Summary

One fifth of the complaints voiced by patients of Dutch general practitioners (GPs) consists of psychosocial problems. In most cases these complaints are presented in physical terms. This thesis examines the way in which GPs and patients relate physical complaints to psychosocial aspects. It is an explorative, descriptive study in conversation analysis in which the research materials consist of videotaped conversations between GPs and patients.

Chapter 2 presents a survey of the literature on the communication between GPs and patients. From the late sixties onwards, researchers of various disciplines have studied many aspects of this communication. Among other things, various styles of communication and the relationship between communication and patient satisfaction have been studied. These studies differ not only with respect to their subject, but also with respect to their methodological aspects. On the basis of the methodology adopted, I make a distinction between quantitative studies and qualitative studies. The first type of research focuses on determining the extent of certain communicative behaviours, for example the amount of information provided by the GP. Such studies involve large numbers of interactions, in which the conversation is scored by means of an observation system, after which the scores are subjected to statistical analyses. The second type of research focuses on the description of certain aspects of communication, for example the way in which GPs present information. These studies involve small numbers of consultations, and the communication is usually recorded verbatim, after which it is analysed in detail. I have chosen the latter methodology — more specifically conversation analysis — for the study presented here.

Chapter 2 further presents a detailed description of the methodology of conversation analysis. This methodology originated as a branch of sociology in which recorded natural discourse is studied to investigate the way in which the participants continually accomplish the interaction they are engaged in and the methods they use for doing so.

Chapter 3 centres around psychosocial problems in the general medical practice. A large proportion of the complaints voiced by patients to GPs consists of psychosocial problems. Various terms and definitions have been formulated to describe this concept, and various measurements have been used to determine the extent of such problems. Usually the opinion of the GP is used to determine whether the problems are psychosocial in nature. However, GPs differ in their judgment about the number of psychosocial problems they are confronted with, since psychosocial problems cannot be simply classified as a particular symptom or disease. They consist of a complex interplay between somatic and psychosocial aspects of the patients' complaints. I have opted for the term 'psychosocial aspects', which I define as all the aspects of the complaint that are related to the patient's living situation or biography.

Literature on consulting pays little attention to psychosocial aspects, and empirical studies of the way in which psychosocial aspects of consultations are dealt with are few and far between. The research presented here aims to fill this lacuna. It describes the way in which GPs and patients discuss psychosocial aspects during the consultation. Only those consultations in which such aspects were actually discussed have been included in the study. The sample was further reduced by including only those consultations in which the patients present with physical complaints that are somehow related to psychosocial aspects,

since most patients couch their psychosocial problems in physical terms. Finally, I only included those consultations in which the psychosocial aspects were seen as the factor causing the patient's complaints. The research question therefore is: *how do GPs and patients relate physical complaints to psychosocial causes in the course of the consultation?*

A total of 279 consultations of eight GPs were recorded on videotape. Twenty-four of these were selected for analysis, namely the first three consultations of each GP in which a patient presented with physical symptoms that were subsequently related to a psychosocial cause. Each of these consultations was then transcribed verbatim for the purpose of detailed analysis. After each consultation the patient was asked to fill out a questionnaire. It is interesting that these patients do not always indicate that psychosocial aspects had been a topic of conversation.

Chapters 4 to 8 describe the empirical research. I examine the ways in which patients and GPs bring up psychosocial aspects of the complaint. Chapter 8 deals with the treatment phase of the consultation.

Chapter 4 describes the way in which patients relate their physical complaints to psychosocial causes. Patients usually present their symptoms at the beginning of the consultation. In terms of their function, these presentations of the complaint can be regarded as reports. I distinguish between two types of reports: general reports and specifying reports. General reporting usually occurs at the beginning of the consultation when the patient initially voices his or her complaint. Specifying reports occur at a later stage, usually in response to questions asked by the GP about specific aspects of the complaint. In both types of patient report psychosocial causes of the complaint may be mentioned. I call such patient utterances ‘explanations', and I make a distinction between explanations and diagnoses, since a diagnosis ‘labels' a particular complaint as a particular type of disease, while an explanation defines a causal relationship between a complaint and a specific fact. Since psychosocial problems cannot simply be classified as symptoms or diseases (chapter 3), I use the term ‘psychosocial explanations'.

Patients may present two kinds of psychosocial explanations. In explicit explanations patients explicitly mark a causal relationship between a psychosocial cause and a complaint. In implicit explanations patiets present psychosocial facts or events, by which they suggest a potential causal relationship between these facts or events and the complaint. Chapters 5 and 6 describe the ways in which patients present explicit and implicit explanations.

Explicit explanations are the topic of chapter 5. Such explanations have four components: the complaint (’a headache’); causal relationship (’caused by’); cause (’stress’); and an elucidation of the causes. These elements may be arranged in two ways: either the elucidation is part of an initial report before the cause is mentioned, followed by the causal relationship and the complaint (’i think, well, that must be what caused it’), or the elucidation is given in a report presented after the complaint, the causal relationship and an explicit mention of the causes (’i myself think it may have something to do with (...) there has been some aggravation at school’).

There are two types of explicit explanations: stated explanations and rejected explanations. Rejected explanations are a means through which the patient indicates that his or her symptoms are not caused by a particular psychosocial aspect (’i didn’t get this because of stress’). Such rejections may be explicit or implicit. In the former case, patients explicitly state that their symptoms are not caused by a specific psychosocial aspect. In the latter case, they present a psychosocial explanation which is then followed by ’but’ and a

subordinate clause in which the explanation is implicitly refuted ('I thought it was stress, but I no longer experience any'). In other words, an expectation is denied, as it were. It appears that patients generally feel it is not necessary to elaborate on potential causes once they have rejected them.

The explanations given can be further divided into outspoken explanations and candidate explanations. In the former case, the explanations are formulated as plain statements ('this is caused by tension because of our daughter'). In the latter case, the statements are formulated more prudently ('i think the stress just became too much'). The last type of explanation is common in our corpus, which illustrates that patients are cautious when presenting statements about causality in connection with their complaints, even though these explanations relate to their living situation. They present their own subjective lay opinions with caution, thereby showing that they regard the act of 'explaining' as part of the professional responsibilities of the GP.

The discourse function of the candidate explanations is that they are presented to the GP so that he or she can judge them. They are often not direct statements, but couched in the form of a quasi-question. To the patient, the function of the rejected explanation is on the one hand a justification for going to the GP, and on the other hand an attempt to induce the GP to provide an explanation. A rejected psychosocial explanation also paves the way for a somatic explanation of the problem and a somatic solution.

At the end of chapter 5 I describe the ways in which GPs respond to the explanations given by the patients. The GP's judgment depends on the phase of the consultation in which the explanation is presented. The elucidation of the explanation also plays an important part. GPs respond to explanations without prior elucidation by giving the patient opportunities for elaborating on the explanation, without presenting an opinion themselves. It seems as if GPs use elements from the explanation to initiate the process of testing its accuracy. Through their responses GPs reveal their professional identity vis-à-vis the activity of 'explaining' during the consultation.

Chapter 6 describes the implicit explanations, in which patients present descriptions of psychosocial aspects or circumstances that may be the cause of their symptoms. The patient's reporting therefore has a potentially dual function: in the context of describing or elucidating the complaint, the patient may simultaneously offer an implicit explanation for the complaint. In other words, patients may present potentially explanatory statements that are subsequently transformed to a psychosocial explanation by the GP.

The patient's implicit statements are essentially a kind of indirect use of language. Conversation analysis assumes that participants in a conversation create meaning through a process of negotiation. Meaning is seen as a result of methodic interactional work. This means that when a speaker performs an implicit act, it depends on the listener whether he or she will respond to the message implicit in the act. This can be gleaned from the listener's response. Patient reports can be characterized as a specific type of indirect language. They have the potential to be understood and treated as an explanation, but it is ultimately the GP who determines whether the report is regarded as such or not.

Through their use of implicit statements patients show that they regard the presentation of explanations as a delicate affair. They use the potentially dual function of reports since, strictly speaking, the patients only report information. They leave it to the GP to infer the explanation from the report. In the same way as with explicit explanations, patients show that they regard the activity of 'explaining' as part of the GP's professional responsibilities.

It appears that GPs very rarely distil the potential explanation from the report.

Usually they treat the report as information, by responding with silences, phatic utterances ('yes'), or by incorporating elements of the report in follow-up questions. Only in one consultation did the GP immediately infer a potential explanation from the patient's report. It subsequently turned out, however, that the patient had not implied an explanation in her report.

Unprompted, patients may present explanatory material in a global report that has the potential to be understood as an explanation. By using the explanatory potential of reports, GPs may strategically guide patients in the direction of a psychosocial explanation. They may ask questions about psychosocial circumstances, so that the patient is provided with the opportunity to come up with a specific psychosocial report, and subsequently convert elements from the report into a psychosocial explanation. This is one of the ways in which GPs can bring up psychosocial explanations for the patient's complaint.

Chapter 7 describes two other ways in which GPs can achieve this. It appears that they always do so in the form of questions, which I call 'cause-seeking queries'. In this respect, psychosocial explanations differ from somatic explanations. The latter are nearly always presented in the form of assertions, while cause-seeking queries are always couched in cautious terms. I distinguish two types of cause-seeking queries: the exploratory query and the verificatory query. The two differ with respect to their formulation and their place within the consultation. The follow-up to these questions also differs.

In verificatory queries ('do you think this may also have something to do with stress?'), the GP mentions a psychosocial fact that may be the cause of the patient's complaint. In this way, he or she explicitly leads up to a psychosocial explanation of the complaint. These questions are always couched in cautious terms. The word 'also', for example, is often used to qualify the statement. The verificatory queries are often posed at the end of the consultation. If they are part of the verbal examination phase of the consultation, the GP uses a lengthy introduction to lead up to the question, to justify it and to initiate another activity. Patients respond to this type of question with cautiously formulated confirmations or denials.

GPs use exploratory queries ('have you any idea how this came about?') to explore the knowledge and insights of the patient concerning possible causes of the complaint. This type of question is always posed in the verbal examination phase. By means of 'and' and 'but' at the beginning of these questions GPs demarcates a transition to the activity of explanation-seeking. In response to these questions, patients always indicate that they do not know the cause of their symptoms. The subsequent actions of the GPs show that they use these queries to search for a psychosocial explanation. After listening to the patient's response, they initiate a domain checklist strategy to investigate potential psychosocial causes. This strategy consists of a series of questions in which various psychosocial domains are checked. The GP then tries to relate the answers to the complaint. However, patients often respond negatively to domain checklist questions, which makes it impossible to reformulate their responses as an explanation for the complaint. It appears, therefore, that the strategy is hardly effective. The use of such a domain checklist strategy indicates that GPs use exploratory queries to implicitly lead up to a psychosocial explanation.

Verificatory queries appear to be more effective for determining a mutual psychosocial explanation than exploratory queries. In other words, there is a relationship between the degree of explicitness displayed by the GP on the one hand and the degree of agreement or denial in the patients' responses to cause-seeking queries on the other hand. It is currently being questioned whether GPs should investigate potential psychosocial

causes of symptoms if patients do not bring up this issue themselves. It seems more useful, however, to investigate *how* GPs do so than to decide *if* they should do so.

Chapter 8 describes the effects of the success or failure to find a psychosocial explanation. What kind of advice or treatment is given? It appears that in nearly all cases GPs give more than one piece of advice or suggest more than one therapy. Even in consultations where a psychosocial explanation is found, GPs still appear to focus on the somatic aspects of the complaint. They will hardly ever give advice about a healthy life-style or refer the patient to mental health care. The consultations themselves contain extensive psychotherapeutic episodes. This means that part of the treatment of the psychosocial causes probably occurs immediately. The data further indicates that there is no one-to-one relationship between the type of explanation offered for the complaint and the type of advice or treatment that follows. The analysis shows that GPs and patients depend on each other for the formulation of the explanation, and also for the type of advice or treatment that is suggested in the course of the consultation.

Chapter 9 concludes the thesis and presents the conclusions. The two main discourse aspects substantiated by the data are:

1. GPs and patients are cautious in their formulation of psychosocial explanations. Psychosocial explanations are formulated and treated in the interaction as delicate activities. Because GPs and patients deal with psychosocial explanations in this way, such explanations become a delicate topic within the context of the consultation.
2. Both GP and patient depend on the judgment of the other to come to a psychosocial evaluation of the complaint. In other words, psychosocial explanations are accomplished within the interaction through mutual efforts. The data shows that psychosocial explanations offered by the patient have a greater chance of confirmation than explanations offered by the GP. This confirmation is usually couched in cautious terms, which enhances the delicate nature of the psychosocial explanations even more.

I suggest that this delicacy is not only caused by the language used by GPs and patients, but also by the fact that psychosocial subjects are intrinsically delicate in nature, which is why they are dealt with in this way. In other words, their delicate nature is not only reproduced as part of the interaction but reconfirmed. Therefore, psychosocial explanations may be said to be caught in a cumulative vicious circle of delicacy.

GPs contribute more to this delicacy than their patients, because of the way in which they implicitly lead up to psychosocial explanations by posing cause-seeking queries and then applying a domain checklist strategy. Moreover, such queries appear to be hardly effective for the mutual determination of a psychosocial cause.

Since the data shows that the formulation of a psychosocial explanation has little influence on the type of advice given by the GP, I finally conclude that during the consultation GPs are clearly seeking for psychosocial explanations but do not transfer these explanations to the realm of advice or treatment.

The thesis ends with some practical implications for GPs and their training and recommendations for further research. The main advice with regards to GP behaviour concerns the way in which they seek to establish psychosocial explanations. If a GP has a strong notion about a possible psychosocial cause, I recommend that he or she explicitly mention this explanation. In addition, I discuss the relationship between the literature on consulting and the research findings. Some types of advice mentioned in the literature are confirmed by the data, others will have to be reconsidered. Future research into interaction and psychosocial problems should focus on somatic explanations and on the relationship between the consultation and therapy compliance.