

PATIENT/PROFESSIONAL INTERACTION AND ITS RELATIONSHIP TO PATIENTS' PSYCHOLOGICAL DISTRESS AND FREQUENT USE OF HEALTH SERVICES

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Statement of the Problem

A number of factors affect a person's visit to any health professional or service. At one extreme, use of health services is determined by illness but as Zola (1966) pointed out, there is a "vast bulk of illness as such, defined subjectively and clinically, which is not brought to the attention of the health professional by patients." Antonovsky (1962) argued that the "vast bulk of what is brought to physicians by patients and thus, their use of health services is concerned with quite minor physical disorders."

A large proportion of sociological research on health service utilization has dealt with the organization of health professions (Anderson, 1973; Friedson, 1970) and with access to and distribution of medical care (Mechanic, 1975). Another great mass of utilization studies has dealt with individual client perceptions, psychological traits, satisfactions, stress and health (Eichhorn, 1972; DeMiguel, 1974).

Few studies have examined both what happens to a person and how he behaves with certain utilization patterns once he has sought help. Mechanic (1975) suggested that: "Illness is not only an event that happens to people but an important explanation that can be used to sustain one's social identity and social functioning." Since verbal behaviour is one important expression of identity, this study examined the differences in the patient's verbal presentation of the illness and the professional's verbal response. The study described the interaction process between professionals and patients at the time help was sought or once utilization had occurred.

REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK

Since an illness can be used to sustain one's social identity and social functioning, it can be conceptualized as an interactive role. In this sense, an interactive role is defined as a bridge between intrapsychic and social life. The interactive role both expresses and seeks to

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confirm one's view of self. A disordered view of self is enacted and confirmed through a deviant interactive role. The converse of this deviant role is the co-operative interactive role.

The most sustained definition of illness as a deviant role derives from Parsons' (1952) conceptualizations of the functions of the sick role. Parson' "sick role" refers to activity of those who consider themselves ill, undertaken for the purpose of getting well, which leads to exemption from usual responsibilities. The activities or expectations of an occupant of this role are (1) the sick person is exempt from social responsibility and this exemption requires legitimation; (2) the sick person cannot be expected to take care of himself by an act of decision or will and thus, must be helped; (3) the sick person must want to get well whereby the state of being sick is undersirable and the legitimation of his illness is conditional and relative to his getting rid of the illness as soon as possible; and (4) the sick person should both seek help and co-operate with medical advice (Parsons, 1952).

In contrast to Parsons' (1958) view of illness as deviance, this study was developed from the premise that adherence to the Parsonian expectations of the sick role is a type of conformity. A divergence from one or more of the expectations of the sick role (rule breaking) was considered an element of the "real" deviant.

Becker's (1975) work has emphasized the social definition of deviance and has expanded it to include not only the quality of rule breaking that lies in behaviour itself, but also the product of a process which involves the responses of others to the behaviour. That is, deviant acts must be implicitly or explicitly labelled by the audience.

In particular, this study investigated sick persons' verbal deviation from their obligation to co-operate or work on getting well (the task) and health professionals' implicit verbal sanction of that deviant process by co-operating in the "avoidance" process. "Avoidance of the task" was defined as the act of verbally departing, withdrawing, leaving, keeping away from or approaching the issue at hand such as "feelings," "symptoms," etcetera.

This lack of co-operation in getting well has performed some of the following functions: a means of relief from social tensions (Sigerist, 1960), a way of achieving particularistic goals (Field, 1957), a means of catharsis, legitimation of failure and resolution of conflict (Shuval, 1970, 1973), and a form of liberation from the burdens of everyday life (Herzlich, 1973).

These psychosocial studies have addressed the situational and trait factors leading to a person seeking help, but have failed to look at the

interaction during the help seeking process which may maintain the frequency of the pattern. These studies have focused on more easily measured characteristics of the patient which are "neither predictive, alterable" (Becker, 1975), nor consistent with theoretical notions of co-operation and deviance which underlie compliant or non-compliant behaviour.

Co-operation and deviance by definition (Webster, 1971) and as theoretical constructs (Becker, 1968)* suggested a study of the interaction (communication) versus individual traits of patients and health professionals. The issues investigated were: (1) was the avoidant, or co-operative, interaction of patients and professionals related and (2) was the avoidant, or co-operative, interaction of patients and professionals related to the frequency of patients' use of health services or their health status? An interactionist view of help seeking and help giving focusing on deviating from or avoiding the task was an alternative to the trait or situational view (Bowers, 1973).

This plan was in keeping with Becker and Maiman's recent systematic reviews of over two hundred studies (1952-1975) on sociobehavioral determinants of compliance. These studies recommended the investigation and actual recording of the health professional-patient interaction as a most productive dimension for future exploration (Becker and Maiman, 1975; Watzkin and Stoeckle, 1972). It was this issue of interactional correlates of symptoms distress and utilization patterns that was investigated in the present study.

To test this argument of interactional correlates of patients' symptom distress and utilization patterns a conjecture was advanced. Briefly, it stated that there was a relationship between health professional and patient verbal behaviour. The deviant behaviour of patients would relate to their high distress and utilization patterns.

From this conjecture, three hypotheses were deduced.

Hypotheses

1. There is a significant relationship ($p < .05$) between the proportion and type of health professional and patient verbal behaviour. The avoidant verbal behaviour (deviance) and approach verbal behaviour of the health professionals and the patients are related.

* "Co-operation" refers to the act of working with another or others to a common end characterized by mutual benefit. In P.B. Gove (ed.), *Webster's Third New International Dictionary*, p. 501. "Deviance" refers to the state of diverging from an accepted, normal or expected conduct (rule breaking) and the implicit or explicit label of that departure by the deviants' audience. In H. S. Becker, "On Labelling Outsiders," *Deviance: The Interactionist Perspective*, pp. 13-17.

- II. There is no significant difference ($p > .05$) in the verbal behaviour of general practitioner and nurse practitioner types of professionals.
- III. There is a significant relationship ($p < .05$) between patient verbal behaviour patterns and their psychological distress and utilization of services. Patients' avoidant verbal patterns (deviance) relate to their high psychological distress and use of services; health professional and patient approach-approach verbal behaviour relate to patients' low psychological distress and use of services.

Definition of Terms:

- 1. Avoidant verbal behaviour consists of utterances which can be described as intellectualizations, defensive jokes, long narratives or story telling, blaming or hostile attacks.
- 2. Reciprocal speech refers to a short (3 second) length of time that a participant in communication "keeps the floor." Extended speech, in contrast, refers to either participant talking for longer than 3 seconds.
- 3. Approach verbal behaviour consists of utterances which can be described as clarifying, reflective, building, an addition to the topic at hand.
- 4. Psychological distress consists of anxiety, depressive, obsessional or interpersonal types of distress or symptoms.

DESIGN OF THE STUDY

Description of the Population Sampled

During two weeks in April, a random schedule was devised for audiotaping the eight professionals (nurse practitioners and family physicians) in general practices, each in conversation with eight patients. Each morning prior to office hours, eight patients who had made appointments for the day with that professional scheduled to be taped were selected on the basis of their frequency (above and below 5 visits/year) of use of services during the previous year (April, 1975 to April, 1976). The four most frequent and least frequent users for the day were selected for each of eight professionals during a two week data gathering period.

INSTRUMENTATION

The following sources of data were gathered on each patient:

- a. Audiotape recordings were made of the 64 professional-patient interviews. Typescripts of three randomly sampled minutes, one from the beginning, middle, and end of each interview were prepared. Three-second utterances or a change in the type of utterances were marked on the typescript. The utterances were coded

on to the typescript as they were simultaneously heard on the audiotape. The codes used were those developed by Agazarian and Simon (1967) in their Sequential Analysis of Verbal Behaviour (SAVI System).

This system categorizes 28 types of verbal behaviour into approach, contingent, and avoidance categories of behaviour. The three-minute fashion sample from each audiotape was based on (1) the 3 minute precedent in the psychotherapy research literature and (2) a preliminary validity study conducted to determine the representativeness (adequacy) of various sample sizes from the 64 audiotapes (Browne, 1977).

b. Patients were asked to fill out:

- i) the 58-item self-report Hopkins Symptom Checklist - HSCL (Derogatis, 1974),* on a four-point scale of distress from (1) "no-distress" to (4) "extreme distress," in areas of somatic obsessive, interpersonal, depressed, or anxiety types of distress.
- ii) a one-question function level index on a five-point scale from (1) "no dysfunction" to (5) "extreme dysfunction."
- iii) an eight-item "days of sickness" and "frequency of use of services inventory."

The frequency of the patient's use of services during the preceding year, number of consultations with specialists, and length of the patient's relationship with the practice was noted from the patient's record.

This information was gathered prior to the patient's interview with the professional during the usual 5-7 minute "waiting period."

RESULTS

Over the sum of the 64 three-minute random samples of conversation a total of 5,745 codes units of verbal behaviour were derived. Professionals had 2,993 coded units and patients had 2,752 coded units of verbal behaviour.

These instances of patient and professional verbal behaviour were paired sequentially and summed into a SAVI Matrix as in Table 1.

The four quadrant SAVI Matrix in Table 1 distinguishes between who is responding to whom in either reciprocal (short) or extended speech. Since the verbal behavior is paired, it is possible to determine the probability of the patients' or the professionals' avoidant or

* The Hopkins Symptom Checklist (1974) has been assessed for its factorial invariance across professional assessments versus patient assessments and also within patients across social class (Derogatis, 1971, 1972). Results, in general, indicated a high level of invariance for HSCL dimensions, both between doctors' reports and patients classified as depressed, neurotic and normal and among patients of various social classes (Derogatis, 1974).

TABLE 1
TOTAL INSTANCES OF UTTERANCE PAIRS IN 64 PROFESSIONAL/PATIENT
INTERVIEWS DISPLAYED BY SAVI AREAS AND
QUADRANTS

EXTENDED PROFESSIONAL RESPONSE TO THE PATIENT - (QUADRANT I)						RECIPROCAL PATIENT RESPONSE TO THE PROFESSIONAL - (QUADRANT II)												
		AVOIDANCE		CONTINGENT		APPROACH				AVOIDANCE		CONTINGENT		APPROACH				
AVOID	A	34	1.2%	B	19	0.6%	C	8	0.3%	A	14	0.5%	B	18	0.6%	C	7	0.2%
	D	17	0.6%	E	692	23%	F	243	8%	D	119	4%	E	270	10%	F	318	12%
	G	8	0.3%	H	114	4%	J	117	9%	G	91	3%	H	154	6%	J	598	22%
CONTING.	A	14	0.5%	B	120	4%	C	90	3%	A	290	11%	B	33	1%	C	7	0.2%
	D	16	0.5%	E	296	10%	F	174	6%	D	44	2%	E	228	8%	F	99	4%
	G	15	0.5%	H	368	12%	J	488	16%	G	23	1%	H	94	3%	J	345	13%
APPROACH	A	14	0.5%	B	120	4%	C	90	3%	A	290	11%	B	33	1%	C	7	0.2%
	D	16	0.5%	E	296	10%	F	174	6%	D	44	2%	E	228	8%	F	99	4%
	G	15	0.5%	H	368	12%	J	488	16%	G	23	1%	H	94	3%	J	345	13%
TOTALS		104	3.6%	1609	53.6%	1280	42.3%			581	21%	797	28.6%	1374	50%			
(QUADRANT IV) RECIPROCAL PROFESSIONAL RESPONSE TO THE PATIENT									(QUADRANT II) EXTENDED PATIENT RESPONSE TO THE PROFESSIONAL									
TOTAL PROFESSIONAL PAIRED INSTANCES = 2993									TOTAL PATIENT PAIRED INSTANCES = 2752									

approach response given the similar nature of the antecedent verbal stimulus. In this way the "relational" hypothesis I can be tested with the reciprocal speech quadrants II and IV.

Table 2 tests the significance of the difference in the proportion (Ferguson, 1971) of patient avoidant responses under the two different professional antecedent verbal stimuli.

Table 2 illustrates that the proportion of patients' avoidance was greater following professional avoidance than following professional approach verbal stimuli. Similarly, the proportion of patients' approach verbal behaviour was greater following professional approach antecedent conditions than professional avoidant antecedent conditions.

Inspection of Table 2 shows that the proportion of the nature of the patient response and the immediate professional stimulus are related.

While the raw data in Table 1 illustrated that professionals approached most of the time regardless of the patients' antecedent stimulus, Table 3 offers a test on that data and can be interpreted to mean that professional avoidant verbal behaviour was significantly greater under patient avoidant antecedent conditions than under patient approach antecedent conditions.

TABLE 2

THE SIGNIFICANCE OF THE DIFFERENCE IN THE PROPORTION OF
PATIENTS' AVOIDANT AND APPROACH RESPONSE UNDER TWO DIFFERENT
PROFESSIONAL ANTECEDENT CONDITIONS:

A TEST OF INDEPENDENT PROPORTIONS

	PROFESSIONAL AVOIDANT STIMULI	PROFESSIONAL APPROACH STIMULI	DIFFERENCE IN PROPOR- TION	ERROR	Z SCORE
	P_1	P_2	$P_1 - P_2$	$S_{P_1 - P_2}$	
PROPORTION OF PATIENT AVOIDANCE RESPONSE	14/39 (.36)	91/843 (.11)	.25	.0530424	4.71**
PROPORTION OF PATIENT APPROACH RESPONSE	7/39 (.18)	598/843 (.71)	-.53	.0737265	-7.18**

** = THE PROBABILITY OF Z VALUES OF 2.58 OR MORE IS $< .01$

TABLE 3

THE SIGNIFICANCE OF THE DIFFERENCE IN THE PROPORTION OF
PROFESSIONALS' AVOIDANT OR APPROACH RESPONSE UNDER TWO
DIFFERENT PATIENT ANTECEDENT CONDITIONS:

A TEST OF INDEPENDENT PROPORTIONS

PROFESSIONAL RESPONSES	GIVEN PATIENTS' AVOIDANT STIMULI	GIVEN PATIENTS' APPROACH STIMULI	DIFFER- ENCE IN PROPOR- TIONS	ST'D ERROR	Z SCORE
	P_1	P_2	$P_1 - P_2$	$S_{P_1 - P_2}$	
PROPORTION OF PROFESSIONALS AVOIDANT RESPONSE	14/224 (.06)	15/871 (.02)	.04	.0120249	3.33**
PROPORTION OF PROFESSIONALS APPROACH RESPONSE	90/224 (.40)	488/871 (.56)	-.16	.0373991	-4.28**

$$\text{WHERE } S_{P_1 - P_2} = \sqrt{PQ \left(\frac{1}{N_1} + \frac{1}{N_2} \right)}$$

$$Z = \frac{P_1 - P_2}{S_{P_1 - P_2}}$$

$$P = \frac{F}{N_1 + N_2}$$

$$Q = 1 - P$$

** = PROBABILITY OF Z $< .01$

TABLE 4
THE SIGNIFICANCE OF THE DIFFERENCE IN THE VERBAL
BEHAVIOUR OF 3 SENIOR FAMILY PHYSICIANS & 3
NURSE PRACTITIONERS

1. RAW SCORES						
	NURSES			DOCTOR		
	1	2	3	1	2	3
	14	10	18	10	7	28
	212	210	202	184	226	119
AVOID	166	220	162	165	143	134
CONTINGENT						
APPROACH						
2. TOTAL SCORES						
	AVOID E	CONTINGENT	APPROACH	TOTAL		
DOCTOR	45 (39.64)	529 (525.31)	442 (451.05)	1016		
NURSE	42 (47.36)	624 (627.69)	548 (538.95)	1214		
TOTAL	87	1153	990	2230		
$\chi^2_2 = 1.7126$ NOT SIGNIFICANT						

Similarly, professional approach verbal behaviour was significantly greater under patient approach antecedent conditions. The proportions in Table 3 show that the nature of the patients' verbal stimulus affects the nature of the professionals' response. Thus, professional behaviour was related to patient behaviour. It could be said that, unwittingly, patients taught professionals how to behave.

Table 4 presents the number of paired instances of avoid, contingent and approach behaviour for each nurse and senior physician.

The chi square on the total nurse and physician scores is 1.7126 which at two degrees of freedom is not significant.

Thus, it can be further said that there is no difference in the pattern found for nurse and doctor groups.

Each SAVI area was tested in a search for the type of behaviour which was related to patients' distress and use of services. This lengthy analysis is reported elsewhere (Browne, 1977).

Table 5 illustrates that:

1. The proportion of patients' avoidant response to the professionals' approach was significantly greater for patients who were (a) frequently off work; (b) frequently in hospital; (c) frequently

TABLE 5

THE RELATIONSHIP BETWEEN PATIENTS' AVOIDANT
OR APPROACH RESPONSE TO PROFESSIONAL APPROACH
AND THEIR HIGH PSYCHOLOGICAL DISTRESS AND USE
OF HEALTH SERVICES:

A TEST OF INDEPENDENT PROPORTIONS

UTILIZATION	FREQUENCY	PROPORTION OF AVOIDANT RESPONSES					PROPORTION OF APPROACH RESPONSES				
		.00	.10	.20	.30	.40	.50	.60	.70	.80	.90
1. OFF	LOW	.08					.74				
	HIGH	.17					.65				
2. IN	LOW	.10					.72				
	HIGH	.16					.67				
3. DOCTOR	LOW	.06					.75				
	HIGH	.18					.65				
4. VOLUNTARY	LOW	.06					.75				
	HIGH	.22					.62				
5. PHONE	LOW	.04					.79				
	HIGH	.18					.62				
PSYCHOLOGICAL DISTRESS											
6. OBSESSIVE	LOW	.09					.73				
	HIGH	.17					.55				
7. INTER- PERSONAL	LOW	.07					.73				
	HIGH	.26					.59				
8. ANXIETY	LOW	.07					.73				
	HIGH	.25					.56				

WHERE THE FORMULAE FOR THE TEST OF INDEPENDENT PROPORTION IS:

* Z OF 1.96 ($P < .05$) (1) $S_{P_1 - P_2} = PQ \left(\frac{1}{N_1} - \frac{1}{N_2} \right)$ (3) $P = \frac{F}{N_1 - N_2}$

** Z OF 2.58 ($P < .01$)

*** Z OF 3.02 ($P < .001$) (2) $Z = \frac{P_1 - P_2}{S_{P_1 - P_2}}$ (4) $Q = 1 - P$

WHERE THE FORMULAE FOR THE TEST OF INDEPENDENT PROPORTION IS:

$$\star Z \text{ OF } 1.96 \text{ (} P < .05 \text{)} \quad (1) \quad S_{P_1 - P_2} = PQ \left(\frac{1}{N_1} - \frac{1}{N_2} \right) \quad (3) \quad P = \frac{F}{N_1 - N_2}$$

$$\star\star Z \text{ OF } 2.58 \text{ (} P < .01 \text{)}$$

$$\star\star\star Z \text{ OF } 3.02 \text{ (} P < .001 \text{)} \quad (2) \quad Z = \frac{P_1 - P_2}{S_{P_1 - P_2}} \quad (4) \quad Q = 1 - P$$

attending the family practice; (d) frequently initiating the contact in those visits versus responding to the follow up requests of professionals; (e) frequently phoning the practice and who (f) reported high degrees of (i) obsessional, (ii) interpersonal, and (iii) anxiety distress.

It seems the patients' avoidant response to professional approach is the "rule in use" which is broken by the frequent attenders. The avoidance is in the service of the enacted goal — not to get well. Thus illness continues while, on the surface, patients appear to be trying to get well.

Table 5 also illustrates that, conversely, patients who infrequently come to or phone the family practice or hospital are approaching their behaviour and report low levels of psychological distress.

In summary, this study found

- a) a relationship between professional and patient verbal avoidance and approach behaviours during the task of symptom exploration,
- b) no difference between nurses and doctors in their pattern of approach or avoidance conversation, and
- c) strong relationships between patients' avoidance of professional approaching behaviour and their psychological distress and over-use of all health services.

DISCUSSION AND IMPLICATIONS

Implications for Interaction Theory, Sick Theory and Practice

The relationship found between similar approach-avoidance and avoid-avoid behaviours of professionals and patients (reported elsewhere, Browne, 1977) is consistent with Spiegel who, among others, states that a "mutually regulative process is ongoing whenever two people relate" (Bloom, 1965, quoting Spiegel). It is also consistent with Goffman's (1967) proposition that "interaction is a circular and simultaneous co-occurrence of persons fitting their acts into the ongoing acts of another."

The avoidant behaviour findings of patients reported here is important to focus on as this is a crucial theoretical obligation of those who are sick as Parsons has outlined (1951). These findings of avoidance behaviour on the part of patients who produced nine times more avoidance than did professionals when engaged in extended speech support the proposition of Michael Balint (1968) who suggests that the "real reason people seek help is difficult to express and thus, their presentation of symptoms is often laden with avoidant manoeuvres."

Since the proportion of professional avoidance verbal behaviour was greater and related to patient avoidant antecedent stimuli,

Rubington and Weinberg's (1968) "Interactionist View of Deviance" is also supported. Here, the rule-in-use (co-operation) was broken by the patients' avoidance and was implicitly sanctioned by the reaction of the audience, the professionals' avoidance.

However, the relationship found between professional approach and patient avoidance verbal behaviour indicates that a good deal of "therapeutic work" was occurring. Here, professionals met Halpern's (1965) "crucial tactic of therapy by not becoming ensnarled in the patient's disturbance perpetuating manoeuvres" (avoidance). This relationship showed that the proportion of professional approach behaviour was significantly greater than the proportion of their avoidance behaviour under patient avoidant antecedent conditions.

The significantly greater proportion of professional and patient avoidant responses occurring among dyads with patients highly dysfunctional, overusing services, and psychologically distressed, offers a different perspective in which one might interpret the additional meanings of (1) Korsch's (1968) finding that 68% of patients' main expectations were not verbalized, (2) Francis' (1969) finding that friendliness and warmth on the part of professionals did not in itself increase compliance, and (3) Davis' (1968) finding that verbal compliance is inversely related to patients' malintegrative behaviour. The proportion of professional and patient avoidance behaviour being significantly greater, in this investigation, among patients who frequently used health services and reported high levels of dysfunction and distress, explains some of the dynamics that may have been operant in Vuori's (1972) finding that in ambulatory care — "patients' willingness to return to the same doctor was primarily determined by instrumental (sick role confirming) versus expressive factors on the part of the professional." In other words, it seems from this investigation that health service utilization is as Vuori suggests: patients come back when they get what they want from professionals. The findings of this investigation suggest that part of what frequent users of primary care services get from professionals is a confirmation of a behaviour that enables them to stay sick.

The rise in the interest of consumer satisfaction is typified in such statements as that of Korsch (1972) who stated "26 percent of mothers of children in a pediatric outpatient clinic did not verbalize their greatest concern nor were encouraged to do so." While this fact is well taken, it is nevertheless an oversimplification and fails to acknowledge the patients' contribution in defocusing from the issue.

Empirical investigations similar to the present study with which one could relate the findings of this study were not found. It seems

this study makes a special contribution in describing one way in which the verbal behaviour of professionals and patients is reciprocally influenced. Professionals and patients avoided significantly more following the other participant's avoidant behaviour than when following an approach behaviour. Conversely, professionals and patients approached significantly more following the other participant's approach than when following an avoidant behaviour.

Further, on each health status and health service utilization variable, patients' avoidance of professionals' approach was judged to be significantly greater among patients who were dysfunctional, psychologically distressed, and high users of health services. Conversely, patients' approach following professional approach was judged to be significantly greater among patients who were functionally healthy, non-psychologically distressed, and infrequent attenders of family practice services. These findings contribute a description of the difference in the "social treatment" simultaneously elicited and received by psychologically distressed and frequent attenders of family practice services as they compared with non-distressed patients who infrequently attended the practice.

This description of the "social treatment" elicited and received by this "costly" group of patients contributes a little more understanding of one area where health professionals' care of this group of patients may be ineffective. Whether or not this pattern of care can be reversed or eliminated without untoward effects to patients and to other areas of service in the health system is a question for further research.

Implications for Educational Theory and Practice

Perhaps the strongest implication for education in the findings of this study has to do with the subtle, yet mutual, influence process inherent in interpersonal relationships.

In this study it is not exactly clear who teaches whom to avoid the task but in that (1) professionals predominantly approached the task regardless of the patient's antecedent stimulus but (2) were influenced to avoid more under avoidant antecedent stimuli from patients than under approach stimuli, it seems possible to suggest that, at times, the patient is teaching the professional how to behave.

Since a major part of a health professional's initial and continuing education takes place in interaction with patients, it is clear that more attention than is usual in professional schools must be paid to the patients' influence on professionals to act in a certain way. This force of socialization of professionals is rarely mentioned because professionals' control of patients is usually assumed.

In spite of the societally defined
power advantage given to practitioners,
patients do often attempt to exert some
measure of control. . . (in the relationship).
(Bayes-Bautista, 1976)

Second, more interaction research could accompany evaluation of observable student and professional competence. The education in a good many professional schools has remained pre-occupied with content to the exclusion of the interpersonal influence process in groups or dyads. These interaction results clearly indicate that the emphasis in professional education between content and process should be shared.

Finally, the results of this study illustrate how patients may keep themselves ill by avoiding getting well and how professionals collude in that process. There is a great need for professionals to become more active in teaching patients how they keep themselves sick and more active in eliciting from patients a decision to stay well. The need for them to be astutely aware of their interaction process with patients as a correlate of patient outcomes deserves mention.

Implications for Health Care, Research, and Practice

Beginning to place emphasis on interaction studies as an adjunct to "quality of health care" studies is an additional implication of this study.

Presently, a good deal of the "process of giving quality care" studies in the health sector have emphasized the adequacy with which a disease is treated by a methodology which retrospectively analyses patients' records. This study certainly indicates the importance of the "interaction process" by which the symptoms are presented and treatment is offered. The results here clearly indicate that "material" is avoided by both participants which relates with measures of patient outcome. There seems to be a difference in the problem listed on the chart and the problem avoided in the interview particularly with the charts of patients who use services frequently.

Not only the quality of the process of giving care but also the effectiveness of its delivery to frequent users of primary care services is in serious question. The implications for future research elaborates some approaches for dealing with these concerns as well as the limitations of this study.

Future Research

Several lines of enquiry are suggested by the present study. One, a simultaneous study of the process and content of interviews would

suggest the common issues that are avoided by professionals and patients, as well as the interactional approaches that are most successful in uncovering that material, depending on the avoidant strategy used.

Since this study is an ex post facto design based on a purposeful sample, a larger random sample of patients in more than one group practice would help estimate the prevalence of this avoidance of getting well and thus, the degree of effectiveness and quality of giving care which is in question.

Since the analysis of hypothesis I results showed a relationship between avoiders and frequent users, it would be fruitful to see if an educational programme for these same health professionals would be productive in reducing the avoidance, increasing the wellness, and thus reducing the frequency of this population's use of services. This latter type of study would have an experimental design where conclusions about what is causing what could be appropriately made.

This latter type of research could be done in a community of family practitioners with an agreement to investigate the circumstances of a "new patient's" last point of contact with the health system. This agreement would be essential because frequent users of services can go elsewhere when their tactics to influence the professional fail. This selection process on the part of patients serves to set up the same deviant process elsewhere and the circular spiraling overuse and distress can continue.

Methodological Issues in Interaction

I. Methodological Contributions:

A. Design:

1. The development of typescripts in this study controlled and made uniform the rater's perception of what occurred; this tactic amplified the reality to be rated and thereby increased the percent agreement achieved between raters.

Sampling:

2. The high correlations among 1½ minute, 3 minute, 6 minute samples of interaction in the substudy of the thesis (Browne, 1977) was evidence (a) to substantiate the sample precedent in psychological research of three minutes (b) to warrant further investigations of the minute opening of conversations or interviews found to be of such predictive clinical value among clinicians.

B. Statistical:

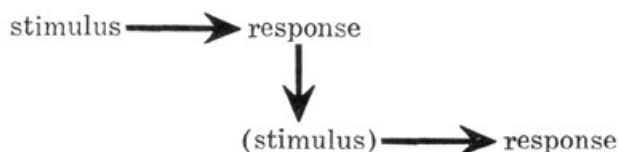
The pairing of utterances and separating out of extended talk within the (1967) SAVI Matrix in this study was a design

method of testing the hypotheses about antecedent stimuli and response. This was a mechanical way to plot out the interactional correlate of high vs low users as the statistical method of "pattern analysis" is difficult to understand statistically and remains an under-developed art.

II. Methodological Limitations or Issues:

A. Design:

1. This study of verbal interaction in the role analysis tradition scores the effect of what was said. The ethnomethodological ("grammatical syntax") analysis of the *meaning*, or *intent* of the message, therefore was not analyzed. It was however argued, as in psychoanalytic terms, that the verbal behaviour was an act. . . "as if" . . . the intent were, in this case, to approach or avoid.
2. This study was one of "interaction" where the stimulus and response of both participants as actor and respondent was analyzed. The limits of the state of the art of pattern analysis made it difficult to develop the investigation into a study of the transactional pattern of



where one could have seen the professionals' response to the patients' avoidant response of his/her original approach. If this were possible it would have been possible to test theoretical notions about interactive deviance where the professional implicitly labels and confirms the views of the patient by his, her own avoidance.

B. Statistical:

3. Some statisticians argue that more sophisticated analysis in the parametric family of statistics could be done with these frequency counts of verbal behaviour. Others argue that the data are strictly nominal and were amenable to only non-parametric analysis. Subsequently only non-parametric proportional analyses are reported. I performed other multiple regression analyses to find the same behaviour ("patient avoidance of professional approach") to be predictive of the frequent attender and psychologically distressed person.
4. A stronger test of agreement than "percent agreement" is a test known as Cohen's Kappa (1960) which subtracts chance

agreement from percent agreement among judges in each discrete category (in this case 28 SAVI categories).

Kappa has been generalized in a number of directions. When the relative seriousness of the different kinds of disagreements can be specified, the statistic "weighed Kappa is appropriate" (Spitzer, Cohen, Fleiss and Endicott, 1967; Cohen, 1968)... Kappa has also been generalized to the case where more than two raters rate each subject (Fleiss, 1971).

(Fleiss, 1973, pp. 146-147)

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RESUME

Interaction bénéficiaire-professionnel relativement à la détresse psychologique et à la fréquence d'utilisation des services de santé.

Au cours des dix dernières années, des centaines d'articles ont traité des bénéficiaires recourant de plus en plus aux services de santé. On a tenté d'expliquer cet usage à partir des traits individuels de personnalité, de l'organisation du système de distribution de soins et de système social. Peu d'études ont investigué le processus d'interaction entre les clients et les professionnels. Parmi ces études, aucune ne tire parti des analyses d'interactions verbales entre les professionnels et les clients en rapport avec l'usage que ces derniers font des services et avec leur état de santé. La présente étude montre la relation qui existe entre les bénéficiaires évitant les interactions verbales et leur fréquence d'utilisation des services de santé de même que leur mauvais état de santé.