"Fire away": the opening sequence in general practice consultations

Joseph Gafaranga and Nicky Britten

Background. Proponents of recent models of the doctor–patient relationship, such as concordance and shared decision making, have emphasized mutuality rather than paternalism or consumerism. However, little attention has been paid so far to the ways in which this might actually be achieved.

Objectives. The aims of this study were to establish whether there are any rules governing the opening sequence in general practice consultations, and to analyse the ways in which the observing or breaking of such rules contributes to the development of mutuality between patients and GPs.

Methods. The paper is based on a qualitative study of 62 patients consulting 20 GPs in 20 practices in the Midlands and Southeast of England. Consultations were audio recorded and transcribed; patients were interviewed before and after each consultation, and doctors were interviewed afterwards. Data were analysed using the sociological method of Conversation Analysis. The outcomes were participants’ own understandings as demonstrated in their speech.

Results. A selection rule was identified whereby doctors choose between the questions “How are you?” and “What can I do for you?” to elicit patients’ concerns. Deviations from this selection rule may be either repairable or strategic. Repairable deviance is based on misunderstanding between participants, and is resolved interactionally, usually by patients. Strategic deviance is the attempt by doctors to emphasize or de-emphasize certain aspects of their relationships with particular patients. Deviations from the rule which are not repaired lead to misalignment between participants.

Conclusion. In relation to concordance, or shared decision making more generally, this analysis demonstrates that alignment or misalignment between participants will occur before any discussion about treatment options occurs. In cases of misalignment, concordance will be much harder to achieve. Mutuality is an achievement of both patients and doctors, and requires the active participation of patients.

Keywords. Communication, family physicians, physician–patient relationships, patient participation.

Introduction

Recent models of the doctor–patient relationship, such as concordance¹ and shared decision making,² have emphasized mutuality rather than paternalism or consumerism.³ These models usually are theoretical, and little attention has been paid so far to the ways in which concordant consultations or shared decisions might actually be achieved. In moving from theory to practice, it is helpful to examine the ways in which experienced practitioners conduct their consultations. As a relationship between people, mutuality (and therefore concordance) develops through and is revealed in social interaction between doctors and patients. By carrying out detailed analyses of what patients and doctors actually say to each other, it is possible to identify the building blocks of concordant consultations.⁴ Naturally, this analysis should focus on the different stages of the medical encounter.⁵–⁹ Although experienced practitioners may know how to achieve mutuality, they are not necessarily able to explain this to other people without a great deal of reflection. Even those involved in teaching may not...
carry out the detailed analysis of consultation behaviour being proposed here.

Our aim in this paper is to examine the organization of one such building block, namely the opening sequence, and draw out relevant implications for both practitioners and researchers in the area of concordance. Nearly 20 years ago, Heath10 analysed opening sequences in general practice consultations in the UK and demonstrated that they were orderly. A central distinction in Heath’s analysis was between new appointments, which were patient initiated, and return appointments, which were doctor initiated. In revisiting the opening sequence in general practice consultations, we will keep in mind three specific objectives. First, by examining actual interactions between patients and GPs, we want to establish whether there are any rules governing the opening sequence in contemporary general practice consultations in England. Secondly, if there are such rules, we wish to analyse the ways in which the observing or breaking of such rules contributes to the development of mutuality between patients and GPs. Finally, we want to think about possible implications, for practice as well as for research, which can be drawn from the fact that the opening sequence is orderly.

Methods

This paper is based on a British study of 62 general practice consultations, involving 62 patients and 20 doctors in the Midlands and Southeast of England. The study design has been described in detail elsewhere11 and early results reported.12,13 Ethical approval was obtained from 11 local health authority ethics committees. Patients were interviewed before and after the consultation, usually in their own homes, and, in a small number of cases, at health centres. Consultations were recorded and transcribed. Doctors themselves were interviewed about each consultation they had had with each of the study patients.

The paper uses a sociological perspective, based on ethnomethodology in general and Conversation Analysis in particular.14,15 A basic assumption of this perspective is that social interaction is structurally organized, and the focus of analysis is to uncover the socially organized features of talk in context. In analysing these data, we proceeded as follows. For each consultation, the opening sequence was analysed sequentially. More specifically, a display of a first medically relevant concern in a particular turn by the patient allowed us to locate the strategy, used by the doctor in immediately preceding talk, that had ‘occasioned’ it. We also looked at the doctor’s talk immediately after the patient’s display of a concern in order to ascertain that our understanding of a particular sequence corresponded to participants’ own understandings. Finally, for each consultation, we went beyond sequentiality and checked every opening sequence against participants’ previous mutual knowledge, interpersonal relationship and the reason they were consulting, as these were reported in the relevant pre- and post-consultation interviews. The examples used in this paper illustrate this methodology in action.

Results

Types of consultation

Observation of the data revealed a key feature of general practice consultations, namely that each consultation is one in a series of consultations. Each consultation has preceding consultations and potential subsequent consultations. On the basis of this observation, two types of consultations emerged: follow-up and new. We defined a follow-up consultation as one in which participants dealt with an on-going concern, and a new consultation as one in which they dealt with a new concern. Unlike Heath,10 we found that whether the encounter was initiated by the doctor or by the patient was of little importance. We also noted that a consultation could start as a follow-up and end as a new consultation, and vice versa.16 In other words, the actual nature of a consultation is negotiated locally by the participants rather than decided externally before it takes place. A consultation is a dynamic process, and its nature is the participants’ own achievement.

Types of first concern elicitor

Two types of “How are you?” were observed. The first type was part of an everyday greeting sequence, while the second was a first concern elicitor (an expression used by the doctor to elicit the patient’s first concern).17 A greeting may, but need not, be produced by the doctor. A first concern elicitor, on the other hand, is necessarily produced by the doctor. Another common first concern elicitor is “What can I do for you?” A range of other elicitors were used by doctors such as: “So, what are we going to do for you today?”; “What are we talking about?”; “There we are”; “How are you getting on?”; “What’s been the trouble?” and “So”. All these were found to be variations of the standard forms “How are you?” and “What can I do for you?”

The selection rule

The selection rule governing opening sequences is such that a new consultation requires “What can I do for you?” as a first concern elicitor, while a follow-up consultation requires “How are you?” However, the nature of a consultation as a follow-up or as a new consultation cannot be taken for granted. Participants jointly establish in situ whether they are follow-up consulting or whether they are seeing each other for a new problem. In this sense, the use of elicitors such as “How are you?” and “What can I do for you?” is best understood as a proposal made by the doctor to the patient as to how to view their
interaction. This proposal may or may not be confirmed in interaction.

The rule works as a normative framework and does not actually dictate what participants do. Rather, it must be understood as a ‘scheme of interpretation’, i.e. although participants overwhelmingly follow it, they may also deviate from it. This deviance may be either repairable or strategic. We now illustrate both types of deviance from the selection rule.

Repairable deviance

Repairable deviance from the selection rule was observed in three possible scenarios. In each of the three scenarios, one may speak of a misalignment, of a ‘misunderstanding’ between participants.

In medical consultations, “How are you?” can have either of two meanings. It can be part of an everyday greeting sequence and it can be a first concern elicitor. Therefore, a patient may sometimes take it to have the first meaning while the doctor meant it to have the second, i.e. the doctor might be operating in ‘the voice of medicine’ while the patient is working in ‘the voice of the life world’. This is particularly likely if a close relationship already exists between a doctor and a patient (see Box 1). In this and subsequent boxes, the following transcription rules apply: first concern elicitors are shown in italics; [ = overlapping speech; (0.2) = pause measured in seconds; : = extended vowel sound; (could see) = transcriber uncertain about what was said; ((laughs)) = actions.

The relationship between the doctor and the patient in this interaction was reported to be excellent. The participants knew each other very well, and knew each other’s friends (see use of first name “Chrissie”). Furthermore, in turns 2–5, participants engaged in the type of small talk that Drew and Chilton (p. 150) refer to as “news updates about events or circumstances which were current when they (participants) last spoke”. According to Drew and Chilton, this kind of small talk is found among people who regularly keep in touch. Because of this relationship, the patient interpreted the doctor’s use of “How are you?” as an aspect of the life world and behaved accordingly. For the doctor, however, the same interactional item was used as an aspect of ‘the voice of medicine’, as a strategy for eliciting the first medically relevant concern. Thus, a misunderstanding developed. In turns 3, 5 and 7, the doctor showed little interest in the patient’s real life story and juxtaposed ‘the voice of medicine’ to it (“Right”). Eventually, in turn 7, the patient picked up the doctor’s cues, readjusted her understanding of the doctor’s talk in turn 1 and produced a medically relevant concern in turn 8.

The use of “How are you?” may also be problematic if, despite a previous consultation, the patient is seeing the doctor for a new problem. In primary care, a previous consultation can require a next consultation. Therefore, when a patient sees a doctor for a second time, this second encounter is by default interpreted as a follow-up. In order to move away from this default understanding, some negotiation between the parties must take place (see Box 2).

In this extract, the doctor used “How are you?” either to elicit the first medically relevant concern or to elicit social talk. In the first instance, the patient responded to this elicitor as an aspect of the life world (“Okay”). He then went on to signal his hesitation as to how to react to the same item as an aspect of the voice of medicine (“erm”, prefacing, “a couple of things”). This hesitation is understandable because there was a
mismatch between the reason he was consulting (a new concern) and the definition of current consultation as projected by the use of the first concern elicitor. In turn 6, he oriented to the standard meaning of “How are you?” and mentioned a concern the doctor was familiar with (“my knee again”). He then went on to highlight the actual reason he was consulting (“headaches”) through the use of expressions such as “mainly”, “really bad” and “basically”, i.e. noticeable interactional work has been necessary for participants (doctor and patient) to disengage themselves from the normal expectations set in place by the use of the elicitor “How are you?”

Similarly, the use of “What can I do for you?” or its equivalent can be problematic if a patient is follow-up consulting (see Box 3). In this exchange, the doctor opened the encounter defining it as a new consultation. The patient resisted that definition, reminding the doctor that it is actually a follow-up from a previous consultation (turn 2). In turn 3, the doctor acknowledged his mistake (“Yes. Yes. Yes”) before proceeding from mutually accepted grounds.

Strategic deviance
Instances of strategic deviance from the selection rule can generally be understood as deliberate attempts by the doctor to emphasize or else de-emphasize some aspect(s) of his/her relationship with a particular patient. In turn, strategic deviance may take either of two forms: a standard form may be used in a context where it is not immediately relevant, or a non-standard form may be used where a standard one would be expected (see Box 4).

This consultation brought together participants who knew each other very well. As the doctor reported in the post-consultation interview, he had been with this patient, now aged 19, ever since he was a child. The doctor knew the patient’s family and their social background and he had long been aware of the patient’s condition. Against this shared background knowledge, the mismatch between the two parties’ conduct is obvious. In the greeting sequence, the doctor maintained social distance (“Hello”) while the patient claimed social solidarity (“Hi”). In the opening sequence, the doctor used “What can I do for you?” as if this were a new consultation. In turn 5, the patient packaged his concern display in a manner that indicated that he had seen this doctor before about the same problem. The issue therefore is: why this systematic misalignment? In the post-consultation interview, it appeared that, for the doctor, the patient was a “very tricky one”, someone who was “a bit of a challenge really” and “very difficult to relate with in a meaningful way really”. Therefore, the doctor’s use of “What can I do for you?” or, or at least his failure to repair it after the patient had made it clear that he was follow-up consulting, can be understood as a deliberate decision to distance himself from this ‘difficult patient’.22 The doctor was flouting the rule strategically. Doctors may adopt such distancing strategies when having a bad day or running late, for example.

Alternatively, strategic deviance from the selection rule may be meant to emphasize solidarity and mutual alignment. Some doctors go to great lengths, such as using colloquial expressions, to claim a solidarity relationship with their patients. An example of such strategic deviance from the norm is given below (see Box 5).

<table>
<thead>
<tr>
<th>Box 3</th>
<th>“What can I do for you?” used in a follow-up consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctor:</td>
<td>Right. Okay. And what can I do for you today?</td>
</tr>
<tr>
<td>2. Patient:</td>
<td>You—my blood test er from er my gout ((laughs))</td>
</tr>
<tr>
<td>3. Doctor:</td>
<td>Right. Yes. Yes. Yes. Th[e uric acid is—is high</td>
</tr>
<tr>
<td>4. Patient:</td>
<td>Is it. Yeah</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 4</th>
<th>Strategic breaking of the rule: creating distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctor:</td>
<td>Hello</td>
</tr>
<tr>
<td>2. Patient:</td>
<td>Hi</td>
</tr>
<tr>
<td>3. Doctor:</td>
<td>(Door closed)</td>
</tr>
<tr>
<td>4. Doctor:</td>
<td>Thanks. Take a seat. ( . . . )</td>
</tr>
<tr>
<td>5. Patient:</td>
<td>The pain in my belly (0.2) er it’s not going away. No matter what I’m doing even I can’t eat properly now</td>
</tr>
<tr>
<td>6. Doctor:</td>
<td>Right</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 5</th>
<th>Strategic breaking of the rule: emphasizing solidarity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctor:</td>
<td>Fine ([(laughs)])</td>
</tr>
<tr>
<td>2. Patient:</td>
<td>([(laughs)])</td>
</tr>
<tr>
<td>3. Doctor:</td>
<td>Erm ah I get myself lost a bit here</td>
</tr>
<tr>
<td>4. Patient:</td>
<td>([(laughs)])</td>
</tr>
<tr>
<td>5. Doctor:</td>
<td>Dee der er. Right (0.3) Right ho. Fire away</td>
</tr>
<tr>
<td>6. Patient:</td>
<td>Right. I’ll show you what it is. Er I’ve got a very sore foot which I’ve had for about a year on and off. And I haven’t sort of</td>
</tr>
<tr>
<td>7. Doctor:</td>
<td>(on off</td>
</tr>
<tr>
<td>8. Patient:</td>
<td>Yes</td>
</tr>
<tr>
<td>9. Doctor:</td>
<td>(On</td>
</tr>
<tr>
<td>10. Patient:</td>
<td>([(laughs)])</td>
</tr>
<tr>
<td>11. Doctor:</td>
<td>off</td>
</tr>
<tr>
<td>12. Patient:</td>
<td>Well I have been on and (off my feet) to be honest ([(laughs)])</td>
</tr>
<tr>
<td>13. Doctor:</td>
<td>(On [off</td>
</tr>
</tbody>
</table>
After this consultation, both parties reported that the quality of their relationship was good. In terms of medical history, this patient is not a regular at the surgery. Therefore, her present visit at the surgery can be seen as a new consultation, and the standard way of eliciting her concern would have been “What can I do for you?” Instead, the doctor used “Fire away” and, as the transcript shows, in subsequent talk, no indication is given that this rather unusual opening needs repairing. A clue to the reason for the doctor’s choice is gained if one takes the whole context into account, particularly the fact that participants laughed and teased each other (repetition of “on” and “off”). The choice of “Fire away” as a first concern elicitor was meant to contribute to the informality of the consultation. As Ragan23 shows, humour and verbal play is one of the strategies that participants in a medical encounter use to maintain a sense of mutuality. In the post-consultation interview, the doctor confirmed this interpretation saying: “I think we had some fun in this consultation, if I remember”.

Conclusions

Using the fine-grained tools of Conversation Analysis to study real life consultations, we have identified a selection rule whereby GPs choose between the questions “How are you?” and “What can I do for you?” as first concern elicitors. This rule works as a normative framework and does not dictate what participants do. Rather, it is understood as a ‘scheme of interpretation’ for each participant, from which deviations are possible. Rule breaking can undermine mutuality if not repaired by either participant. Deliberate rule breaking can be used, usually by the doctor, to create distance from patients perceived as difficult, but also to emphasize mutual alignment with patients perceived positively.

In relation to concordance, this analysis identified the concept of ‘alignment’ as a central building block. Participants in an interaction may be said to be aligned if they have a shared understanding of the here and now situation. Alignment is constructed step by step, and participants aligned at one stage in an interaction may be misaligned at another. Our analysis demonstrates that alignment or misalignment between participants is likely to occur at the beginning of the consultation, well before any discussion about medicine taking occurs. In situations of misalignment, concordance will be much harder to achieve. Doctors wishing to establish concordant consultations need to pay attention to the opening sequence of their consultations as well as to the sometimes neglected second half of the consultation.24

Mutuality, and therefore concordance, may be contrasted with more paternalistic and doctor-centred approaches to health care. However, as Drew25 has argued, doctor-centredness is found not only in the practice of medicine, but also in research on doctor–patient interaction. As the analysis reported here shows, mutuality is an achievement of both patients and doctors, and requires the active participation of patients, i.e. in order to understand the possibilities for shared decision making and concordance, researchers need to go beyond current doctor-centred perspectives and examine the patient’s role as well as the doctor’s. An interactional turn in research on doctor patient communication is called for.

Key points for clinicians

- There is a rule for choosing between “How are you?” and “What can I do for you?” at the beginning of a consultation
- If broken, this rule can be repaired
- If the rule is broken and not repaired, this can lead to misalignment in the consultation
- The rule may be broken for strategic purposes such as creating distance from difficult patients

Acknowledgements

We would like publicly to thank Dr Chris Manning whose consultations provided a major contribution to our understanding. JG is supported by Sir Siegmund Warburg’s Voluntary Settlement. NB was supported by a senior research fellowship from the British Academy and Leverhulme Trust. The study on which this paper is based was funded by the Department of Health as part of the Prescribing Research Initiative. The views expressed in this paper are those of the authors and not the Department of Health. The other members of the study team were Nick Barber, Christine Barry, Colin Bradley and Fiona Stevenson.

References


