the patient initiated a window was divided into the total number of discourse pages, yielding the proportion of discourse that had passed prior to the window attempt. Proportions were changed to percentages and grouped by thirds indicating the beginning, middle, or end of the visit. That is, beginning windows were initiated 0 – 33.33; middle, 33.34 – 66.67; and end 66.68 – 100.00 of total length. In this manner, a patient who initiated a window on page 7 of a 12-page transcript did so during the middle (e.g. 58.33) of the medical encounter.

b Percentages are calculated within rows using number of window attempts.

Table 4.3: Percentage and number of windows initiated during the beginning, middle, and end of the medical visit.
to introduce the window. Sixty-five percent of the patients provided explanatory comments once the window had been acknowledged by the physician.

In terms of the amount of affective discourse, the data show that patients provided three times as many explanatory as window comments and five and a half times as many explanatory as preparatory statements. This finding clearly demonstrates patients' desire to discuss affective topics.

Patients in the sample introduced affective issues explicitly into the conversation more often than by more indirect methods. Preparatory remarks, though few in number, were more often explicit than implicit when they occurred. However, proportionately, patients utilized more preparatory discourse units when introducing topics implicitly.

As for discourse within the actual window of opportunity, patients again were overwhelmingly explicit in their remarks. The data indicate that as a general trend, patients in the sample were explicit in their introduction of windows, while utilizing few preparatory remarks. Overall, almost half (43.6%) of all windows
were initiated during the beginning portion of the medical consultation. One-third (N=26) of windows were introduced during the middle and the remaining 24% were attempted toward the end of the visit.

**Results for RQ2**

Although windows did not occur frequently, what is most important is how the physician responds when a patient does express negative affect and creates a window of opportunity (Roter, et al., 1995). There is growing insight that affective discourse influences the development and severity of almost every disease as well as the recovery and even survival of many patients (Bensing, 1991; White, 1988). A physician's response to a window can impact the remainder of the medical visit and possibly the patient's overall health.

The second research question (see page 37) aimed to establish the extent to which physicians respond to patients' windows of opportunity. Table 4.4 contains the total number of patient windows as well as physician responses and terminators to those
initiations. For all first window attempts, whether explicit or implicit, physicians responded (i.e., immediate and delayed) only 58% (N=28) of the time. Forty-two percent of the time that patients expressed negative affect, physicians terminated the topic. Patients engaging in a second initiation attempt were slightly more successful at eliciting a response than those with first attempts. Physicians responded to 60% (N=12) of patients during their second attempts to express negative affect. The percentage of response/no-response held pretty consistently through the third attempt, but dropped dramatically for patients with 4 initiation attempts. Within the third initiation, physicians responded 57% (N=4) of the time, while exhibiting this behavior only one-third (N=1) of the time when addressing patients' fourth attempts at windows of opportunity. Part of the decline in response percentage is possibly due to the small number of patients who actually engaged in a fourth window attempt. However, it is still worth noting that physicians terminated twice as often as they responded to patients during the fourth initiation attempt.

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3 Physician response was calculated by subtracting the number of terminators from the number of initiation attempts for a given window. For example, looking at Table 4.4, there were 48 first window attempts. Forty-eight minus 20 equals 28 windows to which physicians responded.
<table>
<thead>
<tr>
<th>Window Attempt</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Window</td>
<td>48</td>
<td>20</td>
<td>7</td>
<td>3</td>
<td>78</td>
</tr>
<tr>
<td>Physician Response*</td>
<td>35</td>
<td>15</td>
<td>5</td>
<td>2</td>
<td>57</td>
</tr>
<tr>
<td>Physician Terminator</td>
<td>20</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>33</td>
</tr>
</tbody>
</table>

* Physician immediate and delayed responses are reported together. Therefore, physician response totals more than patient initiation minus terminators because some physicians provided both immediate and delayed responses to the same window. Also, some windows that were originally terminated later received physician delayed responses.

Table 4.4: Frequency of patient window attempts and frequency of physician response.

Separating physician response into immediate and delayed responses reveals an interesting pattern (see Table 4.5). Eighty percent (N=28) of the time physicians responded to first window attempts, they did so with immediate rather than delayed responses.
Table 4.5: Immediate and delayed discourse units for physicians' responses to windows.

This result was the same (e.g., 80%) for second and third windows. During fourth window attempts, the frequency of physician response was divided equally between immediate and delayed responses.

Perhaps a more interesting analysis is the average discourse units per window (also Table 4.5). Physicians uttered more discourse units for delayed than immediate responses during first and second windows. However, this trend was reversed for third
and fourth windows. A closer examination of individual patient window attempts helps to explicate this finding. There were two windows in each of the first and second attempts (N=4) that were originally terminated but later received a physician delayed response. This delayed response was the only response these four windows received, therefore accounting somewhat for the high average of delayed responses during the first two window attempts.

Additionally, physicians providing delayed responses during the first and second windows used several introductory comments in order to reintroduce the topic into the conversation. Some examples of these comments from the transcripts along with the number of discourse units coded for each are listed below:

"You said a couple of things when I first came in that I want to get back to and touch base on. And that's when you said you were feeling suicidal and homicidal. Let's talk about that for a moment. Do you have plans of hurting yourself?" (4 discourse units)

"So, you're a single parent and that has to add a fair amount of stress to your life, I would think."
(2 discourse units)
"The other thing that you asked me about and that I can address now is your hands turning cold and blue, kind of back and forth. That's actually a relatively common complaint that I have, that people come to see me about."

The two instances of physician delayed response during the third and fourth window attempts did not contain such introductory comments. During the interaction involving the delayed response to the third window, the physician returns to the topic at the end of the consultation and provides summary remarks. With regard to the fourth window, not much time elapsed between the immediate and the delayed response. Also, the conversation still centered around the same general topic, although not specifically the anxiety associated with it. For these reasons, re-introduction of the topic was not necessary for third and fourth windows. Therefore, fewer delayed response units were needed.

**Summary.** Overall, physicians responded (i.e., immediate and delayed) to patient attempts 58% (N=45) of the time. The flip side of this is that physicians terminated 42% (N=33) of all window attempts. Although physicians responded immediately more often
than delaying responses, on average they provided more delayed than immediate response discourse units for the first and second window attempts. Delayed responses to these windows consisted of several comments used to reintroduce the topic of the affective expression into the conversation. Such introductory statements did not accompany delayed responses to third and fourth windows.

Results for RQ3

It was of interest to discover if there was anything regarding the manner in which the window was introduced that influenced how the physician responded. The third research question (see page 37) examined variations in patient directness to see if patient style of initiation made a difference in the way physicians respond (see Table 4.6).

In terms of patients' explicit windows, approximately 78% (N=299) of physicians' response units were provided immediately following the patient's expression of negative affect. When patients implicitly introduced windows, physicians responded immediately 82% of the time. The data suggest that the response pattern is
essentially the same for implicit and explicit windows of
opportunity, with physicians responding mostly immediately as
opposed to delaying the response.

<table>
<thead>
<tr>
<th></th>
<th>Explicit</th>
<th>Implicit</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Response</td>
<td>299</td>
<td>68</td>
<td>367</td>
</tr>
<tr>
<td>Delayed Response</td>
<td>86</td>
<td>15</td>
<td>101</td>
</tr>
<tr>
<td>Total</td>
<td>385</td>
<td>83</td>
<td>468</td>
</tr>
</tbody>
</table>

Table 4.6: Frequency of physician responses to explicit and implicit windows.

To further explore the relationship between patient directness
and physician response, the average number of discourse units per
window was calculated for physicians' immediate and delayed
responses (Table 4.7). On average, patients received approximately
eight immediate discourse units and two delayed discourse units per
window, regardless of whether the window was implicit or explicit. Similarly, the percentage of windows terminated was almost identical for explicit and implicit windows, (42.2% and 42.9%, respectively). Overall there is no difference in physicians' response to explicit or implicit windows.

<table>
<thead>
<tr>
<th></th>
<th>Explicit</th>
<th>Implicit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Response</td>
<td>8.08</td>
<td>8.50</td>
</tr>
<tr>
<td>Delayed Response</td>
<td>2.10</td>
<td>1.88</td>
</tr>
<tr>
<td>Terminator</td>
<td>27</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 4.7: Average number of physician discourse response units to explicit and implicit windows.

Physicians in the sample provided about three and one-half times more immediate response units than delayed responses to explicit windows and four and one-half times more immediate than delayed for implicit windows. Physicians provided slightly more
immediate response units to patients' implicit windows. This trend was reversed for delayed responses with explicit attempts soliciting slightly more response units.

Summary. Two separate analyses showed that there appears to be no significant difference between physician response to explicit or implicit windows either in terms of frequency of response or proportion of response units provided. These findings suggest that physicians are equally responsive to explicit and implicit windows.

Result for RQ4

Within the windows of opportunity, patients have a desire to talk about a variety of affective issues. The fourth research question (see page 37) was designed to discover the theme of patient windows. Windows and responses were grouped into two main thematic categories: medical and psychosocial. Topics included in the medical category were: diagnosis, procedure/test,
symptoms, treatment, prognosis, procedural, and other. Topics in the psychosocial category were: behavior, family, social, and work. See Appendix B for definitions and explanations of these topics.

Patients in the sample initiated medical windows almost equally as often as psychosocial windows, accounting for 38 (48.7%) and 40 (51.3%) of windows, respectively. In terms of patient directness, 90% of all psychosocial windows were introduced explicitly, while 74% of medical windows were initiated in this manner.

The first step in addressing the relationship between the theme of the window and physician response was to determine how often physicians respond to or terminate patient windows. The percentage of responses in the last column of Table 4.8 were calculated using the number of patient windows minus the terminations divided by the number of patient windows*. As indicated, psychosocial windows received substantially fewer responses than medical windows. Over three-quarters of all medical

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*This strategy was used because some windows received both immediate and delayed responses. Additionally, some windows that were originally terminated received delayed physician responses at some later point during the visit.
Table 4.8: Frequencies and percentage of physician response to window themes.

<table>
<thead>
<tr>
<th></th>
<th>Windows</th>
<th>Imm</th>
<th>Del</th>
<th>Ter</th>
<th>% of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explicit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>28</td>
<td>24</td>
<td>3</td>
<td>6</td>
<td>78.6</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>36</td>
<td>14</td>
<td>7</td>
<td>21</td>
<td>41.7</td>
</tr>
<tr>
<td>Implicit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>70.0</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>46</td>
<td>11</td>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>

windows received a physician response as compared to only 40% of patients' psychosocial windows. Clearly, the theme of the window makes a difference in whether the physician responds or terminates the window of opportunity. Windows about psychosocial themes were almost three times as likely as medical windows to be terminated by the physician.
One factor that might account for this difference is the timing of the window. For example, if psychosocial windows were introduced late in the interview, they may tend to be terminated due to lack of time. To examine this possibility, the timing of medical and psychosocial windows was examined. Table 4.9 displays the distribution of patient windows within the interview and shows that timing unlikely accounted for the difference because most of the psychosocial windows appeared at the beginning of the encounter.

<table>
<thead>
<tr>
<th></th>
<th>Beginning % (N)</th>
<th>Middle % (N)</th>
<th>End % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>45 (13)</td>
<td>38 (11)</td>
<td>17 (5)</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>63 (10)</td>
<td>19 (3)</td>
<td>19 (3)</td>
</tr>
<tr>
<td>Totals</td>
<td>23</td>
<td>14</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 4.9: Percentage of patient windows initiated during the beginning, middle, and end of the medical visit.
There is no evidence that psychosocial windows are introduced later in the interview. Therefore, the next step to address any potential relationship between the timing of the window and physician response is to look at the percentage of response and non-response (see Table 4.10). Eighty-one percent of medical windows and 56% of psychosocial windows that were introduced during the first part of the encounter received a physician response. While this response rate drops for attempts made during the middle and last part of the consultation, the decline is more drastic with regard to psychosocial windows. Only one-quarter (N=3) of the middle and less than one-third (N=3) of the end psychosocial windows elicited a response from the physician. Some psychosocial windows were originally terminated and later received a delayed response. Including these in the equation as responses, as opposed to terminators, shows that about one-quarter (N=5) of beginning and two-thirds (N=8) of middle-initiated psychosocial windows were terminated by the physician. Seventy percent (N=7) of psychosocial
<table>
<thead>
<tr>
<th></th>
<th>Beginning % (N)</th>
<th>Middle % (N)</th>
<th>End % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terminator</td>
<td>81.3 (13)</td>
<td>78.6 (11)</td>
<td>62.5 (5)</td>
</tr>
<tr>
<td></td>
<td>18.8 (3)</td>
<td>21.4 (3)</td>
<td>37.5 (3)</td>
</tr>
<tr>
<td>Totals</td>
<td>16</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Psychosocial Response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terminator</td>
<td>55.6 (10)</td>
<td>25.0 (3)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>Term/Delayed b</td>
<td>27.8 (5)</td>
<td>66.7 (8)</td>
<td>70.0 (7)</td>
</tr>
<tr>
<td></td>
<td>16.7 (3)</td>
<td>8.3 (1)</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>18</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

* Percentages are calculated in columns using category column totals.

* Four windows that were originally terminated later received physician delayed response.

Table 4.10: Percentage of patient windows initiated during the beginning, middle, or last third of the medical visit according to physician response or termination.

windows presented at the end of the visit were terminated. The data demonstrate that patients who have psychosocial issues to discuss with the physician should introduce these topics during the
beginning of the medical visit in order to elicit a physician response. However, even them physicians' likely response rate is significantly lower than it is to medical windows.

Given a physician response, the next analysis examined whether more discourse was provided for medical or psychosocial themes. Physicians provided over two-thirds (247/367) of immediate discourse response units to patients' medical windows (see Table 4.11). However, delayed responses were almost equally split between the two themes. This examination demonstrates that the theme of the window made a difference in the amount of immediate but not delayed response units provided to the patient.

One last analysis was to examine the average amount of discourse units per physician response. Table 4.11 reveals that physicians provided about equal discourse units for medical and psychosocial windows. The notable finding here is that explicit psychosocial windows received three times as many discourse units as implicit psychosocial windows. This finding suggests that patients who want to discuss psychosocial windows should be direct in their initiation of such topics.
<table>
<thead>
<tr>
<th></th>
<th>N^a</th>
<th>Imm^b</th>
<th>Del^c</th>
<th>Total</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explicit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>22</td>
<td>182</td>
<td>35</td>
<td>217</td>
<td>9.86</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>18</td>
<td>117</td>
<td>51</td>
<td>168</td>
<td>9.33</td>
</tr>
<tr>
<td><strong>Implicit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>7</td>
<td>65</td>
<td>15</td>
<td>80</td>
<td>11.43</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3.00</td>
</tr>
</tbody>
</table>

^aNumber of windows to which physician responded  
^bImmediate response  
^cDelayed Response

Table 4.11: *Average number of physician discourse per window theme.*

**Summary.** It is clear from these analyses that the theme of the expression makes a difference in whether the physician responds to a window of opportunity. Over three-quarters of medical windows elicited a physician response, while only 40% of psychosocial windows were acknowledged.
The timing of the window appears to have more of an impact on psychosocial windows than medical windows. Medical windows continued to receive a fairly high response rate throughout the visit. Response to psychosocial windows, on the other hand, dropped from 56% in the beginning, to 25% in the middle, and 30% in the last part of the consultation. This finding suggests that patients who want to discuss psychosocial issues should bring these up early in the visit. Finally, given a physician response, theme is irrelevant to the amount of discourse units provided per response.

Results for RQ5

As noted earlier, the number of patient windows in the sample ranged from one to four. All 48 patients in the sample had at least one window of opportunity; however some patients had more than one attempt. The fifth research question (see page 37) was designed to examine the circumstances under which patients might initiate additional windows of opportunity.
Table 4.12 displays the distribution of second, third, and fourth window attempts within the medical and psychosocial themes. Overall, less than half (42%) of patients engaged in a second window attempt. Seven patients initiated three windows of opportunity and three patients had four window initiation attempts. The following pages discuss some of the circumstances under which patients initiated subsequent windows.

Same theme. Of the 20 patients who attempted second windows, seven (35%) did so regarding the same theme as the first window. Note that these patients are independent of the eight patients whose first window was terminated and who attempted a second window about the same theme. Perhaps these patients did not receive an extensive enough response to their first window attempt, thus prompting them to attempt a second initiation.

To examine this possibility, the average discourse units given to previous windows was calculated. Patients initiating first windows about medical themes received on average 11.46 response discourse units. Patients who went on to initiate a second window about the
same medical theme received 11.20 response units to their first attempts. Overall, patients introducing psychosocial windows received on average 10.63 physician discourse units to first windows, while patients initiating a second psychosocial window received 8.50 units to their first psychosocial attempt.

During third window attempts, there were no patients who initiated psychosocial windows about the same theme as the previous window. However, two patients presented medical windows on the same medical theme and elicited on average 6.50 response units. All other medical windows received 8.17 units to the previous medical window.

The data demonstrate that patients who initiated subsequent windows about the same theme received approximately the same amount of physician response discourse units to their previous window as other patients with windows about similar issues. The tendency to present windows regarding the same theme is perhaps a reflection not of the amount of response discourse, but rather of
<table>
<thead>
<tr>
<th>Window Attempt</th>
<th>2 N (%)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>3 N (%)</th>
<th>4 N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Windows</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same Theme</td>
<td>5 (50)</td>
<td>2 (50)</td>
<td>0 (---)</td>
<td>7 (50)</td>
</tr>
<tr>
<td>Different Theme</td>
<td>2 (20)</td>
<td>2 (50)</td>
<td>0 (---)</td>
<td>4 (29)</td>
</tr>
<tr>
<td>Termination of previous window (same topic)</td>
<td>3 (30)</td>
<td>0 (---)</td>
<td>0 (---)</td>
<td>3 (21)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td><strong>Psychosocial Windows</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same Theme</td>
<td>2 (20)</td>
<td>0 (---)</td>
<td>0 (---)</td>
<td>2 (13)</td>
</tr>
<tr>
<td>Different Theme</td>
<td>3 (30)</td>
<td>1 (33)</td>
<td>2 (67)</td>
<td>6 (38)</td>
</tr>
<tr>
<td>Termination of previous window (same topic)</td>
<td>5 (50)</td>
<td>2 (67)</td>
<td>1 (33)</td>
<td>8 (50)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>16</td>
</tr>
</tbody>
</table>

* Percentages are calculated within columns using column totals. They are rounded, therefore accounting for sums more than 100.

Table 4.12: Frequencies and percentages of additional window attempts.
the appropriateness or adequacy of the physician response. To discover this requires a closer examination of the individual discourse.

**Different theme.** Returning to Table 4.12, approximately one-quarter (N=5) of patients with second attempts initiated the window about a theme that was different than the first window, regardless of the outcome of the previous window. An examination of the individual data shows that four of the five patients received responses to their first window attempts. This suggests that, even though they had received responses from the physician, patients in this group had more than one window to discuss during the medical encounter. One patient whose psychosocial window was terminated during the first attempt, received a response to a medical window during the second attempt. Conversely, two patients whose medical windows had elicited physician response at first attempts were met with terminators to their psychosocial windows during the second attempt. The remaining two patients
both received responses to their second windows about different themes.

Three patients initiated third windows about a theme different than the previous window. Of these, two patients had initiated psychosocial windows and one had introduced a medical window during the second attempt. While the previous medical window received a response along with one of the psychosocial windows, the other psychosocial window was terminated. The response outcome for third window attempts was that the two medical windows received a response; however, the psychosocial window was terminated.

During fourth attempts, two patients initiated windows about a psychosocial theme rather than the medical theme of their previous window. Both patients elicited responses from the physician during the previous attempt. However, at the fourth window regarding psychosocial topics, only one patient received a response while the other patient's window was terminated.

The data illustrate that the overwhelming majority (80%; e.g., 8/10) of patient subsequent windows regarding a different topic
received a physician response to the previous window. This result suggests that some patients in the sample had a variety of affective issues to discuss involving both medical and psychosocial themes.

**Termination.** Many patients, after having been ignored by their physician, will not again attempt to broach the subject. Of the 20 patients whose first windows were terminated, only about forty percent (N=8) attempted a second window about the same theme (see Table 4.12). Five of the windows were about psychosocial issues and three were regarding medical topics. All three medical windows received a physician response during the second attempt. However, three of the five psychosocial windows were terminated a second time by the physician.

At the third window attempt, only two patients initiated additional windows after previous attempts were terminated. Both of these windows were psychosocial. One received a response and one patient was a third time terminated. This patient, whose three
attempts thus far had all been terminated, attempted a fourth time to discuss the psychosocial issue with the physician. Once again, the physician terminated the conversation.

Summary. This examination of the individual patient data reveals the circumstances for subsequent patient windows of opportunity during the medical encounter. Half of all subsequent medical windows (N=7) were initiated due to the patient wanting to discuss a topic within the same medical theme, even after having received a response from the physician. Additionally, these patients received approximately the same amount of response discourse as patients who did not initiate subsequent windows about the same medical theme. This result suggests that it may not be the amount of discourse but perhaps some other aspect of the physician response such as the appropriateness or adequacy of the response.

With respect to psychosocial windows, patients introduced additional windows most often due to their previous psychosocial window having been terminated by their physician (N=8). This finding reinforces the reports that patients want to discuss
psychosocial issues during the medical encounter, but that physicians often do not address such issues (Bensing, 1991; Branch & Malik, 1993; Hall & Dornan, 1988; Suchman, et al., 1997).

Results for RQ6

The sixth research question (see page 37) was formulated to examine if there was some other patient behavior that might explain physician termination of windows. Specifically, the analysis aimed to discover whether the use of introductory comments aids the patient in eliciting a response from the physician.

As evidenced by Table 4.13, 26% of medical windows with preparatory remarks and 21% of medical windows without preparatory remarks were terminated. The data seem to suggest that using preparatory comments to signal that a window of opportunity was being presented had little effect on whether physicians responded to medical windows.

However, patients who utilized preparatory remarks to introduce psychosocial windows fared much better than those who did not use these introductory comments. Approximately half
(N=6) of psychosocial windows with preparatory comments were
terminated, while those not containing introductory remarks were
terminated almost two-thirds (N=18) of the time. Some
psychosocial windows that were originally terminated received a
delayed response at some point later in the interaction. Fifty
percent of originally terminated windows that eventually received a
response contained preparatory statements. Conversely, a mere five
percent (N=1) of terminated windows without preparatory remarks
eventually received a physician response.

Summary—The data indicate that the use of preparatory
statements had little effect on whether physicians' responded to
medical windows; however, they did impact physician response to
psychosocial windows. Preparatory remarks proved especially
beneficial for patients whose psychosocial windows at first were
terminated.
<table>
<thead>
<tr>
<th></th>
<th>Response</th>
<th>Terminator</th>
<th>Term/Delay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td></td>
</tr>
<tr>
<td><strong>With Preparatory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>14</td>
<td>5 (26.3)</td>
<td>0</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>7</td>
<td>6 (46.2)</td>
<td>3 (50.0)</td>
</tr>
<tr>
<td><strong>Without Preparatory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>15</td>
<td>4 (21.1)</td>
<td>0</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>9</td>
<td>18 (64.3)</td>
<td>1 (5.6)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>45</td>
<td>33</td>
<td>4</td>
</tr>
</tbody>
</table>

* Percentages were calculated using the total number of windows in that category.

* Windows that were originally terminated, but received physician delayed response at some point later in the interaction. Percentages are based on originally terminated windows. For example, 6 psychosocial window with preparatory remarks were originally terminated. Three of those received delayed response yielding the following: 6/3 = .50 or 50%.

Table 4.13: Frequencies and percentages of terminated windows with and without preparatory remarks.
Results for RQ7

It was not only important to determine if physicians responded to or terminated patients' expressions of negative affect, but also to examine the types of responses provided. The seventh research question (see page 37) was formulated to explore the type of response the physician provided to the patient. Physician response was coded as information, understanding, question, reassurance, redundancy, other, and continuer. Table 4.14 displays the distribution of physician response according to theme of the window. Not surprisingly, medical windows most often elicited information from physicians. Statements aimed at reassuring patients accounted for about one-third (N=78) of the physician immediate response discourse units to medical windows. Understanding and physician questions made up a little more than 10 percent of the immediate response discourse, accounting for 7.3% and 4.9%, respectively.
<table>
<thead>
<tr>
<th></th>
<th>Medical n(%)</th>
<th>Psychosocial n(%)</th>
<th>Total n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immediate Response</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>126 (51.0%)</td>
<td>30 (25.0%)</td>
<td>156 (42.5%)</td>
</tr>
<tr>
<td>Understanding</td>
<td>18 (7.3%)</td>
<td>32 (26.7%)</td>
<td>50 (13.6%)</td>
</tr>
<tr>
<td>Question</td>
<td>12 (4.9%)</td>
<td>31 (25.8%)</td>
<td>43 (11.7%)</td>
</tr>
<tr>
<td>Reassurance</td>
<td>78 (31.6%)</td>
<td>17 (14.2%)</td>
<td>95 (25.9%)</td>
</tr>
<tr>
<td>Redundancy</td>
<td>4 (1.6%)</td>
<td>2 (1.7%)</td>
<td>6 (1.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (0.8%)</td>
<td>5 (4.2%)</td>
<td>7 (1.9%)</td>
</tr>
<tr>
<td>Continuer</td>
<td>7 (2.8%)</td>
<td>3 (2.5%)</td>
<td>10 (2.7%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>247</td>
<td>120</td>
<td>367</td>
</tr>
</tbody>
</table>

| **Delayed Response** |              |                   |            |
| Information          | 26 (52.0%)   | 16 (31.4%)        | 42 (41.6%) |
| Understanding        | 0            | 9 (17.6%)         | 9 (8.9%)   |
| Question             | 0            | 13 (25.5%)        | 13 (12.9%) |
| Reassurance          | 24 (48.0%)   | 13 (25.5%)        | 37 (36.6%) |
| Redundancy           | 0            | 0                 | 0          |
| Other                | 0            | 0                 | 0          |
| **Total**            | 50           | 51                | 101        |

* Percentages are calculated in columns using category column totals.

Table 4.14: Frequency and percentage of discourse units by response type and window theme.
Physician immediate response to psychosocial windows was split rather equally among understanding, question, and information with each category sharing about one-quarter of the total immediate responses. Statements of reassurance to psychosocial windows received the least amount of discourse units among the top four categories (N=17).

With respect to delayed responses, physicians provided information and reassurances about equally to medical windows. Psychosocial windows received approximately equal amounts of discourse units that provided information or reassurance or that solicited information. Statements that conveyed understanding made up about 18% (N=9) of physicians delayed responses to psychosocial windows.

Returning to the two main communicative purposes of the medical consultation (i.e., information exchange and relational development), physician responses were grouped according to function. Information and Question responses were placed in the information exchange category, while Understanding and Reassurance responses were grouped into the relational
<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Psychosocial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
</tr>
<tr>
<td>Immediate Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Exchange</td>
<td>138 (59.0)</td>
<td>61 (55.5)</td>
</tr>
<tr>
<td>Relational Development</td>
<td>96 (41.0)</td>
<td>49 (44.5)</td>
</tr>
<tr>
<td>Total</td>
<td>234</td>
<td>110</td>
</tr>
<tr>
<td>Delayed Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Exchange</td>
<td>26 (52.0)</td>
<td>29 (56.9)</td>
</tr>
<tr>
<td>Relational Development</td>
<td>24 (48.0)</td>
<td>22 (43.1)</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>51</td>
</tr>
</tbody>
</table>

Table 4.15: Frequency and percentage of type of response discourse units by function category.

development category (see Table 4.15). While in all conditions (i.e., immediate and delayed responses to both medical and psychosocial windows) physicians provided more discourse units within the information exchange function than the relational development category, this difference is not significant. Overall, there is reasonable balance between the two categories. This finding is interesting in that physicians responded to medical
windows with approximately equal amounts of informative and affective responses. The same holds true for psychosocial windows in which one might expect more affective responses than informative. A closer examination of individual physician response is needed to determine the appropriateness of such responses.

**Summary.** The data seem to suggest that when physicians respond to windows of opportunity, they do so with a variety of responses that appear to be appropriate for the window. Follow-up research should examine the discourse to see how appropriate responses are for individual patient windows.
Chapter 5

IMPLICATIONS AND CONCLUSIONS

This chapter provides (a) a summary of the major results, (b) conceptual and practical implications of the findings, and (c) limitations and future research.

Summary of Results

The following pages summarize the major results of the study and are organized by research question to maximize clarity.

RQ1: To what extent do physician-patient dyads evidence windows of opportunity?

Windows of opportunity did not occur frequently within the medical consultation. Only about one-third of the physician-patient dyads in the original sample of 150 interviews contained
such discourse. Within dyads containing windows, affective
discourse constituted only 10% of the total patient discourse units.
Some patients initiated more than one window during the visit;
thus, the total number of windows in the sample was 78.

The analysis revealed some general trends regarding patient
initiation of windows. Almost half of all windows were introduced
during the beginning of the visit, rather than the middle or the end.
In terms of directness, patients most often expressed their negative
affect explicitly rather than by more indirect methods. Preparatory
remarks, though few in number, were utilized by over half of the
patients in the sample.

Finally, the majority of patient discourse units were
explanatory statements. These comments were only uttered after
the physician had responded to the window. Overall, eighty-two
percent (37/45) of all windows that received a physician response
contained patient explanatory comments.
RQ2: To what extent do physicians respond to patients’ windows of opportunity during the medical consultation?

Overall, physicians responded to 58% of all patient expressions of negative affect, while terminating 42% of these expressions. When physicians did respond, they provided immediate responses more often than delayed responses to first and second window attempts. This response ratio was reversed for third and fourth windows.

RQ3: Does physician response vary according to the directness of the patient?

An examination of directness revealed that patients overwhelmingly explicitly introduced windows into the conversation. Ninety percent of psychosocial windows and 74% of medical windows were introduced explicitly. However, patient directness had no affect on whether the physician responded to or terminated the window. When physicians did respond, they provided about the same amount of discourse units to explicit and implicit windows.
RQ4: To what types of expressions of negative affect do physicians respond?

The analysis indicated that the theme of the window appears to make a difference in whether the window is responded to or terminated. Of the 38 medical windows, less than one-quarter (N=9) were terminated as compared to 60% (N=24) of psychosocial windows. However, if the physician did respond to the window, theme made no difference in the amount of response units the patient received, either in terms of total discourse units or average response units per window.

An additional factor influencing physician response is the timing of the window. Patients who introduced windows during the beginning, as opposed to the middle or end of the consultation, generally received a higher percentage of physician response. Timing was especially critical for psychosocial windows in which the response rate fell from just over half during the beginning, to one-quarter in the middle, and less than one-third during the last part of
the visit. Overall, 68% (15/22) of psychosocial windows introduced during the middle or last part of the visit were never acknowledged by the physician.

**RQ5:** What are the circumstances under which patients initiate subsequent windows of opportunity?

Less than half of patients (N=20) initiated more than one window during the visit. The data point to several reasons why patients may initiate subsequent windows of opportunity: the patient did not receive the desired response to his or her previous initiation; the patient had more than one issue to discuss during the medical encounter; or the window was terminated by the physician, thereby requiring a subsequent initiation to elicit a response.

The circumstances for additional windows varied according to the theme of the window. Half of all subsequent medical windows were introduced due to the patient’s desire to discuss a topic within the same medical theme. In terms of psychosocial windows, the majority of additional patient initiation attempts were a result of termination of the previous window.
RQ6: Does the inclusion of patient preparatory comments make a difference in securing a physician response?

Using preparatory comments to signal that a medical window was being presented did not appear to affect whether a patient received a response. However, the results suggest that patients stand a better chance of eliciting a physician response to psychosocial windows if they utilize preparatory remarks. This also appears to be the case with psychosocial windows that were originally terminated and that eventually received a delayed response. Seventy-five percent (N=3) of initially terminated windows contained preparatory remarks when the window was introduced.

RQ7: What types of responses do physicians offer their patients?

Physicians responded to expressions of negative affect with information, understanding, questions, and reassurance. In terms of immediate responses, medial windows elicited mostly information, while psychosocial windows obtained approximately
equal amounts of understanding, questions, and information. The majority of delayed responses took the form of information and reassurance for medical windows and information, questions, and reassurance to psychosocial windows. Although small differences in the types of responses were witnessed between medical and psychosocial windows, these differences were not significant. The most interesting finding here was that, contrary to what one might expect, physicians responded with approximately equal amounts of affective as informative responses to medical windows as well as psychosocial windows.

Implications of the Study

This study attempted to explicate the affective discourse that occurs during the primary care visit. The results presented herein have both conceptual and practical implications which are explained in the following pages.
Conceptual Implications

As discussed in Chapter 1, the affective domain of the physician-patient relationship has been conceptualized and operationalized in a variety of ways. Researchers have used various terminology to describe behaviors within the affective domain including humanistic, socioemotional, and psychosocial. The impression one gets from the literature is that the terms affective and psychosocial are synonymous. However, the data presented in this study point to expressions of negative affect that are tied not only to psychosocial issues (work, family, behavior, social), but also to medical topics (symptoms, diagnosis, procedures). Almost half (N=38) of all patients' expressions of negative affect were concerning medical issues. This medical component of affective behavior gets lost in a literature that often refers to the affective domain as consisting of discourse about non-medical topics (Arborleius & Osterberg, 1995; Bensing, 1991; DiMatteo, Prince, & Taranta, 1979; Freeman, Negrete, Davis, & Korsch, 1971; Levinson & Roter, 1995; Rodin & Janis, 1979).
The importance of the affective domain in physician-patient communication has been documented in studies that have shown how the physician's treatment of affective behaviors within the medical consultation impacts the patient's health (Bensing, 1991; Ben-Sira, 1984; Forde, 1996; White, 1988). However, previous research in this area has not distinguished the particular aspects of affective discourse. While studies report that patients want to talk about affective issues during the medical visit, what has not been clarified is what exactly it is that patients want to discuss. This study provides an extensive description of patients' expressions of negative affect during the primary care visit.

Little research has focused on how physicians respond to patient expressions of negative affect, other than reports that physicians do not usually discuss such issues (Bridges & Goldberg, 1985; Campbell, Neikirk, & Hosokawa, 1990; Katon, Williamson, & Ries, 1981; Novack, 1981; Roter, et al., 1995; Verhaak & Wennick, 1990; Von Korff, et al., 1987). Physicians are often criticized for being impersonal and not responding to the patient's needs (Engel, 1980). Contrary to these assertions, physicians in this study

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responded to 58% of all patient windows of opportunity. This result suggests that the blanket statement implying physicians do not respond to affective expressions is misleading. Rather, from this analysis it appears that physicians respond to that which they know best, namely medical matters.

Patients expressing negative affect concerning medical issues experienced a high response rate. Physicians in the sample responded to 76% (29/38) of all medical windows by providing mostly information. However, it should also be noted that physicians provided a considerable amount of affective responses to medical windows.

Where physicians appear to be less responsive is to psychosocial windows. Sixty percent of psychosocial windows were terminated. When physicians did respond to these expressions, they provided understanding, questions, and information, suggesting that an appropriate response to psychosocial matters may not always be affective.
The current study provides a more complete conceptualization of the affective domain of the physician-patient relationship than has occurred in the past. Earlier research has neglected the medical component of the affective domain. This new definition demonstrates that expressions of negative affect may consist of non-medical as well as medical concerns. This dimension was lacking in previous conceptualizations of the affective domain.

**Practical Implications**

There is growing insight that affective behaviors influence the development and severity of almost every disease as well as the recovery and even survival of many patients (Bensing, 1991; Bensira, 1984; White, 1988). Even when the resolution of a technical aspect of the physician-patient encounter might appear to be the most important decision to the end result of medical care, effective communication within the affective domain is still an important component of the success of the interaction (Inui & Carter, 1985). While researchers continue to explore physician and patient affective behaviors, the implications from such studies are rarely
translated into everyday medical practice (Bensing, 1991). The following section describes some implications of the findings for communication skills training for both patients and physicians.

**Patient training.** Patients who initiated medical windows experienced a high physician response rate, regardless of whether the topic was explicitly or implicitly introduced. However, the results suggest that when initiating a discussion about psychosocial topics, patients should be explicit in their desire to talk about such issues. Although medical windows experienced a relatively high response rate throughout the visit, 68% of psychosocial windows initiated in the middle or last part of the interview were terminated. The data suggest that patients who have psychosocial concerns should introduce windows early in the consultation, and do so explicitly.

Another practical result comes from the manner in which patients express negative affect. Preparatory remarks appeared to be helpful in soliciting response for psychosocial windows. Patients who used introductory statements were more likely to receive an
immediate or delayed response from the physician. Patients should also note that psychosocial windows were terminated more often than medical windows. Therefore, the goal of discussing psychosocial concerns might involve some persistence on the part of the patient.

One way to incorporate these implications is through patient communication skills training. Current training efforts involve the use of text, videotape, and face-to-face methods of intervention. Modeling techniques have also been shown to yield positive results. The data set provides some rich examples of successful and unsuccessful patient expressions of negative affect. These could be incorporated into the text of brochures and role-played for patients in video and face-to-face training situations.

Physician Training. At first glance, the data in this analysis appear to demonstrate that physicians do not respond extensively to expressions of negative affect. The findings further appear to suggest that physicians continue to rely upon the biomedical approach that disregards the subjective aspects of illness. While
physicians terminated 42% of windows, they did respond to 76% of all windows regarding medical concerns and 40% of psychosocial windows. Physicians responded similarly by providing information, understanding, questions, and assurance.

The literature appears to create a false dichotomy between medical and affective discourse. The data herein suggest that there is overlap among the two domains. That is, one can talk about a medical issue both technically (information) and affectively (reassurance). What appears to be important is the appropriateness of the response.

The data indicate that physicians need to be sensitive to patients' expressions of negative affect during the medical visit. They need to hear what is being said and be responsive to such expressions when they occur.

The data provide some examples of physician responses and terminators to both medical and psychosocial windows of opportunity. Excerpts from transcripts could be used in communication skills training for physicians to enhance their affective behavior. Specifically, physicians could be trained to
recognize a potential opportunities, especially those concerning psychosocial issues. Medical students could be exposed to these types of patient expressions early in their training so that they will be better able to incorporate this type of communication into their interactions with patients. Practicing physicians could be required to attend continuing medical education (CME) programs designed to enhance physician communication skills.

Limitations and Future Research

One limitation of the current study is the small sample of patients initiating windows. Although this supports previous findings that windows do not occur as often as other types of discourse (Roter, et al., 1995), the relative small frequencies did not allow for extensive statistical testing. Frequencies and percentages were used to explore the composition of patient windows and physician responses to those initiations.
The current study was a preliminary testing of a new coding system designed to discern affective discourse. Although reliabilities in most areas were high for a new system, additional studies should be conducted to expand and refine the categories as needed, with specific attention to the operationalization of explicit and implicit windows. The data indicate that the majority of windows were introduced explicitly by patients. This raises the question of whether more indirect expressions were really as implicit as they appeared.

The results of the study are exciting because of the expectations going into the investigation. The literature on physician-patient communication leads one to believe that physicians do not respond to patients' demonstration of negative affect during the medical visit. The expectation was that this data would support earlier findings. However, categorical analysis of the data found that physicians responded to 58% of all windows presented during the visit. Additionally, physicians responded with
both technical and affective responses to medical and psychosocial windows. Further examination of individual responses is needed to determine the appropriateness of these responses.

Physicians provided similar amounts of response discourse units to both explicit and implicit windows. Discourse theory would predict that implicit expressions are more ambiguous and therefore would be more difficult for the physician to respond to appropriately, if at all. However, physicians in the sample picked up on and responded to voice qualities in implicit expressions. The results here suggest that, although the conceptualization and operationalization of explicit and implicit windows was based on previous research, this is an area that requires more focused attention.

The timing of windows was roughly calculated by using the number of typed, double-spaced pages of discourse. While this procedure provided one indication of when windows were initiated, follow-up study should be conducted using the number of actual discourse units between window initiations. This would provide a more accurate picture of how much time elapses before subsequent
windows are introduced. Discourse units could also be used to examine the time that elapses between a physician's immediate and delayed response as well as a physician's initial terminator and delayed response. Another way to examine the issue of time is through the standard phases of the interview: history, examination, and post-examination. Discourse could be analyzed to discover in which phase windows are initiated and what types of responses these windows receive. Such information could have additional implications for communication skills training.

This study focused only on windows of opportunity for physicians to discuss patients' expressions of negative affect; however, other windows may exist within the medical consultation. For example, future studies might examine opportunities for physicians to praise or reinforce good health behaviors (i.e. progress on smoking cessation). This study's exclusive focus on negative affect neglected physician windows of opportunity to express positive emotion. Other potential windows include opportunities to discuss the patient's physical limitations or ability to perform the task. For example, a diabetic patient's ability to give
him/herself an insulin shot. Also, opportunities exist to discuss problems with treatment or for physicians to provide the patient with more directives. There are opportunities within the medical visit for physicians to address the patient's lack of knowledge or to discuss misunderstandings. Discussion within these potential windows could have implications for patient non-compliance with medical recommendations as well as patient overall health status and thus should be explored.

While seven physicians responded to all windows that were presented to them, two-thirds of the physicians in this study provided both responses and terminators to medical and psychosocial windows of opportunity. Since a large portion of physicians provided mixed responses, it would be worthwhile to explore the factors that influence the physician's decision to respond or terminate. Analyses were run on the demographic characteristics of both physicians and patients in the sample. None of these analyses were significant. Additional analyses on compliance, perception of competence, and severity of illness were run. Again, these results were non-significant. Further examination
of such factors as location of the practice and time of day for the visit should be conducted. Exploration of these and other aspects of the interaction might hold the key to discovering under what conditions physicians respond.

The current investigation attempted to provide a quantitative analysis of a phenomenon that would also be well-served by a more qualitative approach. While much has been described herein regarding both patient and physician behaviors, much more can be gained by an in-depth, individual analysis of the windows of opportunity initiated by the patients.

For example, this study reported relative frequency of response and the amount of discourse provided. Although the coding system reflects the topic of the discourse, qualitative analysis is needed to examine the appropriateness or adequacy of individual responses. What is most important is the content and sequencing of what is said and not necessarily the functional category in which the discourse is placed. Analysis of this nature would allow for inquiry into whether the response provided was appropriate.
One analysis of physician response seemed to suggest that the responses were appropriate given the theme of the window. However, patients initiated subsequent medical windows about related medical themes even after having received the same amount of response discourse units as other patients with similar expressions. Additionally, reassurance might, at first glance, seem the appropriate response to a window about psychosocial concerns. However, a window about losing one's job suggests that information about unemployment insurance or job opportunities might be a more appropriate response than offering reassurance, even though the window is psychosocial in nature. What is not clear from the current analysis is whether the physician response was appropriate for the individual patient window. Future study involving a more qualitative assessment is needed to accomplish this goal.

Such an approach could also be beneficial in discovering the nature of delayed responses. Qualitative techniques could examine the discourse that is presented between immediate and delayed responses as well as that which is provided between a terminator and a delayed response. Additionally, this type of analysis could
explore the content of delayed responses. That is, do these responses contain additional or merely summary content. Also, is the delayed response more appropriate or less appropriate than the immediate response provided. Finally, a more qualitative approach to the data could explore how much the physician allows the patient to discuss the emotion before he or she interrupts or responds as well as how much opportunity is afforded the patient for explanatory comments. It is only when the discourse is examined at this level that issues such as these can be addressed.

The generalizability of these observations has to be tempered by a number of other factors which can only be addressed in future research. For example, the organizational structure of the health care practice could affect the physician's willingness to respond to windows of opportunity. The physicians in this analysis were primary care providers. However, response rates might also be influenced by whether the physician is a family physician administering primary care or a specialist in a particular area of expertise such as cancer or heart health. Finally, the financial structure of health care might have implications on physician
response. None of the facilities in this analysis were health maintenance organizations (HMOs). Rather, physicians were either part of a private practice facility or members of university-supported clinics. Differentiations in financing should also be evaluated to determine the effects, if any, on physician response to patient expressions of negative affect.

In closing, this dissertation provides detailed explication of patient expressions of negative affect during the primary care visit. Further, it provides the basis and justification for a new conceptualization of the affective domain of physician-patient communication. Affective behaviors have been shown to impact patients' illness recovery and overall health status. For this reason, it is imperative that proper focus and attention be paid to research in this area. Hopefully, this study will contribute to that effort.
## APPENDIX A

### Patient Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Trained N</th>
<th>Informed N</th>
<th>Untrained N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>35</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td>African American</td>
<td>13</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Mean Age</td>
<td>43</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grammar</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>High School</td>
<td>14</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Some College</td>
<td>14</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>College</td>
<td>14</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Graduate School</td>
<td>8</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>
There are some basic concepts that are essential in understanding this discourse coding system. These include expressions of negative affect, windows of opportunity, patient initiation, current emotions, unitizing, and coding. The following paragraphs provide a brief explanation of these concepts. It is difficult to explain some concepts without using terms from other constructs that have yet been discussed. For this reason, it is imperative that you read the entire code manual BEFORE you begin listening to tapes and coding transcripts.
Negative Affect

Physician-patient discourse has been classified into two distinct domains: instrumental and affective. Instrumental or task-focused behaviors include the technical aspects of the medical visits such as asking questions, discussing treatment results, giving directions, and physical examinations. Affective behaviors are designed to establish and maintain a positive relationship between the physician and patient. These involve showing interest in the patient's personal, family, and social issues as well as being tolerant to his or her behavior as an anxiety-laden individual and not simply as a detached instrumental object.

Affective behaviors can be either positive or negative. This study focuses on the patient's expression of negative affect during the medical consultation. Negative affect is defined as the expression of worry, concern, anger, tension, or anxiety.

Some expressions may necessarily be tied to medical topics, but the ones of interest to this study go beyond simply the somatic description of the illness to how the medical condition impacts the patient's life.
**Windows of Opportunity**

Some patients will express negative affect explicitly during the visit. Other patients will indirectly make reference to these issues in hopes that the physician will realize the patient's desire to discuss the emotion further. There exist within the medical visit a limited opportunity for the physician to respond to the patient's expression of emotion. This is the physician's "window of opportunity" to allow the patient to discuss the negative affect and to respond to the patient. You will code these windows.

**Patient Initiation**

The most basic assumption of this coding system is that the "window of opportunity" must be initiated by the patient. At times, the physician will initially inquire about a patient's emotional state. These instances will not be coded since the focus of the study is patient initiation of and physician response to expressions of negative affect during the medical consultation. Negative affect is
defined as the expression of worry, concern, anger, tension, or anxiety about a variety of topics such as family, work, behavior, and medical diagnosis.

**Current Emotions**

The coding system focuses only on expressions of current emotions. If a patient explains that he or she was worried about something in the past, this instance will not be coded. The tense of emotion can often be determined by the choice of words. However, do not let a past tense verb choice be the only criteria in determining if the emotion is past or current. Rather, the decision depends upon whether the patient is bringing the emotion to the current interaction. Therefore, if a patient has been concerned about an issue in the past and continues to experience anxiety, this is considered a current expression.

Additionally, if the reason for the visit is affective in nature, DO NOT code the exchange. That is, if a patient is seeing the physician to discuss anxiety levels and this is the stated reason for the visit, do not code the discourse that pertains to this anxiety.
The current study is only interested in expressions of negative affect that are initiated during the course of the physician-patient interaction and not those that are scheduled topics of discussion.

**Unitizing**

Only patient expressions of emotion and physician responses to those expressions will be coded. The basic unit of analysis will be the participant's utterance or uninterrupted word or series of words. Therefore, once an expression of negative affect has been identified the discourse must be unitized. Only that portion of the participant's talk that pertains to the emotion should be unitized and coded. You may find that a participant begins to display affective behaviors, but then turns to a more biomedical line of conversation. Unitize only the affective discourse.

**Coding**

The code refers to an 8-character symbol that defines the discourse unit. Each unit will receive a code. The patients' codes have only 6 defined characters, so the last 2 characters are
placeholders. The physicians' codes are 8 characters in length. Remember that the patient must initiate the conversation about the affective issues. Again, you should code only that discourse that pertains to negative affect. If the conversation turns to another topic or turns back to the technical aspects of the topic, coding of the participants' utterances is terminated.
Code Categories

Speaker

Each utterance is assigned a speaker code identifying which participant spoke the utterance. D is used to signify utterances spoken by the physician, while P is assigned to utterances spoken by the patient.

Number of the Window

The first step is to identify instances in which a patient initiates the discussion of an emotion. Some patients will attempt to bring up a topic with the physician in which the line of conversation is terminated. The patient may then attempt once again to introduce the topic. During other medical visits, a patient may have several topics that need to be discussed. For these reasons, it is important to note the number of the expression. This is a simple accounting
for the number of times a patient expresses negative affect and creates a window of opportunity. A patient may discuss several topics within the same window. The number of the window is determined by a brand new introduction of an issue either after the initial expression has been terminated or explored.

1 = 1st Window
2 = 2nd Window
3 = 3rd Window
4 = 4th Window

There are a few idiosyncrasies when assigning the Number of Window Code.

a) The patient may open a window of opportunity for the physician and then turn to other topics. If a patient opens the window and the physician terminates the conversation and then the patient attempts again to
bring up the topic, count this as 2 separate expressions. The first one is coded as a terminated expression and the patient then introduces the second.

b) If the patient opens a window and the physician explores the topic, then the patient returns to that same issue later in the visit, count this as an explanation of the original window, NOT another expression.

c) If the patient opens a window and the physician explores the topic, then the physician returns to that same issue later in the visit, count this as a delayed response to the original window.

**Explicit and Implicit Expressions**

Patients may express emotions explicitly by expressing their concern about something. Other patients will be more indirect when providing the opportunity to discuss the emotion. Once an
opportunity has been identified, a code indicating whether the expression is explicit or implicit should be assigned to the discourse unit.

<table>
<thead>
<tr>
<th>Type</th>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explicit Expression</td>
<td>E</td>
<td>Explicit expressions are those instances that are flagged linguistically. The patient explicitly states that he or she is worried or concerned about something or the discourse is such that it is obvious that an emotion has been expressed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EX: &quot;But I have some concerns and I haven't had the opportunity to talk to anybody.&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EX: &quot;I'm feeling homicidal, suicidal.&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EX: &quot;I mean, I have a hard time separating out what's emotional, what's hormonal, and you know, what's physical.&quot;</td>
</tr>
</tbody>
</table>

| Implicit Expression | I      | Implicit expressions are those instances in which the patient does not directly state the emotion, but that                               |

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can be inferred by word choice or by vocal qualities. There is a nonverbal component within the implicit expressions so you must be attentive to vocal tone. Some patients will hesitate or hedge as they attempt to express the emotion but will eventually be able to express it directly. For this reason, it is imperative that you listen to the audiotape in conjunction with the transcript in order to gain a better understanding of dynamic of the interaction.

EX: "Then there was the other thing was just a minor thing, I hope."

EX: "I thought sometimes at night I didn't know if I was going to wake up the next morning alive or not. Because you know, I mean you think that it's going to move or something. But you said it wouldn't move, right?"

EX: "But if down the road there would be a comfort level with not using condoms, is it, am I safe enough I guess as far as the pregnancy issue?"
**Progress of the Expression**

Some patients take several utterances before the eventual expression of negative affect, while others are very direct with their emotions. Likewise, some physicians will invite a patient to continue to express and explore the emotion before responding. For this reason, the coding scheme takes into account where in the progression of the expression the utterance occurs. That is, does the utterance consist of introductory or preparatory remarks before the patient formulates the expression. There is the actual window of opportunity in which the patient actually expresses the emotion. Finally, after the physician gives permission, the patient may give additional explanation or information.

<table>
<thead>
<tr>
<th>Type</th>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparatory</td>
<td>P</td>
<td>Preparatory remarks involve patients' comments leading to a window of opportunity.</td>
</tr>
</tbody>
</table>
**Window**  
\textit{W}  
The window of the expression is content-based; therefore, the window begins when the patient expresses negative affect. Once the window is opened, all utterances are coded "W" until the physician speaks.

**Explanatory**  
\textit{X}  
The explanatory code is used only after the physician has responded to a window. That is, after the physician acknowledges the expression, all subsequent patient utterances are coded as explanatory. In this manner, we can see how much the physician allows the patient to explore the emotion.

From these definitions, you see that all utterances are coded as  
Preparatory (P) or Window (W) until the physician has  
acknowledged the topic. All utterances subsequent to the  
physician's acknowledgment are coded as Explanatory (X)
Patients express emotion regarding a variety of topics within the medical consultation. This step requires that you identify the topic of the utterance. That is, what the utterance is about generally. The patient initiates the window of opportunity and determines the topic. When coding the physician's discourse, you will need to carry forward the identified topic so that it is apparent to what the physician is responding. The topical codes are listed below under "Symbol."

<table>
<thead>
<tr>
<th>Topic</th>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>F</td>
<td>Emotions related to a patient's family and home life, including pressures associated with children, spouse, and relatives.</td>
</tr>
<tr>
<td>Social</td>
<td>S</td>
<td>Emotions related to the patient's social life or feelings toward society in general. Included in this category is a general feeling of anxiety.</td>
</tr>
<tr>
<td>Category</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>Work</td>
<td>W</td>
<td>Emotions related to the patient's work environment including pressures from the position and responsibilities or the people with whom the patient works.</td>
</tr>
<tr>
<td>Behavior</td>
<td>B</td>
<td>Emotions related to the patient's behavior including smoking, drinking, diet, sleeping habits, etc.</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>D</td>
<td>Emotions related to a patient's diagnosis of a medical condition. This may be in response to a physician's current diagnosis or a self-diagnosis by the patient.</td>
</tr>
<tr>
<td>Procedures/Tests</td>
<td>P</td>
<td>Emotions related to procedures or tests including details about the procedure or test as well as results from procedures or tests.</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Y</td>
<td>Emotions related to symptoms associated with a patient's medical condition; how symptoms impact the patient's life. This is different from a simple accounting for or description of symptoms.</td>
</tr>
<tr>
<td>Treatment</td>
<td>T</td>
<td>Emotions related to a patient's treatment for a medical condition. Included in this category are such matters as medications, physical therapy, and referrals to other medical professionals.</td>
</tr>
</tbody>
</table>
**Prognosis**  R  Emotions related to the long-term aspects of a medical condition. Included in this category are concerns about how long the condition will last, whether or not a full recovery can be expected, etc.

**Procedural**  G  Emotions related to health care benefits, plans, etc. to pay for treatment including paperwork, third party-provider, and disability benefit.

**Speech**  K  
**Disfluencies**  Statements within the expression of negative affect that carry no contextual contribution to the conversation. These include incomplete statements, redundancies, and repetitions in speech.

**Other**  O  Emotions that do not fit into one of the previous categories but that are classified as affective in nature.
Topical Subcategory

Four of the above topics have subcategories (family, social, work, and behavior). All of the remaining topics receive a placeholder (zero) for this code. This will be assigned as the 6th and final code for the patient utterances. Please place zeros (0) in the two remaining character locations of the 8 character discourse code.

<table>
<thead>
<tr>
<th>Family</th>
<th>1</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Emotions related to a patient's child(ren)</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Spouse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotions related to a patient's spouse</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Relatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotions related to a patient's relatives other than children or spouse including siblings, parents, in-laws, etc.</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotions related to a patient's family that do not fit into one of the above categories.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social</th>
<th>1</th>
<th>General Anxiety/Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Statements that indicate a general sense of anxiety including being stressed out.</td>
</tr>
</tbody>
</table>
2 Social Life/Relationships
Statements about a patient's social life or interpersonal relationships including intimate relations.

3 Emotional State
Statements regarding a patient's current emotional state such as feeling upset or being angry.

4 Other
Statements about a patient's social circumstances that do not fit into one of the above categories.

Work 1 Dangers
Emotions related to dangers at the patient's place of business such as the threat of disease or exposure to other harms.

2 Too much work/stress
Statements expressing the amount of work, number of hours worked, or stress that the patient experiences while at work or as a result of work.

3 Co-workers
Statements related to co-workers and/or other employees at the patient's place of business.

4 Other
Statements related to a patient's work that do not fit into one of the above categories.
### Behavior 1
**Eating/Exercise**
Emotions related to a patient's diet or eating habits or about a patient's level of activity

### 2 Smoking/Alcohol
Emotions related to a patient's smoking habits or alcohol consumption

### 3 Sexual Behavior
Emotions related to a patient's sexual behavior including partners, practices, disease, etc.

### 4 Other
Emotions related to a patient's behavior that do not fit into one of the above categories.

---

**Physician Response**

Once a patient's initiation and topic of the expression have been identified, it is important to examine the manner in which the physician responds to the patient. A physician may respond immediately by continuing or terminating the discussion. The physician may also address the emotion at some other point in the consultation. The physician may respond to an accumulated string
of expressions of emotion with a response at the end of the visit.

Distinctions between immediate and delayed responses are listed below. Again, you will need to carry forward the topical code (and topical subcategory code when applicable) assigned to the patient utterance to which the physician is responding.

<table>
<thead>
<tr>
<th>Type</th>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>R</td>
<td>A physician's immediate response to the patient's expression of negative affect.</td>
</tr>
<tr>
<td>Continuer</td>
<td>C</td>
<td>A physician's statement following an expression of negative affect that allows the patient to further explore the emotion. This could be as simple as &quot;uh-huh,&quot; &quot;OK,&quot; or &quot;go on.&quot; The physician could repeat the patient's expression in part or full in a manner that seeks to have the patient continue with explanation. A continuer does not provide information, but rather invites the patient to elaborate and to explore the expression.</td>
</tr>
<tr>
<td>Terminator</td>
<td>T</td>
<td>A physician's statement following the patient's expression of emotion that ignores the demonstration of affect.</td>
</tr>
</tbody>
</table>
Delayed Response

L

A physician's delayed response to a patient's expression of emotion. Discourse is only considered a delayed response if the physician voluntarily comes back to the topic. If the patient has to bring up the issue again, this is counted as another expression and assigned the next corresponding number of expression.

Type of Response

If the physician provides a response or delayed response to the patient's expression of negative affect, the type of physician response should be coded.

<table>
<thead>
<tr>
<th>Type</th>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>I</td>
<td>The physician responds by providing additional information about the topic or issue.</td>
</tr>
<tr>
<td>EX:</td>
<td></td>
<td>&quot;No, it may get bigger. . . .it is a cyst as well.&quot;</td>
</tr>
</tbody>
</table>
Understanding U or Compassion

The physician responds by showing compassion and understanding toward the patient. One way to do this is that the physician will "name" the emotion. For example, the physician might say, "it sounds to me like you are upset," or "you feel guilty." Another way to show compassion is that the physician might demonstrate some sort of confirmation. For example, the physician might say, "You know, if that happened to me, I'd be upset too."

EX: "We'll, try to see if we can't get a handle on things, make you feel a little better here."

Question to Q Gather More Information or Check for Understanding

The physician asks question(s) of the patient in an attempt to further his or her understanding of the situation and to better prepare a response. This could take the form of a direct or indirect question.

EX: "Do you have plans of hurting yourself?"
EX: "I don't know how that sounds to you."
**Reassurance**  A  The physician responds by offering assurance to the patient regarding the emotion. These are statements that are designed to allay the patient's concerns. Examples might include assurances that the patient will not die from a procedure, that the patient's feelings are normal, or that the patient will be OK.

EX: "But what I want to give you is also some assurances."

**Redundancy**  D  Physician utterances consisting of repeated information or statements that do not provide additional information or content.

**Other**  O  A physician's response to a patient's demonstration of emotion that does not fit into one of the previous categories.

An important note to remember is that you are coding people's naturally occurring discourse. I am looking for particular behaviors that may or may not occur during these interactions. These individuals are not aware of my interests or research goals. There will necessarily be talk that does not fit into the specific criteria for inclusion in this particular examination of physician-patient interactions.
communication. Therefore, it is important for you to always keep in mind to code only that portion of the discourse that is of interest to the study (e.g. discussion of psychosocial topics).
APPENDIX C

Sample Physician Responses, Delayed Responses, and Terminators

Examples of Responses

P Yeah, I'm just kind of compare it to too much stress. I've been stressed out a little bit more lately than usual. Although I've been under stress for the past seven, sixteen, seventeen months.

D Was that because of work, or . . ?

P No, because of family problems with children. You know how it is.

D I got a 16 year old.

P Actually,

D 16 is more stress than the rest of them put together.
P No, now, I think when they start getting in their late 20s, early 30s, is when they go completely crazy.

D Oh, mean it gets worse?

P The guy has problems with condoms.

D What kind of problems?

P It ruins the mood and he gets kind of klutzy. And he may have to find a different brand or a different size. And he may just have to, you know, go along with my insistence.

D So far, so far he's described all the things that men come up with not to use the condom.

P Yeah.

D OK. Well, it's very . . .

P There was part of one evening that we didn't.

D It's, it's very easy. You say no condom, no sex. Which one's more uncomfortable for you?

P Right. That's the way it's going to be, you know.
D  It's pretty darned simple. Now if you had latex allergy or
something like that, I mean if his, if his, if the penis swelled up
and turned red and got, you know, and got in the terrible shape
from the latex allergy, that'd be one thing. But it's very
important in today's society (right) that you look at every
protective mechanism that you can until you can be absolutely
sure. When's going to be that point? When are you going to be
absolutely sure?

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P  Well, I'm under a ton of stress.

D  OK, when did that start?

P  What the stress? (um hm) Oh, probably in July

D  About the time your wheezing and asthma started?

P  It was about then. First my dad was in the hospital. Get that all
over with and then we're in the process of selling our house and
we're trying to move.

D  Did he survive?

P  Yeah.
D Where’s he at now?

P Home.

D OK. But your selling, he’s selling his house?

P No, we’re selling our house.

D OK.

P So I got people coming through. I hate my job. Other than that
life’s just great.

D Is there anything in your life that’s going really great, that helps
relieve the stress?

P No.

D OK. How’s your social life, relationships?

P Great.

D Those are all OK?

P Yeah.

D So those are not a source of stress.

*******************************************************************************
P It probably gave the pace maker, it probably gave air to those protein and probably caused it to do all this. Because none of this started before.

D No, you know what? I bet, I think this is actually been going on for awhile. Longer than probably the last year. Probably it's been going on before you even, I started seeing you a year ago. And most likely what happened is that you started developing the, the symptoms of the amiloidosis, the protein, when the first symptom was that funny heart beat. (oh) OK? That funny heart beat is, is not, is not that uncommon. But one of the unusual causes of it is this protein, this amiloidosis. OK? We, we went ahead and tried to control the heart beat. Had difficulty doing it, and that's why the cardiologist recommended putting in the pacemaker, OK? The, you know, the pacemaker is helping your heart beat. Certainly it's keeping it at a regular beat.

******************************************************************
I work in human resources. But I work for a printing company. Exposed to some chemicals.

OK.

But I do work closely with our environmental coordinator, too. We are way below limits.

All right. Do you know what chemicals you’re exposed to?

I have about a 12 page list. (OK) Methaline chloride we just got rid of. Mostly it would be adhesives and solids.

All right, that’s a good, for a summary sheet, that is a good thing. Married, single?
Examples of Delayed Responses

D You said a couple of things when I first came in that I want to get back to and touch base on. And that's when you said you were feeling suicidal and homicidal. Let's talk about that for a moment. Do you have plans of hurting yourself?

D And then you're going to let me know what you want me to do about this other. You want me to try and set something up?

D So, you're a single parent and that has to add a fair amount of stress to your life, I would think.

D The other thing that you asked me about and that I can address now is your hands turning cold and blue, kind of back and forth. That's actually a relatively common complaint that I have, that people come to see me about.
Examples of Terminators

P  Well, I've had a headache way before the Redux. And it's because I've been under stress.

D  OK. Why don't you look up in that corner there.

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P  You know, still stressed out a little. But nothing unusual for me. I been stressed out now for the last sixteen, seventeen months. But I've been trying to get it under control. And having a shoulder problem from the accident don't help any.

D  Your headaches have been the whole head maybe?

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P  Then I started thinking well maybe it's just work, starting to put a little pressure on me here recently.

D  What's the pain feel like?

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P  That's when I started considering maybe it was something work
related. So I tried to put my mind on other things when I was at
work, but it just, all this didn't seem to go away.

D  Any nausea?

D  And you've been under more stress at work lately?

P  Yeah. That's why I was beginning to consider . . .

D  Have your eating habits changed? Diet?

P  Yeah, because I mean I'm an electrician and I run work and it's
not unusual for me to have several jobs going at the same time
all over the place. (Um hm) You know, and you're only one
person. You can only be at one place at one time. And it does
build up over a period of time.

D  Want you to look up at the ceiling. [p] Now look at me.
It looks like you did a pretty good job.

Maybe I'm just so tired. You know, everyone have problems.

But sometimes I feel like when I'm driving in the darkness.

You haven't had hepatitis?

You know, the hepatitis and everything going around and all.

Now are you able to have intercourse?

But my body says not quite.

You know my physical body. (um hm) My mind says yes, yes.

In my mind it's still there. (um hm) But as far as being able to

But as far as seeing a, seeing somebody or things like that, but
REFERENCES


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