INSTRUCTIONS FOR USE OF CODING SHEET TO RATE TAPED INTERVIEWS

PURPOSE: To rate various aspects of communication between the doctor and patient during a routine clinic visit.

INTRODUCTION: In the clinics, the usual doctor-patient interaction proceeds as follows: the Dr. introduces himself to the patient, determines the reason for the patient's visit, takes a history (which may or may not involve assessing the patient's beliefs about the causes of his/her condition, or self-treatment prior to the clinic visit), conducts the physical exam, arrives at a diagnosis, and suggests a therapeutic regimen.

Ideally, the physician strives to involve the patient as a "partner in health" by communicating fully in all areas of interaction. Open communication is demonstrated by instances of: mutual self-disclosure (most often instigated by the physician); expressions of concern and caring by the Dr.; use of psychosocial questions; sensitivity to personal issues (e.g. cross-cultural differences, sexual mores, s.e.s); procedural explanations about the exam and diagnosis (understandable at the patient's level of knowledge); eliciting patient feedback -- to name but a few.

Of course, the routine Dr.-patient interaction falls short in one or more areas fundamental to open communication. By comparing our own audiotaped interviews to an ideal situation, we can determine where both deficiencies and strengths in communication exist. Hopefully, this information can then be used to develop an educational instrument to help the residents develop stronger communication skills.

DESIGN: The overall format of the coding sheet is structured in such a way that the rater, with some practice, can record the responses as he/she listens to the tape. However, before experimenting with both coding sheet and tapes together, familiarize yourself first with coding sheet's design.

The coding sheet format follows a logical sequence of action in the same way that a routine Dr.-patient encounter does (i.e., introduction, history, exam, diagnosis, treatment). Each section for numerals I through VI represents one stage of the Dr.-patient interaction, e.g.: I. Establishing Rapport, II. Etiology of health condition...VI. Therapeutic Regimen. The remaining sections, VII and VIII, assess the general quality of the entire interaction. Section VII examines certain aspects of the Dr.'s interpersonal style, use of language and use of feedback techniques. Section VIII asks the rater to assess the physician's attitudes about and behaviors toward his patients in four different categories.

Under each section is listed 3 to 5 statements which reflect specific characteristics of that section's topic. For example, under section II (Etiology of Health Condition) there are three statements, each suggesting different instances where you, the rater, circle the point which corresponds to your impressions (formed while listening to the tape) about that statement.

HOW TO USE THE SEMANTIC DIFFERENTIAL SCALE (Sections I-VII)

Sections I-VII on the coding sheet show a series of 5 point scales with 2 opposing descriptive phrases or adjectives (e.g. "positive" and "negative") at either end of each scale. Before marking your responses, read through the coding sheet as you listen to the entire tape. This will promote your familiarity with the contents of both the coding sheet and the tape; it will enable you to determine if the coding sheet and the tape both follow the same sequence of action; also, you can be forming initial impressions about the nature and quality of the Dr.-patient interview.

The time has come to begin marking your responses on the coding sheet. As you read each statement, think about its meaning in the context of each section's topic. If you feel that the statement is best represented by a point at one or other end of the scale, circle that response. For example, if under section I the Dr. did not ask any psychosocial questions, you would circle point #1 to indicate that the behavior was "non-existent".

E.G.: NON-EXISTENT (1) 2 3 4 5 EXTENSIVE

If you feel that your response lies somewhere in between, or that the statement is only slightly related to one or other end of the scale, circle numbers 2, 3, or 4. Generally, point #3 will be interpreted as a neutral response. Observe that the numbers increase from left to right to correspond to the way the negative adjectives on the left move to positive adjectives on the right. The direction in which you circle a response, of course, depends on which of the two ends of the scale seem most characteristic of each particular statement.

In the event that the statement does not in any way apply to the contents of the tape, i.e. where use of the scale would clearly misrepresent the data, resort to the "not applicable" (N/A) response. Please do not circle N/A where any possibility exists for using the scale to make an appropriate response. Be flexible, think carefully and objectively before circling each point; the key is to exercise common sense in rating the statements in the context of the tapes. In the final analysis, your good judgment will have significan bearing on the accurate reporting of this data.

After rating sections I-VI you should have listened to the entire tape at least once. In sections VII and VIII, you will need to turn off the tape and concentrate on your overall impressions about the Dr.-patient interview. (You may even need to listen to the tape several times through to clearly understand the dynamics of the interaction).

Section VII will require evaluating each statement in the context of the entire Dr.-patient encounter; circle your response on the 5 point scale, where point #1 indicates that the particular issue occurred "NOT AT ALL", point #3 indicates a neutral response, points #2 and #4 are for in-between responses, and point #5 signifies "A GREAT DEAL".

Section VIII also requires that the rater use an overall perspective to evaluate the Dr.'s attitudes about and behaviors toward his patients. This scale is similar to the others in that the attitudes/behaviors on the left are unfavorable (negative) responses, while those on the right are favorable (positive). Use of the 6 point scale forces the rater to state whether the Drs's attitude/behavior was definitely more positive than negative, or vice versa. In the event that any of the attitudes or behavior in Section VIII cannot be rated due to inadequate information in the tapes, or that circling a response will misrepresent the data, mark the N/A (not applicable) response. Please evaluate all your responses carefully, and be especially discriminate in using the N/A option.

DEFINITIONS OF TERMINOLOGY

These will be presented in the order that you encounter them on the coding sheet. As it is not always possible to provide precise definitions, many of the behaviors you are asked to rate will require subjective evaluations. Use common sense as a guide when responding to your impressions.

I. Establishing initial rapport:

A. Introduces self: Self-explanatory. (Note: it may well be the case that many of the interviews lack the Dr.'s introduction due to a sequencing problem in startir the tape recorder).

B. Appropriate use of patient name: In this category, listen for indications that the Dr. is sensitive to issues of age, sex and marital status in the way he addresses his patients. You many not be able to discern the patient's age and/or marital status from an audiotape in order to know what is appropriate, but you can listen for such things as: the Dr. asking the patients how they prefer to be adressed (e.g. Mr., Mrs., Ms.), or permission to use their first names. In general, does the Dr. attempt to put his patients at ease by being friendly and approachable, or is he distant and formal? "Appropriate" is whatever seems right for the situation.

C. Initial Demeanor: Refers to the Dr.'s outward behavior towards his patients. Is the Dr. warm and caring, cold and businesslike, or somewhere in between? Raters can assess this behavior by listening to the Dr.'s tone of voice, for expressions of concern, for indicaitons that the Dr. is feeling pressed for time (e.g. rushing the interview), and so on.

D. Psychosocial questions: These types of questions are not directly related to the physical symptoms of the patient; instead, they reflect concern about the patient as a person. Such questions may inquire about the patient's family, work, social life, recreation, sexual concerns, adjustments to stressful life events, etc. Drs. may ask their Hispanic patients (especially those who speak only Spanish) if they have any concerns regarding assimilation into American society.

II. Etiology of disease: In this section, the Dr. tries to determine from his patients what the cause/origin is of their particular health condition.

A. Patient Health Belief System: This category will probably occur during the patient history-taking. Here, the Dr. attempts to learn how his patient perceives his/her own health status. He may question his patients about their thoughts on the causes of their conditions, or their knowledge about health matters in general.

What about situations where it does not seem appropriate or necessary for the Dr. to survey the patient's health belief system? For example, many of the patients seen in the Family Practice Clinics are return O.B.s (routine pregnancy check-ups). The Dr. wil probably not ask questions about the cause of her condition (as this is obvious to most), but he can ask what her thoughts and feelings are agout her pregnancy. In this way, the Dr. can still assess the patient's health beliefs. There is no "N/A" option for this category -- you must respond in all situations.

B. Physician Evaluation: Refers to how the Dr. reacts to the patient's stated health beliefs. Does he accept/support the patient (e.g. by verbally agreeing), remain neutral (e.g. does not comment), or respond in a negative/derogatory fashion? (Be aware that the Dr. can disagree with the patient's beliefs and still be supportive). On the scale, a negative response = 1, neutral = 3, and positive = 5.

If the patient does not ask questions about the patient's health belief systems in the first place, he cannot evaluate them -- in this case you should circle "N/A".

C. Culture-specific patient health beliefs: The Dr.'s knowledge of cross-cultural health beliefs will nost likely be domonstrated in interactions with Hispanic patients. Raters should listem for references by the Dr. to such culturally-specific beliefs as susto, nervios, witchcraft, curanderos, spiritual dimensions of illness, and so on. Also listen for instances where the Dr. may try to elicit folk-belief information about the causes of illness, e.g. asking the Hispanic patients whether they suffered a "fright", or were exposed to "mal aire".

III. Treatment prior to visit:

A. Prior treatment: This category should also arise during the history-taking part of the exam. Here, we want to determine how extensively the Dr. inquires Into the patient's health behavior prior to coming to the clinic. This would be exemplified by questions about the use of home remedies, or seeking health advise from the patient's significant others.

B. Home remedies: Refers to any patent or non-prescription medicines, herbs, teas, special foods (e.g. chicken soup), poultices, etc. Generally, anything taken for curative purposes that is of a non-medical nature.

C. Knowledge of alternative, cultural-specific treatments: References by the Dr. to treatments whcih might be used by Hispanic patients (e.g. herbs, teas, incantations, visiting the curandero). See II-C. above.

D. Evaluation of prior treatment: Refers to the Dr.'s subjective evaluation of the patient's stated health behavior (i.e., positive, neutral, negative). See II-B. above.

IV. Physical Examination: This section requires the raters to assess the manner in which the Dr. conducts the physical exam. If it appears that the Dr. might have switched off the taperecorder before conducting the exam, mark this information on the coding sheet.

A. Verbal Sensitivity: This can be determined by listening for instances where the Dr. anticipates his patients' concerns, reassures them, insures reciprocity of communication (gives and asks for feedback), makes empathetic, friendly remarks,

B. Quality of explanation of procedures: During the physical exam, you will rate how well the Dr. explains the procedures. Assuming that procedures are explained to begin with, their quality can be determined by examining the approach taken by the Dr. For example, is the patient told what to expect, and how the procedure might feel (e.g. a reflex test, or a shot)? Are the explanations cursory, or alternatively, overly complex? If the Dr. uses medical jargon, listen to whether or not he clarifies meanings in language understandable to the patient. Basically, a good explanation clearly and completely provides the relevant details, yet does not technically overwhelm the patient.

C. Eliciting feedback: Refers to any attempts by the Dr. to seek out the patient's thoughts and feelings during the physical exam. Positive indications of this would be exemplified by the Dr. encouraging his patient to ask questions, asking how the patient feels about the medical procedures, inquiring about the patient's feelings in general, and/or other ways of drawing out communication.

D. Issues of modesty: With special regard to female patients, rate the degree of the Dr.'s sensitivity to issues where modesty might be a concern. THis could be demonstrated by the Dr. leaving the room while his patient undresses, or asking the patient's permission to conduct the physical or pelvic exam, or asking about the patient's sexual behavior as tactfully as possible.

V. Diagnosis: This section requires that the raters assess the manner in which the Dr. presents his diagnosis. If it appears that the Dr. might have turned off the tape recorder before presenting the diagnosis, mark this information on the coding sheet.

A. Quality of explanation: Refer to IV-B.

B. Eliciting feedback: Refer to IV-C.

C. Use of appropriate language: Simply stated, appropriate language means that the Dr. speaks to his patients in terms they can understand. This does not necessarily exclude the use of medical terminology, but if such language is used it should be "translated" into terms suitable to the patient's level of knowledge.

D. Integration of patient ideas/language into explanation: Regardless of the reason for coming to this clinic, patients often have certain preconceived ideas about the etiology (cause/origin) of their health problems, as well as certain expectations about treatment. During the diagnosis, the Dr. might try to intergrate the patient's ideas and expectations into his explanation, either for the purpose of clarifying misconceptions or to state the diagnosis in language familiar to the patient. If the patient is being seen for a routine physical or pregnancy check-up, the nature of the visit may not necessitate spending much time discussing the patient's ideas and expectations. In these cases, circ point #3 to indicate a neutral response.

VI. Therapeutic Regimen:

A. Quality of explanation: Refer to IV-B.

B. Assessment of patient understanding: i.e., does the Dr. elicit feedback from his patients to determine whether they understand his instructions for treatment? This might involve, for example, asking the patients to repeat instructions, or to phrase the instructions in their own words, or to state any questions they might have.

C. Incorporate medical regimen with home treatment: Refers to any indication that the Dr. has considered how the patient's lifestyle might be affected by the prescribed medical treatment. E.g. if the Dr. prescribes a low sodium diet, he might suggest ways to incorporate this into the patient's regular meals with the family.

D. Exploration of impact of regimen on family/significant others: If a regimen is prescribed, does the Dr. try to determine what effects it will have on the patient's relationships with family/significant others? E.g. Dr. suggests abstaining from sex, does he explore the patient's feelings, or ask if this will create physical, emotional, psychological or marital problems?

If it seems obvious that the regimen is fairly simple or routine (e.g. prescribing Maalox or multivitamins) it probably will not be a disruptive factor to the patient's lifestyle, in which case it seems unlikely that the Dr. will explore any "impacts". In these situations, your best response is to circle point #3 for a neutral response. If no regimen is prescribed, circle N/A.

E. Tangible treatment: It is often true that patients expect to leave the Dr. having been given some kind of tangible treatment, be it a shot, prescriptions for pills (anything from Tylenol to antibiotics), or even just an appointment for a return visit. Depending on the situation, the Drs. sensitivity to this issue will be indicated by the kind of treatment he prescribes. As raters, you will need to assess this category based on your understanding of each particular interview, and how appropriate the prescribed treatment seems in context.

VII. Overall Rating of Interview: In this section, the physician's behavior is rated in three general categories: A. Interpersonal style; B. General use of language; and C. Feedback techniques. Each behavior can be rated according to the frequency of its occurence. Circle the point from 1 to 5 to indicate whether the behavior occurred "NOT AT ALL" to "A GREAT DEAL". Most of the behaviors listed are self-explanatory, with the exception of the following which will be defined in the order that they appear on the coding sheet.

A. Physician Interpersonal Style:

3. Maintained appropriate relationship: By "appropriate relationship" we mean the degree to which the Dr. maintains a professional attitude in the presence of his patient. Ideally, the Dr. mediates a traditionally formal relationship by conveying warmth, concern and interest in the patient's well-being.

4. Created atmosphere of personalismo: This category is very to similar to VII-A.3. above. "Personalismo" is an Hispanic term, referring to a special type of relationship that can exist between a professional, e.g. a doctor, and a layman, e.g. the patient. In Hispanic cultures a desireable relationship between Dr. and patient is one where the Dr. retains a professional attitude, yet also strives for an air of familiarity. In addition to conducting his duties as a practitioner, the Dr. inquires into matters not directly related to his patient's health, e.g. the family, business and social activities. In this way, the Dr. conveys "dignidad", i.e. respect for the patient as a whole person.

14. Balanced participation by Dr. and patient: The degree to which communication is shared equally between Dr. and patient, as opposed to complete one-sidedness.

15. Reciprocity: Amount of "give and take" between the Dr. and patient, i.e. how much the Dr. shares his thoughts with the patient and asks for feedback, and vice versa for the patient.

The remaining behaviors in VII-B. and VII-C. are self-explanatory.

CODING SHEET * PHYSICIAN RATINGS IN DOCTOR-PATIENT INTERACTIONS

I. Establishing rapport

A. Introduces self.....Yes/No/Not Recorded

B. Appropriate use of patient name.....Yes/No

C. Initial demeanor	Cold, businesslike	1	2	3	4	5	Warm, caring	
D. Use of psychosocial questions	Non-existent	1	2	3	4	5	Extensive	

II. Etiology of health condition

A. Assessment of pt. health belief system	Non-existent	1	2	3	4	5	Extensive	
B. Physician evaluation of pt. health beliefs	Negative	1	2	3	4	5	Positive	N/A
C. Expressed knowledge of culture-specific pt. health beliefs	Non-existent	1	2	3	4	5	Extensive	N/A

III. Treatment prior to visit

A. Assessment of prior pt. health behavior	Non-existent	1	2	3	4	5	Extensive	
B. References to "home remedies"	Non-existent	1	2	3	4	5	Extensive	
C. Knowledge of alter culture-specific treatments	Non-existent	1	2	3	4	5	Extensive	
D. Evaluation of prior treatment	Negative	1	2	3	4	5	Positive	N/A

IV. Physical examination							
A. Verbal sensitivity during examination	Poor	1	2	3	4	5	Excellent
B. Quality of explanation during examination	Incomplete, absent	1	2	3	4	5	Thorough
C. Eliciting feedback and/or questions	Non-existent	1	2	3	4	5	Extensive
D. Sensitivity to issues of modesty, sexual concerns	Poor	1	2	3	4	5	Excellent
V. Diagnosis							
A. Quality of explanation	Incomplete, absent	1	2	3	4	5	Thorough
B. Eliciting feedback and/or questions	Non-existent	1	2	3	4	5	Extensive
C. Use of appropriate language	Poor	1	2	3	4	5	Excellent
D. Integration of pt. language and/or ideas about treatment into explanation	Non-existent	1	2	3	4	5	Extensive
VI. Therapeutic Regimen							
A. Quality of explanation	Incomplete, absent	1	2	3	4	5	Thorough
B. Assessment of pt. understanding	Poor	1	2	3	4	5	Excellent
C. Attempt to incorporate medical regimen with home treatment	Non-existent	1	2	3	4	5	Extensive
D. Exploration of impact of regimen on family	Non-existent	1	2	3	4	5	Extensive
E. Sensitivity to pt. need for tangible treatment	Poor	1	2	3	4	5	Excellent

VII. Overall rating of interview	NOT AT ALL				A GREAT DEAL
A. Physician					
1. Appeared in a hurry	1	2	3	4	5
2. Treated patient with respect	1	2	3	4	5
3. Maintained appropriate relationship	1	2	3	4	5
4. Created atmosphere of personalismo	1	2	3	4	5
5. Appeared to be interested in patient	1	2	3	4	5
6. Time focused on socioemotional concerns	1	2	3	4	5
7. Time focused on medical concerns	1	2	3	4	5
8. Listened to patient's concerns	1	2	3	4	5
9. Asked questions about family/significant others	1	2	3	4	5
10. Used humor with patient	1	2	3	4	5
11. Joked inappropriately with patient	1	2	3	4	5
12. Was supportive and reinforcing toward patient	1	2	3	4	5
13. Was punishing toward patient	1	2	3	4	5
14. Balanced participation by Dr. and pt.	1	2	3	4	5
15. Encouraged reciprocity	1	2	3	4	5
16. Explained procedures	1	2	3	4	5

VII - continued

	NOT AT ALL				A GREAT DEAL
B. General use of language					
1. Appropriate for pt.'s level of understanding	1	2	**3**	4	5
2. Avoided medical jargon	1	2	3	4	5
C. Feedback techniques					
1. Gave pt. opportunity to ask questions	1	2	3	4	5
2. Asked pt. to repeat instructions	1	2	3	4	5
3. Encouraged pt. self-disclosure	1	2	3	4	5
4. Asked about pt. expectations for treatment	1	2	3	4	5

VIII. Rate the extent to which the physician exhibits the following attitudes or behaviors during the doctor/patient interview. Note that this is a 6 point scale -- you must state whether the attitude/behavior is more positive than negative, or vice versa.

1. DIFFERENCES in attitudes, beliefs, and values emphasized.	1	2	3	4	5	6	SIMILARITIES in attitudes, beliefs and values emphasized.
2. DISAPPROVAL of behavior in relation to medical condition or treatment.	1	2	3	4	5	6	CONTINGENT PRAISE of behavior in relation to medical condition or treatment.
3. HARSH ATTITUDE, unconcerned with patient's welfare.	1	2	3	4	5	6	BENEVOLENT ATTITUDE, concern with patient's welfare.
4. LOW REGARD for patient as a person. Patient is not accepted as a worthwhile person.	1	2	3	4	5	6	HIGH REGARD for patient as a person. Patient is accepted as worthwhile.

LENGTH OF TAPED INTERVIEW:_____MINUTES

SUBJECTIVE IMPRESSIONS: (use back if necessary)

DOCTOR QUESTIONNAIRE

(please respond to all of the following)

1) This patient definitely understood all my instructions:

_____ 1) strongly disagree
_____ 2) moderately disagree
_____ 3) slightly disagree
_____ 4) slightly agree
_____ 5) moderately agree
_____ 6) strongly agree

2) This patient will definitely follow all my instructions:

_____ 1) strongly disagree
_____ 2) moderately disagree
_____ 3) slightly disagree
_____ 4) slightly agree
_____ 5) moderately agree
_____ 6) strongly agree

3) This patient will definitely keep his/her follow-up clinic appointment:

_____ 1) strongly disagree
_____ 2) moderately disagree
_____ 3) slightly disagree
_____ 4) slightly agree
_____ 5) moderately agree
_____ 6) strongly agree
_____ 7) not applicable

4) This patient's needs and questions were satisfied by this interview:

_____ 1) strongly disagree
_____ 2) moderately disagree
_____ 3) slightly disagree
_____ 4) slightly agree
_____ 5) moderately agree
_____ 6) strongly agree

5) Think of your best initial patient interviews and examinations. How did this interview compare with your ideal?

_____ 1) terrible
_____ 2) did not go well, most of the time.
_____ 3) not so hot (more bad than good
_____ 4) Fair (more good than bad)
_____ 5) pretty good, most of the time
_____ 6) excellent

PATIENT QUESTIONNAIRE

1) Name: _____ 2) Sex: M _____ F _____

3) What was the reason for your visiting the doctor?

4) Is this the first time you've been seen for this condition? _____

5) What do you believe is the cause of your illness?

6) What did the doctor tell you about your health (conditions)?

What instructions did the doctor give you about the following:

7) Medication: _____

8) Diet, alcohol, smoking: _____

_____

9) Rest habits: _____

10) Physical Activity: _____

11) Follow up clinic appointments: _____

12) Other: _____

13) Age: _____ 14) Marital Status: _____ 15) Children? yes _____ no _____

Number of children between the ages of:

16) _____ 0-4 17) _____ 5-9 18) _____ 10-14 19) _____ 15-19

20) Your occupation: _____ 21) Spouses occupation: _____

22) Religous affiliation: _____ 23) Number of years of school attended? _____

24) Place of birth: _____

25) If not born in the U.S.A, number of years in U.S. _____

Generation in U.S.? 26) 1st _____ 27) 2nd _____ 28) 3rd _____

29) Do you need further explanations about any of the doctors instructions? _____

(Nurse, please answer any further questions asked by the patient).

Thank you for your cooperation!!!

30) Please circle one: CCOC/Bldg 9