

Differences in Verbal Behaviour Style in Interviews of Patients Females with Patient's Companion (Triads) and Without Patient's Companion (Dyads) in Family Medicine

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Abstract

Objective: To describe differences in verbal behaviour style in interviews of patients females with patient's companion (triadic consultations) and patient's females without patient's companion (dyadic consultations) in family medicine.

Participants and Methods: Secondary analysis of existing dataset coded to explore patient-clinician verbal communication during ambulatory visits in a family medicine office in a health Centre in Toledo (Spain) was carried out. A qualitative study was performed by audio recording of the consultations and verbal content analysis of the interviews, based on the identification of 6 categories of classification of behaviours of the interaction process (Proposing, Supporting/Agreeing, Disagreeing, Giving Information, Seeking Information, and Building). A convenience sample was carried out. A suitable sample number was considered when saturation occurred. Quantitative methodology was used as a technique to control the reliability and biases.

Results: 5 unaccompanied consultations and 7 consultations with companion were included in the analysis. The female patients with a companion show 2/3 more verbal behaviours (165 vs. 101) with slightly more behaviours of "Supporting or Agreeing" (42% vs. 34%), but less of "Giving Information" (43% vs. 53%) than when the female patients go unaccompanied, predominating these two types of behaviours in both modalities. Consultation with female patients with a companion shows almost twice as many verbal behaviours of the doctor vs. the consultation with unaccompanied women (186 vs. 100), and is longer (6.4' vs. 7.7').

Conclusions: This study shows that consultations of female patients with a companion are longer and more verbal behaviours are performed. In patients female the triadic consultations have more agreements, but less information is obtained than in the dyadic, and in general there is mixed results. Female patients show a clear predominance of verbal behaviours of "Giving information" and "Supporting or Agreeing", both with or without companion in the consultation.

Keywords: Family practice; Physician-patient relations; Methodology; Gender differences; Verbal behaviour style; Communication; Language; Family members

Introduction

The cornerstone of general practice is the consultation, about which much has been written, from psychology to sociology, psychiatry and anthropology. The consultation focuses on an encounter between two people: the patient and the physician. In practice, a third person (companion, who is usually a family member) frequently accompanies a patient during medical encounter (triadic consultation), but nevertheless reviews about the presence of a companion of the patient in consultation are rather scarce in our environment. The subjective experience of disease is built by patient in the family context and it is expressed in the medical consultation, often, with the presence of a companion of the patient. The companion shapes the experience obtained by the patient's physician [1-4].

On the other hand, the majority of companions of patients in the family medicine practice are women. It has been described that there is a gender bias in the patient's companion: she is a middle-aged woman, wife, with poor health, low social class, housewife or worker, accompanying a middle class patient, male or student. Implicit stereotypes associating to female gender with providers of health continue to express themselves in accompany the sick in the family medicine office [5]. Regarding verbal communication in the triadic consultations there are more agreements and more initiatives are proposed, but no more information is obtained than in the dyadic and with the cost of a longer duration of the consultation [6]. The verbal behaviour of female patients shows slightly more agreements/supports and fewer disagreements, than that of male patients [7]; that are to say they show a profile that favours better results. But, 25% of patients are accompanied, and preferably of women. In this context, one might ask: Is the presence of these companions in the consultations of female patients, in any way, a modify factor of this verbal behaviour favourable to obtain good results?

In this context, we carried out a secondary analysis of an existing dataset to explore female patient verbal communication, during ambulatory visits in a family medicine, in triadic consultations (physician-female patient-companion), and in dyadic consultations (physician-female patient) to assess their similarities and differences and the implications in clinical management and interpersonal relationship.

Patients and Methods

Secondary analysis of existing dataset coded to explore patient-clinician verbal communication during ambulatory visits in a family medicine office was carried out. The methodology of the study was qualitative, observational, and narrative and has already been described previously [6,7]. Through the audio recording of the consultation, the verbal content of the interviews was analysed, based on the identification of 6 categories of classification of the behaviours in meetings that describe the class or behavioural style of the interaction process, not its content [8]:

- **Proposing:** a behaviour that advances a new concept or suggests a course of action.
- **Supporting or agreeing:** a behaviour that includes a conscious and direct statement of support or agreement with another person or their concepts.
- **Disagreement:** a behaviour that involves a conscious and direct statement of difference of opinion, or criticism of the concepts of another person.
- **Giving information:** a behaviour that offers facts, opinions or clarifications to other individuals.
- **Seeking information:** a behaviour that seeks facts, opinions or clarifications of another individual or individuals.
- **Building:** a behaviour that extends or develops a proposal that has been made by another person. Other variables that were collected: age (the companion and the patient), sex the companion, and time in minutes of the consultation.

The companion was defined as any person who accompanied the patient in the consulting room. Patients were included only one time, thus, were excluded the repeated consultations of same patient. Also excluded were interviews in which the patient was not present, when there was more than 1 companion with the patient (since it made the verbal analysis very complicated by the interference of one another), and emergency consultations. The phrases of courtesy of initial and final greetings were not included in the content analysis of the interview. A non-random sampling, intentional was carried out by the investigators. A suitable sample number was considered when saturation occurred. The informed consent of all patients and companions for using of data in research was obtained.

Once the qualitative study is completed, the results of the number of behaviours in the total of triadic and dyadic consultations are presented in a quantitative way. This is only as an orientation, because the size of the sample was not calculated as a quantitative, but qualitative. The bivariate comparisons were performed using the test of chi-square and exact probability Fischer. The techniques to control bias (triangulation: to get different perspectives of the phenomenon studied), were different evaluators: the written transcripts of voice recordings of the interviews were read by the research team to reach agreements on the categories that were used and methodological triangulation: the integration of qualitative and quantitative findings [9].

Results

Female patients who go to the family doctor's office with companion vs. those who come without companion, present slightly more behaviours of "Supporting or Agreeing" (42% vs. 34%), but less of "Giving Information" (43% vs. 53%), predominating these two types of behaviours in both modalities. In the consultation, the female patients with a companion show 2/3 more verbal behaviours than when the female patients go unaccompanied (165 vs. 101) (Table 1) [10].

	Dyadic : Female patients (n=5)	Triadic: Female patients (n=7)	Statistical significance
Verbal behaviours	N(%)	N(%)	
Proposing	1(1%)	7(4%)	$X^2=2.2718$. NS Fisher exact test=0.265732.
Supporting	34(34%)	70(42%)	$X^2=2.0195$. NS
Disagreeing	1(1%)	7(4%)	$X^2=2.2718$. NS Fisher exact test=0.265732.
Giving information	54(53%)	71(43%)	$X^2=2.7387$. NS
Seeking information	9(9%)	9(6%)	$X^2=1.1863$. NS
Building	2(2%)	1(1%)	Fisher exact test=0.563298. NS
Total	101(100%)	165(100%)	
Age	X=41 (rank: 32-46)	X=45 (rank: 14-64)	

Table 1: Comparison of verbal behaviours among female patients who consult with and without a companion.

The verbal behaviour of the physician in consultations with female patients with companion's shows less behaviours of "Supporting or agreeing", but also less disagreements, and slightly more behaviours of

"Giving Information", "Seeking information", and "Building" [11]. Consultations with female patients with a companion show almost

twice as many verbal behaviours of the doctor vs. the consultation with unaccompanied women (186 vs. 100), and is longer (6.4' vs. 7.7') [12].

Table 2 shows some "verbatim" (literal phrases) in relation to the behaviours of each actor in consultations.

Behavior Styles	Dyadic: Female patients (N=5)	Triadic: Female patients (N=7)
Proposing	- ...let me have a complete analysis... -To do the test again ... in 6 months and ... already according to whether or not there is difference ...	-That, make me a study, I do not know why... -You have to measure me the blood pressure ...
Supporting/ Agreeing	-Yes Yes. Ok agreed . Yes. That's the bacteria ... my brother had it.	-Yes, I've been doing it for many years. -That's ... ok, ok
Disagreeing	- No, nothing - No, no ... No, it was to be warned before February, but now it is not...	-No, nothing like that. The one that hurt me was the other, the one of the three days... -I do not want sick leave ... just a voucher for today
Giving Information	- Well the truth... I did not know whether to come here or not, because I have always been a little delicate..., but I have been many years that I noticed that my gut swells a lot and... -I still have this area from behind, but I imagine it will be ...	-He gave me some other little pills and I almost died... -I do not get to have a fever but I do have plaques in my throat and it hurts me here.
Seeking Information	-And if it goes more? ... -Do you know if there is any medication, or any food that helps to rebuild the veins?	-He has prescribed these patches for me and I have not bought them because ... I'm afraid to wear them, and I'm waiting for your opinion... -And the envelopes that I took for the mucus ... I still take them or not?
Building	-I also have and ... a complete blood test that doctor of the skin has given me because of the problem I have because I calculate and...	-I also very much, I am very happy. Already the boys are big and...

Table 2: Some "verbatim" (literal phrases) in relation to the behaviours of each actor in consultations.

Discussion

The clinical interview: dyads and triads

The clinical interview is an essential competence of the family doctor and communication a key piece in the doctor-patient relationship. The conceptualization and physician training focuses on an encounter between two people: the patient and the physician. In practice, a third person (companion) frequently accompanies a patient during medical encounter, and there is a high prevalence of the presence of companion (25% of the interviews are with companions) [1,13]. This triadic relationship can be drawn as shown in (Figure 1).

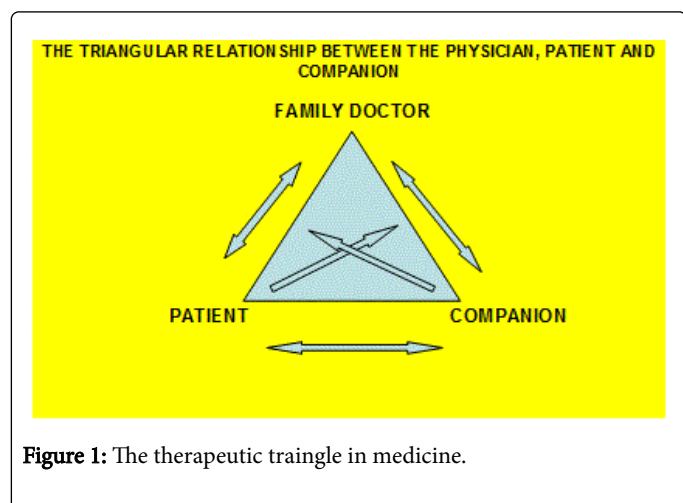


Figure 1: The therapeutic triangle in medicine.

The group communication dynamics that are developed in the bipartite and tripartite meetings are not identical. But previous research on communication in the interview has focused primarily on "dyadic" consultations between physician and patient [14,15], and attempts at investigation of the dynamics of communication in consultations in which the interview is with "triads" in family medicine are scarce and partial [16-21].

Verbal behaviour of female patients

Why focus on female patients? Many large-scale studies based on survey data have reported greater use of primary healthcare services in women, and several data sources suggest that women make higher use on average of primary care than men. For example, in the United Kingdom or in Spain, where most health care is free at the point of delivery under National Health Service, women consult their general practitioner more often than men, particularly in the peak of reproductive years [22-26]. Women consult the doctor more than men because, among other reasons, they assume the greatest responsibility for conception/contraception, visit to the doctor during pregnancy and childbirth, the anatomy of the woman seems more complex than that of the male, there are gender differences in perception of symptoms, and women go more to the doctor because they are more able to ask for help [27-30]. On the other hand, the verbal behaviours of the women seem to be more useful to obtain better results in the consultation. Women's conversations focus more frequently on feelings, relationships, and personal problems [31] and present more verbal behaviours of "Supporting," and less "Disagreement" [7]. We found that the female patients with a companion show 2/3 more verbal behaviours than when the female patients go unaccompanied (165 vs. 101).

Presence of patient's companion

It has been reported that the presence of a companion can improve medical proposals or interventions [6,32-35]. We found that female patients with companion present slightly more verbal behaviours of "Supporting or Agreeing" but less of "Giving Information", predominating these two types of behaviours in both modalities (triads and dyads).

Duration of the consultation

We found that female patients with companions had longer consultations (7.7' vs. 6.4'); this figure is greater than that which has been reported for the hospital setting (4 minutes and 17 seconds for each patient on the ward and 20 seconds for his or her relatives) [36] (Figure 2), but less than the communicated by other authors in general medicine (10-12 minutes) [37], and it may be interpreted that longer consultations are associated with more adequate diagnoses, at least in psychological problems [38], although in our study the content of the interview was not collected (Table 3).

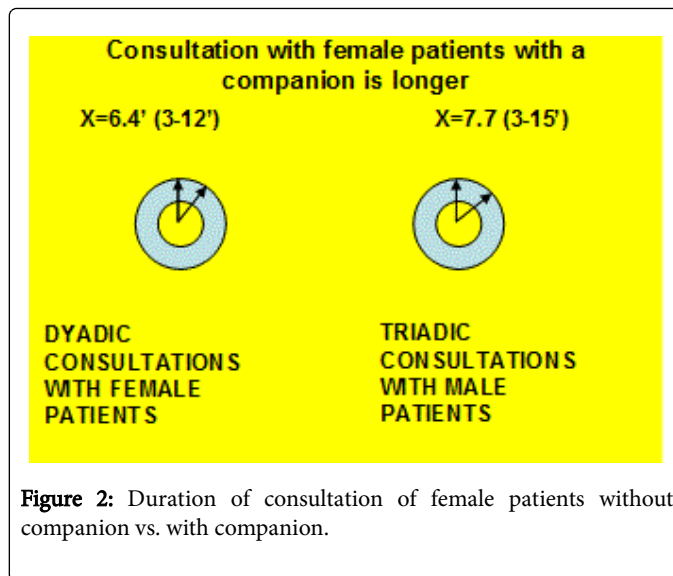


Figure 2: Duration of consultation of female patients without companion vs. with companion.

Behavior Styles	Dyadic : Female patients (n=5) Doctor [N(%)]	Triadic: Female patients (n=7) Doctor [N(%)]	Statistical Significance
Proposing	18(18%)	31(17%)	$\chi^2=0.0814$. NS
Supporting	15 (15%)	17(9%)	$\chi^2=2.2476$. NS
Disagreeing	5(5%)	2(1%)	Fisher exact test=0.053157. NS
Giving information	35(35%)	73(39%)	$\chi^2=0.4992$. NS
Seeking information	22(22%)	47(25%)	$\chi^2=0.3796$. NS
Building	5(5%)	16(9%)	$\chi^2=1.2403$. NS
Total	100(100%)	186(100%)	
Average duration in minutes (range)	6.4' (3-12')	7.7 (3-15')	

Table 3: Comparison of physician behaviour in triadic and dyadic consultations.

Physician behaviour in triadic and diadic consultations with female patients

It has been suggested that the patient begins the consultation by offering one or more problems to the doctor. The physician respond to these offers, indicating his acceptance or rejection of them, until some kind of compromise is worked out [39]. In our study, the verbal behaviour of the physician in consultations with female patients with companions shows less agreement/support behaviours, but also less disagreements, and slightly more behaviours of giving, seeking information, and building.

Limitations of the study

Our study has limitations, which have already been published in part [6,7] in relation to:

- Coding difficulties [8].
- Transcription from audio to text: doctor, patient and companion contribute to the discourse, and thus present overlaps,

juxtapositions and narrations together, and these are difficult to transcribe and codify [9].

- Difficulties in the role of patient and companion: in the triadic interviews: the companion, not infrequently consults for herself or herself, and there is an inversion of roles: the one who was a companion becomes a patient, and vice versa. This situation complicates the coding of behavioural styles.
- The question of representativeness of the sample: interviews were recorded on normal consultation days, communication was not subject to fluctuations, and we thought that by maximizing the diversity of the participants, they represented the patients and companions usual of the consultation. It may be thought that the size of the sample is small, but in qualitative studies this usually is small, and the sample size was given by the saturation of the data, and was similar to that of other studies of the same subject [10,11].
- The content of the interviews was not collected: only the class or behavioural style of the interaction process. The conceptualization of the disease is another point of interest that can vary between participants, doctor, patient and companion. A different

understanding of the origin of a disease, for example, can cause communication problems and lead to misunderstandings [12].

Conclusions

Our group had reported previously that female patients agree/support more; i.e. they show a profile that favours better results, but 25% of the patients come accompanied, and preferably of women. In this context, one might ask: Is the presence of these companions in the consultations of female patients, in any way, a factor that modifies verbal behaviour? This study shows that consultations of female patients with a companion are longer and more verbal behaviours are performed. In patients female the triadic consultations have more agreements, but less information is obtained than in the dyadic, but in general there is mixed results. It is suggested that the important thing is that the consultations of female patients show a verbal profile that suggests good results in the consultation. Female patients show a clear predominance of verbal behaviours of Giving information and Agreeing, both with or without companion in the consultation. One could study whether the gender of the companion influences, which requires a study with greater numbers of patients.

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