CHAPTER 63

Qualitative approaches to clinician–patient communication

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Introduction to qualitative approaches to clinician–patient communication

In *The Country Doctor*, Kafka's central character laments that writing a prescription is easy, but coming to an understanding with people is hard (Muir and Muir 1952). If the practice of medicine were as simple as sending a clear message, then the practitioner's job would be reduced to correctly formulating the right words. The reality, however, is that patient care is not simply about message transmission; it is about a dynamic interplay of information, emotions, expertise, goals, beliefs, and so on. To study the artful management of the complexities of healthcare communication, qualitative approaches are highly productive and can stimulate new insight because 'how' may be a more relevant question to begin with, than 'how much'.

In oncology and palliative care, as in any medical domain, both physicians and patients have concerns, regarding preferred treatments trajectories, and outcomes of the medical visit. Whether or not these preferences are realized during a consultation, patients come away with information about the nature and course of their illness, as well as with recommendations on how, or whether, to proceed with treatment. Physicians, from their side, face the tension of maintaining the delicate balance between informative yet hopeful communication (Helft 2006), deftly navigating the line between recommending yet avoiding guarantees (Roberts 1999). For those concerned with understanding these kinds of communication tensions in the practice of oncology and palliative medicine, the inductive and interpretive approaches presented in this chapter, along with several illustrative research examples, will prove useful. Necessarily, reference will be made to a wider scope of research than just those studies that focus on face-to-face communication because empirical work based on actual clinical interactions is still relatively scarce in the oncology setting (Beach and Anderson 2003). The final sections of the chapter reflect on the special ethical challenges facing researchers engaged in field-based studies, and a brief discussion is offered concerning the trade-offs between reliability and validity in qualitative research.

Unique contribution of qualitative methods for studying clinician–patient communication

Engaging in health communication research presumes a wide range of goals: to discover something new or to understand a phenomenon more fully; to make the world better in some way; or to advocate for a position in a manner that is acceptable to a community of practitioners, scholars, or policy makers. Regardless of the research goal, each person engaged in the process brings preconceptions of how the world works, what constitutes knowledge, and what is the most appropriate way to find answers to his or her individual questions.

What distinguishes the qualitative study is its commitment to understanding lived experience by privileging the dialogic nature of human life. From this vantage point, understanding is created in concert with others; it is not the result of a correct message being sent down a correct channel. Hence the lament of Kafka's country doctor who recognizes that it is our discursive involvement with others that produces the challenges of everyday life. For doctors, as for all of us, meaning is created socially; we cannot produce understanding in isolation. Ironically, it is that very essence of creating meaning through talk that can also lead to misunderstanding or missed opportunities for connection. If it were as simple as writing prescriptions, medical visits would be much shorter.

Taking a qualitative approach, the researcher is committed to being reflexively aware of his or her own meanings as an analysis emerges of the participants' orientations. The aim is to reconstruct participant sense-making practices, not to confirm a theoretical concern of the researcher. In addition to providing rich interactional detail, qualitative approaches can also serve as groundwork for further exploration and informed development of testable hypotheses.

Representative approaches and relevant empirical studies

In this section, data collection techniques and interpretive approaches are discussed with examples from relevant empirical healthcare research. The goal is to present a variety of frameworks that share grounding in terms of basic field techniques for data collection (observation, interviews, recordings) but which differ in scope, focus, or fundamental philosophy. First, field-based frameworks are presented that draw on an approach of observing and describing real entities. Gubrium and Holstein (1997) have termed this the 'naturalist idiom' in qualitative research, because it adheres to a belief in a discoverable truth, one which will 'truly' represent participant lives. Included here are ethnography, grounded theory, and conversation analysis.

In contrast to these naturalistic approaches, postmodernism is also briefly presented because it offers a different philosophical basis, one which highlights paradoxes, disrupting the traditional sense of a shared or monolithic truth that can be captured and represented. The value of this form of scholarship is that it can provide openings for new insight, offering a way into understanding the healthcare setting that would be inconceivable from more traditional vantage points.

Whatever the philosophical grounding (e.g. naturalist vs. postmodern) researchers using these approaches are generally interested in patients' and practitioners' beliefs, practices, and understandings of health and illness. They are attempting to derive participants' understandings from the researcher's detailed observation, description, and analysis of behaviour and artefacts.

Ethnography

'Ethnographic methods' has become an umbrella term for a wide array of procedures for data collection, analysis, and description of findings. Under this heading, interviewing and focus groups will be discussed, though these techniques are not unique to ethnographic studies.

For studies of medical interaction, an ethnographic approach can provide a wide scope, taking in a setting as large as an oncology unit as a unique culture, or studies can be more focused on particular segments of that culture. There is a long tradition of ethnographic work in medical settings, beginning with a description of medical student life (Becker *et al.* 1961) and the groundbreaking work that enabled an understanding of hospitalized dying as an orchestrated process (Glaser and Strauss 1965).

In this descriptive tradition, Linnard-Palmer and Kools (2005) examined nurses' attitudes and interactions in the context of paediatric oncology. Using field interviews and observations, the researchers addressed the ethical complexities embedded in nurses' interactions with parents who refuse treatment for their children. Inman (1991) likewise uses multiple field methods (observations, interviews, gaze interaction charting, and analysis of childrens' drawings) to examine the child's view of their cancer experience. Using a more traditional ethnographic approach, observing patients and families over several years from the clinic to their homes and even to some funerals, The *et al.* (2000) excavated underlying patterns of communication that result in cancer patients' false optimism about recovery. While these field studies used recording technologies, the effort was primarily to record interviews with participants, not necessarily the medical visit itself.

nterviewing

n many field-based approaches, interviewing is a core technique; t is a conversation with a purpose that primarily benefits the researcher, not the participant. Interview studies are common in patient–provider research and are valuable for exploring perceptions, attitudes, and beliefs.

Types of interviews can be delineated based on the depth and range of the conversation and the type of relationship one has with the participant (Guest *et al.* 2013). 'Ethnographic interviews' are those conversations that can just happen when the researcher is in the study setting and something serendipitously prompts a question related to the research project. In contrast, 'informant interviews' are designed with a purpose and participants comment on their experiences, possibly several times to discuss various topics of interest to the researcher. These can be open-ended conversations, but they are entered into with a general purpose in mind. Further along the continuum, 'respondent interviews' are brief, stand-alone interactions that generally have pre-set questions in a particular order. These are the least naturalistic and may provide only superficial, even socially desirable responses; nonetheless, the approach can be quite valuable for exploratory work. Because of the relative ease and confidentiality afforded by individual interview protocols, this type of study tends to predominate in healthcare research. For example, Kelly *et al.* (2003) interviewed 24 doctors on the topic of cancer patients' wish to hasten death (WTHD). Because the researchers had access to measures of patients' wishes, it was possible to associate the physician's responses with levels of WTHD in their patients. The authors clearly point to the need for more research on actual interactions where these issues are discussed.

Focus groups

Focus groups provide a format for understanding the world of the patient or the practitioner through their own stories, accounts, and experiences. Zimmerman and Applegate (1992) use this technique to examine the ways in which hospice teams communicate, providing insight into coordination and challenges for these healthcare providers. On the patient side, Davey *et al.* (2010) use focus groups to explore the experience of African American breast cancer patients in terms of their accounts of navigating the healthcare system. What these exemplars indicate is that, in contrast to individual interviews, and contrary to conventional assumptions, focus groups provide a setting in which people are more likely to disclose their health or professional concerns (see Wilkinson 1998 for a review). Whereas an individual may be reluctant to disclose deeper feelings to a researcher who does not share their experience, the focus group encourages people to share in a supportive atmosphere, potentially stimulating deeper thinking, and a broader spectrum of response.

Focus groups have been used in a wide variety of health research and allow researchers to observe, if not wholly natural and spontaneous discussions, then at least the process of how beliefs are expressed in concert with others. In addition to possibly promoting disclosure, the focus group format provides a more natural setting for group discussion. Since the participants often share some health or professional concern, this approach can help researchers get deeper and more detailed insight into issues, concerns, and understandings that might otherwise be missed in individual interviews.

Grounded theory

Grounded theory is a research strategy for inductively developing concepts and theories, primarily on the basis of in-depth interviews and field observations (Birks and Mills 2013). The approach, instantiated first by Glaser and Strauss (1965) was motivated from an interest by medical sociologists to grasp the actor's viewpoint. In this particular case, as the researchers attempted to describe and understand the process of dying in a hospital setting.

In grounded theory, analysis proceeds as a coding process that is intended to open up an initial understanding and allow core categories to emerge. The purpose is not to deconstruct an interaction into countable units, but to understand and integrate what is available from interviews and observations. As analysis proceeds, there is a movement away from literal meanings and towards the relationships among concepts. Over time, grounded theory has evolved in two directions: one characterized by a more agnostic stance towards data, and the other by a more question or theory-driven approach. Regardless of the strand that one follows in a grounded theory approach, the focus is always on discovery as opposed to hypothesis testing. While the notion of 'hypothesis' is used in an informal way in grounded theory, it develops in terms of plausibility, not testability.

Clair (1990) used this approach to study the end of life among oncology patients in a hospital setting. From data collected in the oncology unit, the researcher inductively generated the concept of 'regressive intervention', demonstrating how physicians withdraw, whether abruptly or gradually, once the patient has been re-cast, by the physician's diagnosis, from the sick role to the dying role. While medical staff are still expected to maintain humane, palliative treatment, the patient relies less and less on medical staff, and families become more accountable for the patient's activities. Likewise, using a grounded theory and thematic coding approach to the study of recorded clinic interactions (Audrey *et al.* 2008) and family conferences (Curtis *et al.* 2005), studies of palliative and end-of-life care have begun to examine decision-making and 'missed opportunities' for support and provision of information.

Sandgren (2012) used a grounded theory approach to examine how patients, their relatives, and nurses manage uncertainty in both hospital and home palliative care contexts. Using a novel secondary data approach (re-coding interviews and observations from prior field studies) Sandgren addresses the question of what participants' main concern is at this transitional stage, where new roles, values, and attitudes may be hovering under the surface of normalized behaviour. Knowing how to act and behave in this novel, unresolvable end-of-life stage was a core problem for patients and families. The process of deciphering unwritten rules, or figuring out what the unspoken expectations and values were in this new phase, emerged as a key for understanding patterns of behaviour that affect quality of care and quality of life

Conversation analysis

Conversation analysis (CA) has been highly productive for bringing to light the endogenous order and interactional dilemmas in oncology visits. Unlike ethnographic and grounded theory approaches, which can be based on field observations and interviews, CA is predicated on capturing naturally occurring interactions in real time. Researchers using a CA approach are not engaged in describing contexts or in deriving concepts and theories through inductive coding; they are working to discern patient and clinician perspectives and practices as evidenced through embodied action and interaction. Using close transcription of audio and video-recorded materials, the conversation analyst attends to the details of verbal and non-verbal behaviour to see how the participants pursue and co-create an understanding of the situation, including what information, concerns, or behaviours are treated as relevant (or not) within the interaction. Because recordings of actual interactions (as opposed to reported, scripted, or observed/described) are replete with the details of an encounter, researchers have greater access to the momentary contingencies that participants orient to in their activities together. It is thus possible to discern how they accomplish many facets of the work of the clinic through face-to-face interaction, allowing researchers to closely view and describe the visible processes of 'coming to an understanding' (in Kafka's terms).

Several lines of research in the oncology setting have provided insight into clinical tasks, recommendations, and presentation of clinical trials, as well as issues of psychosocial importance. Early research made it clear that health practitioners risk meeting with resistance from their clients when there is a failure to properly justify the advice or recommendation (Costello and Roberts 2001). Indeed, the final formulation of a treatment recommendation can be accounted for by the conversational actions of both participants, including the shaping that occurs when patients subtly resist an initial formulation. Additionally, patients' poor understanding of the risks and benefits of cancer treatment has been partly explained by an examination of the inherently equivocal nature of those recommendations (Roberts 1999), because an unavoidable tension persists between oncologists' presentation of recommendations and their avoidance of guarantees. Moreover, it has been suggested that oncologists' talk about clinical trials is shaped in such a way that it may contribute to differing rates of enrolment (Roberts 2002).

Moving beyond the study of clinical tasks, Beach *et al.* (2005) and Maynard *et al.* (2016) analyse sequences of talk that could be overlooked as oblique to the main agenda of the oncology visit: patients' embedded disclosure of fears during history-taking, and oncologists' orientation to 'appreciation sequences', which occur after reports of test results or recommendations. Both of these interactional phenomena, seemingly ancillary moments relative to other goals of the clinical visit, are actually moments of great potential in terms of providing an 'in' to discuss matters of end of life or other matters of emotional consequence. Without close and repeated examination of actual physician–patient interaction, using techniques from CA, these small, but rich moments of potential connection with psychosocial issues would be lost.

Postmodernism

Postmodernist and critical modernist scholarship, like other interpretive approaches, emphasizes the discursive or social construction of reality. Data collection techniques, such as examination of texts, participant observation, and interviews, are shared with other qualitative approaches. However, in postmodern scholarship, the underlying assumption is that there is no single, observable truth, and a patient's experience of disease is shaped by belief systems and cultural norms along with the physical reality. As Lupton (2003) argues, the value of postmodern and critical modernist approaches for understanding healthcare is their insistence on examining paradoxes. For example, the military and sports metaphors that predominate in Western medicine (Erwin 1987; Seale 2001), along with a belief in the individual will for overcoming adversity, clearly shapes the practice of informing patients. The dominant ideology is for patients to 'fight' their disease; however, the dark side of this metaphor is that cancer patients may experience being at war with emselves, which has implications for the patient's sense of ration-ity (Pinell 1987).

As spotlighted in postmodern and critical research, explorations metaphor and ideology provide points of departure for thinking out the ways in which attitudes and behaviours are shaped, and w patients and clinicians strive to make sense of health and ill-ss within paradoxical webs of meaning.

thical issues in field-based qualitative esearch

qualitative field studies, there is usually an ongoing and inter-tive relationship between the researcher and the setting's par-cipants. Thus, issues of rapport, confidentiality, and consent can particularly delicate matters where the biomedical and social erlap seamlessly. And the ethical challenges can be emergent and predictable. Seeing documents or overhearing conversations at might otherwise have been guarded by participants is bound to cur in busy, public domains. This can be particularly sensitive in edical settings where, perhaps naïvely, staff believe they are doing good job of protecting patient confidentiality.

The sensitive nature of medical settings also raises the critical estion of the incorporation of follow-up with participants who ay have been observed or interviewed at vulnerable moments. olit and Hungler (1995) address this dilemma in the context of ow parents cope with a child's terminal illness. Since such a study ould require a potentially painful probing of parents' emotional ates, the researcher must consider not only whether the benefit of ch knowledge would assist in the design of effective strategies for elping parents, but also what the long-term result of making such emands on parents would be. Once the child has died, what is e researcher's responsibility to the parents? Protection of subjects ust, therefore, be broadly construed and considered integral to llow-up, as well as to implementation.

An additional complexity of field research in medical settings is at social and medical settings are permeable; people who were ot expected, and, therefore, were not part of a consent process, can ter a scene. Thus, the ability to easily obtain informed consent is ndermined. In envisioning projects, researchers should consider e possibility of such contingencies and plan accordingly. Post oc consent may be possible, but is often untenable. Furthermore, me locations are considered public (e.g. corridors) and would e exempt from consent procedures, while others (e.g. patient oms) may be considered private. For those collecting audio or ideo-recorded data, an additional consent form is warranted that utlines possible uses of the recorded data beyond research team eetings (e.g. for use in classrooms, at conferences, in electronic urnals). Participants should initial those uses to which they con-ent; this would constitute full and open disclosure concerning the se of recordings. Clearly, the complexities of attaining informed onsent are many, and must be balanced against the potential social nd scientific benefits to be gained.

Finally, though not an ethical issue at first glance, research-rs must 'consider the possible consequences of their cultur-lly ascribed identities for the ethics and politics of conducting esearch' (Lindloff and Taylor 2002, pp. 141–2). The physical char-cteristics, social attributes, and degree of insider knowledge are mong the 'ambiguous gifts' that fieldworkers can carry unwittingly to a scene, establishing 'axes of difference and similarity' with other participants (Lindloff and Taylor 2002, pp. 141–2). Again, the researcher's reflection and monitoring of these dimensions both in planning and implementation are necessary for considering the ethical challenges of field-based studies.

For those interested in healthcare communication research in cyberspace, Jones (1994) lays out ethical issues that are relevant for that medium where what is considered public, private, and deceptive becomes even more challenging.

Validity and reliability

Scholars differ in their opinions of whether or not reliability and validity are relevant concepts for qualitative research. From a social constructionist perspective, the argument is that the transient and contingent nature of human interaction renders any concern for reliability irrelevant. Validity is probably more relevant, since a particular interaction or event may be accurately analysed, but rare enough that it would be hard to find another just like it for comparison. Although the process of collecting instances and comparing them provides for a grounded claim about a particular action or behaviour, it is also the case that 'one' is a number and that analysis of a particular case holds value (Schegloff 1993) and can be built upon for developing further insights.

However, Silverman (1993) warns that if qualitative researchers are not mindful of issues of reliability and validity then they are at risk of engaging in the romanticism of nineteenth-century thinkers and chroniclers. In that tradition, observers may have selected data for its dramatic or exotic qualities, or because it fit an idealized pre-conception of the culture being studied. Therefore, Silverman suggests formulating hypotheses and testing assumptions through triangulation, and checking for participant validation.

Conclusion

Misunderstandings or missed opportunities for connection, whatever their root cause, can haunt patients and practitioners as they strive to make sense of a complicated interpersonal world within the medical organization. The value of qualitative and interpretive methods for studying medical communication resides precisely in the ability of the researcher to discern practices and beliefs that may give rise to misunderstandings. These participant orientations and behaviours are not necessarily available at a conscious level, and may only be available through systematic observation and interpretive analysis. In addition to gathering patient and clinician narratives about their experiences and beliefs (through interviews and focus groups), a great deal can be learned from systematic observation and recording of actual interactions (ethnographic and conversation analytic approaches), which can capture details of the dynamic, transactional nature of communication. Greater attention to theory development that is grounded in inductive analysis and interpretive procedures (such as grounded theory) can bring to light the interdependent relationship of practitioner and patient, in terms of the larger social context. Critical and postmodernist approaches help to uncover paradoxes and power dynamics that can bring to the surface the webs of social and cultural meaning in which we manoeuver with little awareness.

To better understand patient–clinician communication is to better understand the ongoing, situated processes that constitute communication. How are recommendations made and justified, how is advice given and received, and therefore what opportunities

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are naturally open within the interaction for exploration of psychosocial issues or end-of-life discussions? These kinds of questions imply understanding of the communication process, not just its outcomes. By definition a process is a series of activities, but in human terms, these activities rarely have discreet, discernible boundaries. Qualitative methods lend themselves especially well to understanding this fluid, socially constructed process of communication.

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