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RESEARCH IN PSYCHOLOGICAL ASPECTS OF MEDICAL ILLNESS

VERBAL INTERACTION CODING MANUAL

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1 INTRODUCTION

This manual is designed to provide a standard method by which interactions between doctors and patients during an oncology consultation can be coded. Each tape is analysed in two ways:

1. Computer Category Coding

Codes representing the source, content, function and emotion are allocated to each speech unit, and entered into the computer in real time. The consultation is conceptually divided into units of speech which are operationally defined as beginning when a person starts speaking and ending when that person stops speaking (either of their own volition or because they are interrupted) or changes function category (as defined on the following pages). A unit of speech may be as short as one word or as long as several sentences. Four codes are assigned to each speech unit, indicating who is speaking (source category), the subject matter addressed (content category), the function of the speech unit (function category) and the emotional flavour (emotion category). All codes are entered into the WinConCode computerised interaction analysis programme. In so doing the length of each speech unit is measured in milliseconds. If speech overlaps (ie. the original speaker does not stop when another starts or more than one person starts speaking at the same time) the dominant speaker is coded (ie. the one who can be understood most easily).

2. Global Analysis

Overall ratings of several characteristics of the consultation are made on LASA scales and frequency counts.

2 GENERAL INSTRUCTIONS

1. Transcribe the tape

2. Divide the consultation into speech units; indicate each new unit with a slash / on the transcription.

3. While listening to the tape code each speech unit along dimensions 1-4 (see below).
   Record on the transcript
   a) emotional and informational cues and responses
   b) minimal encouragers (see description on p.19)and
   c) Dr and patient interruptions.

4. Complete frequency counts.

5. Complete the LASA scales for subjective ratings.

6. Look at the transcription while listening to the tape and use WinConCode to enter into the computer the codes for dimensions 1-4 in real time

3 SUMMARY OF SYSTEM

COMPUTER CATEGORY CODING
DIMENSION 1: SOURCE CATEGORIES.

D11. Doctor
D12. Patient
D13. Family/Friend
D14. ~~Other Doctor or Health Prof.~~
D15. Interruption from outside
D16. Examination

DIMENSION 2: CONTENT

D21. History and symptoms (medical and personal)
D22. Diagnosis
D23. Prognosis
D24. Treatment
D25. Other Medical
D26. Psychosocial issues
D27. Social Support / Counselling / Stress management
D28. Social Exchange
D29. Other/non-specific

DIMENSION 3: FUNCTION

D31. Disclose
D32. Advise / recommend / influence
D33 Question (open)
D34 Question (closed)
D35 Question (leading)
D36 Question (multiple)
D37. Label / judge / Criticise
D38. Express feelings / seek reassurance
D39. Inform / educate
D310. Actively support / empathise / reflect / reassure
D311 Partnership build: confirm / agree / socialise
D312. Check patient understanding

DIMENSION 4: EMOTION

D41 Positive / friendly / warm / caring
D42 Tense / anxious / afraid
D43 Sad / depressed
D44 Matter of fact / impersonal
D45 Frustrated
D46 Angry / annoyed

4 DETAILED DESCRIPTION OF SYSTEM

DIMENSION 1: SOURCE CODES **(who is speaking).**

D11. Doctor

D12. Patient

D13. Family/Friend

D14. Other Doctor or Health Prof.

D15. Interruption from outside
This category relates to any exchange with someone outside unrelated to the consultation.

☞ Examples.

a) A phone call or personal exchange about something irrelevant to the patient

b) Someone coming into the room with eg. patient notes, which breaks the flow of conversation

c) The Doctor being called out of the room.

D16. Examination
This category relates to physical examinations where there is silence or general instructions such as take a deep breath, turn over etc.

DIMENSION 2: CONTENT CATEGORIES

These are based on a) a content analysis of audiotaped Oncology consultations and
b) focus groups and surveys of cancer patients

D21. HISTORY AND CURRENT SYMPTOMS

This category includes a) exchanges between participants about the medical events that have led up to the consultation, including discussion of tests which have been performed to date.
Note: *Discussions of how test results relate to diagnosis should be coded as Diagnosis.*
b) discussion of previous tumours and family history of cancer; c) personal history, eg. age, employment, etc.

☞Examples

a)	P:	I first noticed the problem in July last year and I went to see my doctor. He recommended that I have a mammogram which showed nothing.
	Dr:	Have you had blood tests or a CAT scan.
b)	Dr:	As I understand it, you had a mastectomy last November and you have been sent to me to see whether you should undergo further treatment.
c)	Dr:	Has anyone in your family had cancer?
	Dr:	What do you do for a living?
	Dr:	Are you married?

Note: *Even if a medical condition mentioned is not related to cancer but comes up in the course of gathering information about history it is coded as history and symptoms.*

☞Examples

a) P: .. you asked me about bells palsy and shingles.
b) Dr: ..apart from the melanoma on the leg what other medical conditions have you had?

D22. DIAGNOSIS

This category includes:

1. Any comment about the kind of cancer it is or is likely to be. This may include discussion of the results of tests performed prior to consultation relating directly to the diagnosis of the cancer.

> ☞Example
>
> "From the scan you can see that there is a tumour here."

2. Comments about the spread of the cancer

> ☞ Example
>
> "the cancer has shown that it can spread to and survive in a foreign place"

3. Comments about the size/severity/spread of cancer

> ☞Examples
>
> a) "I think we're seeing multiple cancers on both lungs."
>
> b) "I think we accept that we've got metastatic disease that's spread from the primary into the lungs".

4. How common a particular cancer is, how many times a particular type of cancer is seen.

> ☞Example
>
> "This is a very uncommon cancer. I would only see one a year."

NB: Comments about relapse need to be dealt with carefully: comments indicating that the cancer has actually recurred or may have recurred, should be included under diagnosis.

D23. PROGNOSIS (When an explicit statement abont prognosis is made)

This category includes any comments that refer to the likely course of the disease, or what the outcome might be (eg. chances of survival).

1. Risk factors such as family history (Relating specifically back to the patient's prognosis)

2. Risk of relapse and time frame of relapse.

> ☞Example.
> " there is always a risk of relapse, it is unlikely to be in the next two years but more likely in the next five years. Even after thirty years there is still a risk."

3. Percent chance of being around in the next *x* years

4. Chances of being completely cured.

5. Where it is likely to recur - when it is most likely to recur / when you can consider yourself cured.

> ☞Examples
>
> a) .. "in some types of tumour it's possible to talk about cure but I don't think that's realistic with this melanoma"
>
> b) "So a woman who has had a breast cancer and there are no glands involved isn't always cured of cancer, she's got a 30% chance of the cancer coming back"

Note: *If prognosis is one of the issues in deciding on whether or not to have treatment then it is coded as prognosis*

> ☞Example
> "..... the issue really is whether chemotherapy will help shrink that tumour or keep it stable and keep you alive for a longer period and there is evidence that chemo will improve your survival. "

Note: *One way to help distinguish between diagnosis and prognosis is whether the doctor is referring to what has happened with the disease (i.e.diagnosis), versus what is likely to happen in the future (i.e. prognosis).*

D24. TREATMENT

This category includes all aspects of the cancer treatment, which may include:

1. The advantages and disadvantages of treatment both past and present

2. Goals of your treatment or management

3. Practical details about treatment, investigations or tests

4. Issues involved in making a decision about treatment and recommendations about treatment

> ☞Examples.
> a) "your menopausal status will influence which treatment is best for you.
>
> b) "you have to decide whether the reduced risk of relapse is worth the side effects of chemotherapy."

5. Possible treatment of symptoms / potential symptoms.

> ☞Examples.
> a) "If you get nauseous we can give you drugs called anti emetics.
>
> b) "Don't worry we have very good pain medication. No-one should have to suffer"

6. Clinical trials in which the patient might take part and the reasons for it.

D25. OTHER MEDICAL

1. Diet and nutritional advice, advice about alternative medicine or attitudes.

2. Other recommendations, information.

3. Risks to other members of the family.

> ☞Example
>
> Dr: "Because you and your mother have a history of breast cancer I would advise your daughters to have regular mammograms from the age of 30."

4. Advice or next steps to take

> ☞Example
> When the Dr at the end of the consultation says that he will organise further blood tests X-Rays and make another appointment for the patient.

D26. PSYCHOSOCIAL ISSUES

1. Emotions relating to the cancer (fear, anxiety, etc.).

> ☞ Example
> "Ever since the diagnosis I can't stop crying and nothing makes me feel better."

2. Effects of cancer on work, social life, sexuality, family.

> ☞Example:
> Dr is talking about treatment that will require coming to the hospital 5 days a week
> P: "the only problem there, is the transport"
> Dr: "there are alternatives to that, where we can give you a room in a hostel.."

D27. GROUP SUPPORT / COUNSELLING / STRESS MANAGEMENT

1. Patient's desire for formal support

> ☞ Example
>
> "I've heard that the Cancer Council runs support groups for people like me. What do you think of those Doctor?"

2. Doctor informing patient of services available

D28. SOCIAL EXCHANGE

This category includes interactions about things essentially unrelated to the medical content of the consultation.

> ☞Example
>
> D: "Where are you going on holidays."
> P: "To Hong Kong, for about 10 days."
> D: "Oh. I'm going to Hong Kong myself shortly, actually I'm going to Vietnam and Korea and then to Hong Kong."

Note: *Exchanges in a conversational tone which relate to medical matters should be coded as medical matters*

D29. OTHER / NON-SPECIFIC

Include in this category exchanges which do not fit into the other categories.

DIMENSION 3: FUNCTION CATEGORIES (The underlying purpose of speech acts)

These are based on Stiles & Putnam (Stiles, W.B., & Putnam, S.M. Verbal exchanges in Medical Interviews: concepts and measurement. *Soc Sci Med, 35,* 347 - 355, 1992) and a content analysis of our own tapes. They elucidate the *context* of speech acts. Stiles argues that when the speaker is the doctor, categories such as 1-5 may be described as doctor-centred, and categories such as 6-9 may be described as patient-centred, allowing an objective measure of these consultation styles, in addition to the global rating made by the coder. These categories refer to speech acts which are primarily from the viewpoint of the speaker (addressing the speaker's needs, wishes, interests etc.).

D31. DISCLOSE

Reveals thoughts, perceptions, reasons or motivation (Usually a patient will respond this way)

☞Examples

a) P: " I don't know I really can't remember." or

P: " I don't know, you might have the results here."

b) P: "I wouldn't say stubborn. I was fearful of, it's only in the past 5 or 6 years that I've experienced doctors..., but I was fearful of my bodily self of operations, I had that fear and that's what stopped me in the first instance, probably a fear of operations" (*this was coded as disclose as the patient is revealing why he didn't go to the doctor in the first place. When you look at the overall flavour of the monologue it is coded as disclose, rather than express feelings*).

c) P; " It got to the stage where it was quite obvious to me that something had to be done..." *(a reason/motivation is given for seeing a doctor so it is a disclose. The purpose is to give more than factual information.)*

Purpose or intent of consultation, reveal intentions (Usually a doctor will respond this way)

☞Examples

a). Dr: "Firstly we'll talk about your history, then I'll take a look at you and finally we can talk about treatment options."

b). Dr: "Now what I need to do is get the pathology so I can look at it"

c). Dr: "Well before discussing that in detail I'd like to know a little bit about you"

D32. ADVISE / RECOMMEND / INFLUENCE.

Attempts to guide behaviour, suggestions for the future, commands, permission, prohibition

☞Examples

a) Dr: "What I recommend is that we organise the PET scan and do the EA blood test and then we talk again." or

b) "Would you mind hopping up here and removing your shirt?" or

c) "...we can at least use that technology and forgo the other tests which might otherwise inappropriately be used"

d) "I think that chemotherapy would give you the best chance."

Statements made by the patient in an assertive manner

☞Examples

a). P: "I would rather have chemotherapy now than when I go overseas."

b). P: "When we come back if we could have a little bit more on the treatment."

D33 QUESTION : OPEN

*(***Note***: All questions coded as D33 - 36 should be related to requests for information. Requests for agreement should be coded as partnership build).*

Requests for information or guidance which *invite an extended or detailed reply*

☞Examples

a) Dr: "Tell me about your operation?" or

b) P: "So what does this say about my immune system?"

D34 QUESTION : CLOSED

Requests for information or guidance which *restrict the answer* to "yes" or "no" or a short closed answer. Also, may be used to **clarify** information.

☞Examples

a) "When would that have been?" or
"Did you have radiotherapy?" or
"So that brings us to March?" or
"Any other lumps or bumps?" or
"How much do you smoke?"

b) Dr: "Have you had any other medical problems in the past?"

c) "I have your notes here and from what I understand you have a tumour ?"

In some cases information that has been given by the patient may be reflected back by the doctor as a means of clarifying what was said. This should be coded as D34.

☞Example

Dr: "and so then you went to the ultrasound then the biopsy with the recommendation that you have an operation."

P: "yes"

D35 QUESTION : LEADING.

Framed to favour one particular answer, forces an expected reply.
NB The tone of voice will affect this coding

☞Example

a) "You don't have any aches and pains do you?" or

b) "....and you've done that for years?" or

c) "Your weight is stable enough?"

D36. QUESTION : MULTIPLE.

More than one question included in a single exchange where the concepts are very different

☞Example

"How old are you and when did the cancer first appear?"

NOTE: *a) In some cases even when a question is asked, if the function for example is to partnership build it is given this code rather than a question.*

b) In response to a question the content code for responses remains the same as that of the question that was asked. If, however,a response if given which is unrelated to the question asked, the content changes according to the reply.

D37. INTERPRET / LABEL / JUDGE

Explain or label the other, judgements or evaluations of other's experience or behaviour in a negative way.

☞Examples

a) Dr: "You are too nervous"or
"You smoke like a chimney do you?"
"You've been a bit stubborn about your health lately."

b) Dr: "So you let it go for quite a number of years really before you agreed to have anything done about it." (*this was coded as criticise as the tone of voice had a hint of criticism*)

D38. EXPRESS FEELINGS / SEEK REASSURANCE.

☞Examples

Express feelings

a) "I feel really scared about all this."

Seek reassurance

b) P: "I'm going to be OK, aren't I?"

c) P: "sounds like heavy duty to me" (referring to a drug trial)

d) P: "I just thought I was going to have chemo and that was it"

D39. INFORM / EDUCATE (Doctor or Patient)

States objective, factual information, without attempt to guide behaviour.

☞Examples

a) Dr: "...the disease is not curable by surgery" or

b) "...its much more likely the disease came from lower down" or

c) "...and you've already admitted to smoking" or

d) P: "After that I had the CAT scans"

Includes Yes/No answers which *provide or confirm information.*

☞Example

Dr: "Are you allergic to any medication"
P: " No"

D310. SUPPORT / EMPATHISE / REASSURE / REFLECT

Express sympathy and warmth, provide information with the aim of reassuring and calming other, show understanding and acceptance of other. Reflect back patient feelings.

☞Examples

a) Dr: "You might be feeling a bit anxious"

b) Dr: "I think they said you have a bit of arthritis but nothing to worry about."

c) Dr: "that's alright you can have chemotherapy without going on the trial"

D311. PARTNERSHIP BUILD: Statements which are involved in bnilding rapport confirm-agree / socialise.

Confirm/agree. Both the question and response should receive the same function category code

☞Example

Dr: "Is that alright?"
P: "That's fine."

Socialise - talk about social matters not pertinent to the medical situation. Partnership build is more important than the type of question being asked.

☞Example

a) Dr: "that was in the old days before power steering and things wasn't it ?"

D312 CHECK PATIENT UNDERSTANDING

NB Can refer to the patient's understanding of things outside of the consultation

☞Examples

a) Dr: "Is that clear?"

b) Dr: "Do you understand the issues we need to consider in deciding on treatment?"

c) Dr: "Do you have any questions?"

d) Dr: "What's your understanding of what's going on?"

DIMENSION 4: EMOTION

By default each speech unit will be coded as matter of fact (D44), however, if a change in emotion is detected this should be coded in the transcript.

D41 Positive / friendly / warm / caring
D42 Tense / anxious / afraid
D43 Sad / depressed
D44 Matter of fact / impersonal
D45 Frustrated
D46 Angry / annoyed

5 GLOBAL RATINGS

These allow the consultation to be coded along dimensions not readily reduced to micro coding, but which may nevertheless be important. For each tape the consultation is to be rated on each of the following visual analogue scales by placing a line at the point that most accurately represents the consultation. For each tape the consultation is to be rated on each of the following visual analogue scales by placing a line at the point that most accurately represents the consultation.

G1. Did the Doctor appear technically competent and confident?

COMPETENT ..... INCOMPETENT

G2. Did the doctor communicate information to the patient clearly?

GOOD INFORMATION DELIVERY ..... POOR INFORMATION DELIVERY

G3. Was the doctor's overall message as positive as possible?

POSITIVE ..... NEGATIVE

G4. Was the consultation patient or doctor centred?

PATIENT CENTRED ..... DOCTOR CENTRED

G5. What was the emotional load for the patient in this consultation?

VERY HEAVY ..... VERY LIGHT

G6. Was there a sense of the doctor hurrying the consultation

VERY HURRIED ..... NOT AT ALL HURRIED

G7. In what way did the Dr respond to the patient

COLD/ IMPERSONAL ..... WARM/ CARING

G8. How did the patient seem

ANXIOUS/ AFRAID ..... RELAXED/ CONFIDENT

6 FREQUENCY COUNTS

- Minimal encouragers (ah-hah, yes, OK, right, etc. - encourage patient to continue)

- Responses to cues (given by patient that is an emotional need or expression (E) or a cue that signals the need for more information (I)
  Example of informational cue. P: "I really don't know much about the different treatments."
  Example of Emotional cue. P: "I get so upset sometimes that I can't stop crying."

There are 4 responses from the Dr:

1) Responds to the emotional or information cue expressed by the patient.
eg.
P: "The thought of Chemo is really scary."
Dr: " Yes I understand, you must be very frightened."

2) Responds to content other than emotional content or information content
ie. does not address the cue expressed by the patient but responds in some other way.
P: "The thought of radiotherapy is quite frightening."
Dr: "You'll have to come in for radiotherapy at least 3 - 4 times per week. "

3) Ignored.
ie . ignores the cue expressed by the patient and responds with a completely different subject.
Dr: " I would be very surprised if it had increased enough for us to see it on a scan. I mean it might have increased, but things have got to increase a reasonable size before we can actually pick that up on a scan."
Pt: "This is about 12 cm at the moment I think."
Dr: "So let me try and summarise and put everything together about where we're at."

4) Postponed
ie. a cue is acknowledged and the Dr defers the discussion until later on in the consultation.
Pt : " Ah Dr M said he can't operate because of where it is located, ah he gave me the option of chemotherapy or drugs.
Dr: " Well I'll talk to you a little bit about how treatment goes in a moment.."

5) Interruption to Cue.
eg. Pt: I had the operation 2 years ago and I thought I should have had chemotherapy then.":
Kin: " You were in hospital for 3 weeks then because you had an infection."
Dr: " What kind of infection did you have."
(*Kin* refers to thirds person eg spouse in room at time of consultation. In this case the Kin interrupts an informational cue.)

- Interruptions - When one person begins talking before the other has finished.
  Dr Interruptions and patient interruptions.

7 DOCTOR'S COMMUNICATION STYLE.

- Uses analogies. When Doctors explain concepts by comparison to common experiences.
  eg. Chemotherapy is like a box of smarties. We might get the red ones but the green ones might still be there afterwards.

- Uses medical jargon. When Doctors use medical terms which may not be easily understood by the patient.
  eg. (1) We could put you into a randomised clinical trial.
  eg. (2) In this adjuvant setting we would be looking to give chemotherapy to prevent the disease from spreading in the future.

- Direct, doesn't hide anything. Doctor makes clear statements about diagnosis, prognosis etc.
  eg.(1) What I think we are seeing here is metastatic disease which has spread from the primary site in the lungs.

- Structures information delivery. Where the doctor delivers information using statements which follow a structured pattern. So the doctor will usually follow a pattern where prognostic statement follow diagnostic statements which are in turn followed by statements about treatment.

- Uses question/answer format. The Doctor preempts patients questions. This technique may introduce information the patient does not want and restricts the number of questions the patient can ask.
  eg. Now you're probably wondering what impact this diagnosis might have on your daughters.

- Summarises information. When the Doctor completes a detailed explanation with a statement which summarises the content.
  eg. "So we've talked about chemotherapy. I've explained that the common side effects are nausea, loss of hair, lethargy and lowering of the blood count. We've talked about how it is given and how long you need to have this treatment.

- Uses pictorial or written aids. When the Doctor makes use of these aids.
  eg. (1) Shows the patient scans to explain diagnosis.
  eg (2) Gives the patient a brochure explaining available counselling services.
  eg (3) The Doctor draws a picture which shows the patient how their treatment will be administered

- Uses colloquialisms (ie. uses slang/ layman's terms)
  eg You might be in for a rough trot with the chemotherapy.

- Uses humour.
  eg "yeah it's called informed consent. I inform, you consent".

- Acknowledges the patient. The Doctor responds to the patient's statements.
  eg. P: "...and the tissue around the tumour was clean too."
  Dr: "That's excellent, that's good for me to know."

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