Video Elicitation and the Study of Doctor-Patient Interactions:
Poor Acting and Mixed Reviews

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DPI= doctor-patient interaction
SDM= shared decision making
VE= video-elicitation

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1. Introduction

Improving patient satisfaction and health outcomes is understandably a priority for health care organisations. As medical consultations constitute a large proportion of patient contact with health care providers, improving the effectiveness of doctor-patient interactions (DPI) can make a valuable contribution to achieving this aim (Ogden et al., 2004). However, the DPI is the result of complex interpersonal processes, which can be understood on multiple levels (Saba et al., 2006). As such, a special Issue of Patient and Education Counselling (Volume 83, Issue 3, 2011) discusses the need to apply integrative approaches to enable a deeper understanding of interaction in health care settings. In keeping, the current paper explores the use of video elicitation (VE) also termed video-stimulated-recall) as a method to collect behavioural data (i.e. a video of the DPI) to be analysed by an observer, as well as subjective reports from participants in the DPI (Henry & Fetters, 2012). Moreover, although data is collected in a qualitative format it may be analysed by quantitative methods. These possibilities mean that VE has face validity as a useful approach for investigating what makes an effective DPI. Nevertheless, caveats to the application of VE to study DPI are also noted.

2. Doctor Patient Interactions

2.1. The Nature of DPI

For the purposes of this paper DPI will be regarded as face-to-face interactions between a patient and a single health care provider, be this their local GP, a specialist doctor (e.g. oncologist), or surgeon etc. In these circumstances there is a mutual influence between individuals (Melbourne et al., 2011). This may be shown between speech turns, for example, question-and-answer sequences. Although, cross-contingency may also be shown over the whole consultation, for example, how the patient’s presentation of their symptoms influences the questions that the doctor asks to try and determine the diagnosis (Connor, Fletcher, & Salmon, 2009). Interpersonal processes within DPI are clear from anecdotal experience (Rao et al., 2010). But stronger evidence from statistical sequence analysis and micro- analysis of doctor-patient verbal communication confirms the reciprocal nature of DPI (Bensing, Verheul, Jansen, & Langewitz, 2010; Eide, Quera, Graugaard, & Finset, 2004; Heritage & Maynard, 2006).
However, the medical consultation involves more than verbal communication. Whilst important functions of the DPI can be achieved by verbal means, such as information exchange and medical decision making, these processes also involve non-verbal cues and subjective experiences (Pawlikowska, Zhang, Griffiths, van Dalen, & van der Vleuten, 2012; Zimmerman, Del Piccolo, & Finset, 2007). This can be seen in research which shows that patients can experience task-focused behaviour, such as bio-medical information provision by doctors, as caring and relationship building (Young, Ward, Forsey, Gravenhorst, & Salmon, 2011). This highlights the inter-subjective nature of DPI and development of the therapeutic interpersonal relationship between doctors and patient (Radley, 1994).

Moreover, it also demonstrates that behaviour can be multidimensional, with the doctor’s information giving utterance in the example above serving both instrumental and socio-emotional functions. The complex nature of DPI, therefore, has implications for how DPI should be studied.

2.2. Why Study DPI?

It is important to investigate DPI because how these individuals interact can impact upon the course and outcomes of the medical consultation in a positive or negative manner (Ong, de Haes, Hoos & Lammes, 1995). For example, unvoiced patient concerns can give rise to misunderstandings, incorrect diagnoses and poor patient satisfaction (Bensing et al., 2010). As a result researchers are interested in what constitutes an effective DPI and how this can be promoted in medical practice. In contrast to the ‘authoritarian doctor’ perspective prominent before the 1990’s (Marks, Murray, Evans, & Estacio, 2011), which assumed that the doctor held power over the consultation, many researchers and policy makers now emphasise the importance of ‘patient-centred’ care and ‘shared decision making’ (SDM; Hall, 2003; Kaba & Sooriakumaran, 2007). This means that doctors should aim to create a therapeutic relationship with the patient based on mutual trust and patient involvement in treatment decision making (Mead & Bowers, 2000). However, training programmes to improve doctor communication and shared decision making have produced observable improvements in patient-centred behaviours that have not been mirrored in the views of patients towards the interaction (Davis et al., 2003; Rogers, Kenny, Nelson & Robinson, 2005). Together with evidence that doctors and patients often have different
views of the same interactions (Kenny et al., 2010; Young et al., 2011), this suggests that further research is necessary to uncover what makes a successful DPI.

2.3. Approaches to the Study of DPI

Research surrounding DPI has differed in its epistemological underpinning (Salmon, Mendick & Young, 2011). Two distinctions have been made, based on the source of knowledge and the format of data collected (see Table 1). Firstly, researchers often choose between self-reports from those involved in the interaction (emic) or an observer’s (etic) classification of the event (Saba et al., 2006). For example, a post-consultation questionnaire completed by a patient, versus, analysis of a video-recorded DPI by a researcher. Secondly, data has been collected in a quantitative (i.e. number-based) or qualitative (i.e. language-based) format (Neumann, Kreps & Visser, 2011). For example, analysis of a video-recorded interaction by counting the number of utterances in a coding category, versus, identification of the main themes within the DPI reported as a written description.

Historically these approaches have been applied independently (Bryman, 2006; Zoppi & Epstein, 2002). However, this limits the conclusions that can be drawn from the study. It has already been shown (in sections 2.1. and 2.2.) that self-reports of the DPI from the doctor and patient do not always agree with each other or with etic classifications (e.g. Kenny et al., 2010; Saba et al., 2006; Young et al., 2011). Researchers approaching the study of DPI from only one perspective would, therefore, fail to collect important data, which may have important theoretical and practical implications. This suggests that multiple data sources and formats should be used within the same study to generate comprehensive data.

Table 1. Approaches to the study of doctor patient interactions, varying in terms of the data source and format of data collection.

<table>
<thead>
<tr>
<th>Source</th>
<th>Self-report</th>
<th>Observer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative</td>
<td>E.g. questionnaire, with likert-type scale (i.e. not written answers)</td>
<td>E.g. coding utterances from a video of a DPI and counting the number in each category</td>
</tr>
<tr>
<td>Qualitative</td>
<td>E.g. interview with open questions to allow participants to talk about DPI</td>
<td>E.g. analysis of the main themes within a video of a DPI, reported as a written description</td>
</tr>
</tbody>
</table>
3. VIDEO ELICITATION

3.1. History

VE entails the use of a video-recording to stimulate recall, reliving, and reflection on the recorded interaction by those involved (Henry & Fetters, 2012). The use of VE in research studies was inspired by the work of Norman Kagan and colleagues on a skill development programme for therapists, known as the Interpersonal Process Recall Method (Kagan & Kagan, 1990; Kagan, Schauble, Resnikof, Danish, & Krathwohl, 1969). This programme makes use of a video-recording of a recent therapy session to aid recall and stimulate discussion. The therapist, with the help of a supervisor, views the recording and tries to recall covert thoughts experienced at the time of the interaction. In addition, cues expressed by the client that indicate they may have unvoiced thoughts are also identified from the video. This is intended to aid communication and the development of better therapeutic relationships (Larsen, Flesaker, & Stege, 2008). However, VE procedures have been adapted by researchers to enable the exploration of participants’ views on the interaction and other data that is not explicitly captured within the video-recording.

3.2. Principles

Henry and Fetters (2012) highlight that VE studies have traditionally taken a qualitative approach and adhered to five basic principles (Green and Britten, 1998). Firstly, data is collected from naturalistic settings (i.e. everyday contexts, such as a doctor’s surgery) rather than experimental, laboratory based contexts. Secondly, data should be interpreted with reference to the meaning that participants bring to and take away from the interaction. Thirdly, studies should focus on the social processes within communication, for example, how the meaning of symptoms is created by the doctor and patients (Puustinen, 1999). Fourthly, there is acknowledgement of the reciprocal influence between participants, which is fundamental in face-to-face interactions. Lastly, researchers take a relativist stance, which respects the perspectives of all participants involved. Within the context of medical communication this means that the view of the doctor is not regarded as superior to that of that patient. The philosophy underlying VE is, therefore, beneficial for the study of DPI as it is congruent with current formulations of the nature of DPI (see section 2.1).
3.3. Methodology and Recommendations for Those Conducting VE Studies

Although aspects of VE methodology are flexible, it necessarily involves video-recording of participants involved in an interaction, followed by VE-interviews with one or all of the participants. These interviews are then analysed based on qualitative principles (explained in section 3.2.). Allowing participants to view the video-recorded interaction throughout the interview is believed to facilitate recall, producing a more detailed report than using a standard/non-stimulated interview (Larsen et al., 2008). However, further extensions to the basic methodology, including etic analysis of video-recordings, mean that VE is an appropriate method to explore what makes an effective DPI. These adaptations will be discussed within the four step VE-methodology-framework proposed by Henry & Fetters (2012), an adapted version of which is shown in Table 2.

Table 2. Methodology for video elicitation studies. Adapted from Henry & Fetters (2012)

<table>
<thead>
<tr>
<th>Step</th>
<th>Key concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Conceptualising a video elicitation study</strong></td>
</tr>
<tr>
<td></td>
<td>Choose a research question</td>
</tr>
<tr>
<td></td>
<td>Decide on the scope of data collection</td>
</tr>
<tr>
<td>2</td>
<td><strong>Participants and sampling</strong></td>
</tr>
<tr>
<td></td>
<td>Determine the unit of analysis and sampling frame</td>
</tr>
<tr>
<td>3</td>
<td><strong>Data collection and management</strong></td>
</tr>
<tr>
<td></td>
<td>Protocol for recording</td>
</tr>
<tr>
<td></td>
<td>Elicitation interview structure</td>
</tr>
<tr>
<td></td>
<td>Protocol for data storage</td>
</tr>
<tr>
<td>4</td>
<td><strong>Data analysis</strong></td>
</tr>
<tr>
<td></td>
<td>Integrate data from video-records and interview data</td>
</tr>
<tr>
<td></td>
<td>Method for analysing data</td>
</tr>
</tbody>
</table>

At step one, the researcher should chose a research question and decide on the scope of data collection. As VE interviewing and subsequent data analysis is a lengthy process, Henry and Fetters (2012) stress that researchers should only use this method when suitable data cannot be collected by a different method. It has already been identified that VE would be appropriate to answer questions regarding what makes an effective DPI, such as “how the communication behaviour of SDM is related to patients’ and physicians’ subjective experience of partnership” (Saba et al., 2006, p. 55). Although not demanded by VE methodology, researchers should seek to interview both the doctor and patient to
enable subsequent data triangulation. This may be important to highlight instances in which the doctors’ and patients’ views on the effectiveness of the DPI are discordant.

Step two requires researchers to consider the participants and sampling frame. A representative sample of participants is desirable to increase external validity (i.e. the extent to which the results are generalisable beyond the participants in the study). However, this would require a large sample size, which is often unachievable due to the cost and time involved in VE studies (Henry & Fetters, 2012). Therefore, selective sampling of participants based on characteristics of interest (e.g. women in the early stages of breast cancer [O’Brien et al., 2008]), may be more appropriate. In addition, researchers are required to specify the unit of analysis in step two. It has already been recommended above that VE interviews with the doctor and patient should form two units of analysis. A further unit is the video-recording itself. Etic classification of the video-recording is beneficial as it enables the comparison of the objective behaviour and subjective feelings of participants regarding the effectiveness of the interaction (Kasper, Heesen, Köpke, Fulcher & Geiger, 2011; Melbourne et al., 2011). Moreover, since it has been identified that within DPI individuals show multidimensional behaviour (see section 2.1), the capture of participants’ verbal and non-verbal behaviour within the interaction, as well as their impressions of these behaviours is particularly important.

The third step involves data collection. This begins with the recording of the DPI in video format. In order to stimulate recall and discussion within the VE interview the recording should be of a good quality and capture the behaviour of both the doctor and patient. As a result researchers should give consideration to the video-recording equipment used and how this is positioned within the room (Haw & Hadfield, 2011). How the videos will be used within the VE interview is also worthy of consideration because interview structure, interviewer skills, and question formats have the ability to shape the resulting data (Larsen et al., 2008). For example, interviews may be conducted on the whole video-recording or on pre-selected segments of interest. These interviews may also take a range of formats. The most popular is semi-structured, in which the researcher is free to select questions to elicit information on the unexpressed thoughts and beliefs of the participant (see Figure 1 for example questions). Usually the interviewer and participant can choose to
Can you tell me more about how you felt at this point?
Were there any other thoughts going through your mind?
What were your impressions of the physician’s/patient’s actions at this point?
What do you notice about your actions at this point?
How much pressure did you feel under making this decision?

**Figure 1.** Questions that could be used in a video elicitation-interview. Adapted from Henry & Fetters 2012

stop the video and comment on important elements (Larsen et al., 2008). However, in some cases researchers may feel it is necessary to conduct multiple interviews with the same participant to allow for spontaneous comments and more narrow and focused questioning (Arborelius & Timpka, 1990; Cromarty, 1996). It is recommended that variation in VE interview procedure should be tailored to the research question and expertise of the researchers (Marks et al., 2011). Consequently, the current paper has highlighted multiple strategies for data collection, but does not make a judgement about their objective value.

The final step is data analysis. If researchers have followed the recommendations within this paper they will be required to analyse and integrate three sources of data; video-recordings, doctor-interviews and patient-interviews. Nowak (2011) recognised that there is no ‘gold-standard’, or even standardised procedure for the integration of data from multiple sources. This means that researchers will need to consider a range of strategies. Within the research literature there are three main approaches to integration of video and interview data. Approach one involves editing the interview over the video-recording prior to analysis (e.g. Frankel & Beckman, 1982), which may be beneficial when timing of comments is regarded as important. However, generation of a single data source in this way would not be possible when both the doctor and patient have been interviewed. In this case researchers may choose from the remaining approaches. A second approach uses a single group of researchers working concurrently with all sources to build a comprehensive picture of the interaction (e.g. Young et al., 2011). This is an iterative process, which involves repeated viewing and switching of sources. A caveat of this approach, however, is the tendency to prioritise data from a single source, which may bias the results. The final approach is analysis of individual data sources by different sub-groups of researchers followed by integration of the findings (e.g. Saba et al., 2006). In practice, researchers may
adapt these approaches or generate a novel integration strategy (Neumann et al., 2011). Therefore, comprehensive reporting of methodology is of vital importance.

3.4. Further Considerations for Those Using VE to Study DPI

Two further questions are raised as a result of the extensions to VE studies proposed in section 3.3 and the application of VE to investigate what makes DPI effective. How should the DPI video-recording be analysed? And is it necessary to measure clinical outcomes?

The analysis of video-recordings has been approached from both a qualitative and quantitative perspective. Although VE studies have traditionally taken a qualitative approach to the analysis of interviews there is no reason that this should restrict the methods used to analyse the video-recording of the DPI. Qualitative approaches, such as conversation analysis or thematic analysis (see Howitt & Cramer, 2008) provide a detailed account of the nature of the DPI, including micro-analytic structure and social construction of meaning (Peräkylä, 2004). In contrast, quantitative approaches commonly use a coding scheme to classify units of behaviour into pre-selected categories (e.g. Bales, 1950; Ford, Hall, Ratcliffe & Fallowfield, 2000; Roter & Larson, 2002). The frequency of each code may then be extracted. Behaviours of interest can be investigated by combining codes that measure the construct. For example patient-centeredness has been indexed by features such as discussion of family medical history, patient question asking and physician enquiry about the results of ongoing treatment (Bertakis & Azari, 2011). This approach assumes that meaning is inherent to actions. The relative advantages of these systems and the philosophy on which they are based have been widely debated, with no method the outright winner (e.g. Heritage & Maynard, 2006; Peräkylä, 2004; Sandvik et al., 2002). Therefore, researchers are free to make an informed decision as to which method of video-analysis to use.

It is also important to consider the inclusion of clinical outcome measures in VE studies, for example, treatment adherence, improvement in symptoms or quality of life. This will allow researchers to assess the effectiveness of DPI on improving patients’ health, which is arguably one of the main objectives of the medical consultation (Hugman, 2009). For example, Saba et al. (2006) used VE to explore SDM. In keeping with the recommendations above, the researchers developed a quantitative coding scheme to
identify SDM within the video-recorded DPI interaction and analysed doctor and patient VE-interviews for main themes and experiences of partnership. The data from etic and emic perspectives was integrated in a 2x2 matrix (see Table 3). This revealed that in 59% of cases there was incongruence between the observer perspective and at least one participants’ perspective i.e. it looked good when it did not feel good (simulated engagement), or vice versa (assumed engagement). However, Saba et al. did not examine clinical outcomes, which meant that no conclusions could be drawn as to whether SDM behaviour or the feeling of SDM was differentially linked to health outcomes. Such a conclusion would be desirable if research findings are to inform health care policies and medical training programmes (Neumann et al., 2011).

Table 3. Engagement in shared decision making. Adapted from Saba et al. (2006)

<table>
<thead>
<tr>
<th>SDM as measured by video coding</th>
<th>Present</th>
<th>Negative/non-collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDM as measured by video coding</td>
<td>Positive/collaborative</td>
<td>Negative/non-collaborative</td>
</tr>
<tr>
<td>SDM as present</td>
<td>Full engagement</td>
<td>Simulated engagement</td>
</tr>
<tr>
<td></td>
<td>(22%)</td>
<td>(38%)</td>
</tr>
<tr>
<td>SDM as absent</td>
<td>Assumed engagement</td>
<td>Nonengagement</td>
</tr>
<tr>
<td></td>
<td>(21%)</td>
<td>(19%)</td>
</tr>
</tbody>
</table>

3.4. Limitations of the Suggested Approach

3.4.1. context is disregarded.

VE studies do not take into account the wider context in which the video-recorded DPI interaction occurs. The use of videos enables the capture of the diachronic interaction processes in real time (Haw & Hadfield, 2011). However, the bounds of the video are narrow then compared to the ongoing process in which the DPI is situated. As such, the DPI is influenced by individual, societal and organisational factors, which are not explicitly captured in the video (Kreps, 2011). Researchers are likely to explore individual factors during VE interviews, for example what the illness means to the patient and how it influences their life (Adams, Pill & Jones, 1997). However, wider contextual issues are less likely to be presented or investigated in a systematic manner. For example, the impact of
limited consultation length on patient-centred care (Mead & Bowers, 2000; Ogden et al., 2004) or the influence of gender norms on patients’ presentation of concerns (Kaba & Sooriakumaran, 2007). Puustein (1999) argues that the variability between DPI cannot be explained without reference to the context in which it occurs. Therefore, despite the use of multiple data sources and formats of data analysis, VE studies may still not fully capture the nature of DPI.

3.4.2. data quality.

The use of a video-recording to stimulate recall of a recent DPI may lead to a more detailed and accurate description than achieved by a standard interview because cues displayed in the video can help to trigger memories (Elliot, 1986; Henry & Fetters, 2012). This is particularly important as individuals may have poor memory and meta-cognitive skills, meaning they are likely to forget or misremember events under free recall conditions (Nisbett & Wilson, 1977). However, despite this advantage of VE, researchers should be cautious that interview reports consist of reconstructed memories and may contain inaccuracies and deliberate or unconscious biases (Hertwig, Fanselow & Hoffrage, 2003). For example, patients may not be comfortable expressing negative views about their doctor in VE interviews (i.e. social desirability bias; Kazdin, 2003) or hindsight bias (Fischhoff, 2007) may mean that the patients’ knowledge of the results of their decision may influence how they recall their involvement in decision making.

Also worthy of consideration is Henry and Fetters’ (2012) warning that the self-selected sample of participants may introduce a systematic bias into the results. It has been suggested that doctors and patients who volunteer to let researchers record their medical consultation may differ from those who do not. For example, patients with mental health problems or ‘embarrassing’ conditions may be less likely to consent to video-recording (Coleman & Manku-Scott, 1998). As informed consent is necessary before video-recording DPI (see section 3.4.4.) researchers cannot avoid this potential bias. However, they should acknowledge this and interpret their results accordingly.

In addition, questions have been raised as to whether knowledge that the interaction is being recorded influences the behaviour of the participants. This is a problem because it would reduce the internal validity of the data collected (Coleman, 2000). Through
analysis of video-taped consultations between 14 oncologists and 45 patients, Penner et al. (2007) discovered few camera-related behaviours (e.g. looking at the camera or speaking about the camera). Consistent with previous research (Hargreaves & Peppiatt, 2001; Martin & Martin, 1984), participants in Penner et al.’s study reported that they forgot they were being recorded. In further support, evidence shows that the clinical routine of doctors are not significantly different when the participants are aware that they are being filmed and when they were unaware; participants spent the same amount of time on 26/27 tasks (Pringle and Stewart-Evans, 1990). This can be taken as evidence that doctor and patient behaviour is not greatly affected by video-recording of the medical interaction. Nevertheless, these studies only measured camera related behaviour and time on task, thus limiting the conclusions that can be drawn about the influence of video-recording on the content and social processes within DPI overall.

3.4.3. practical issues.

Despite the rich data generated from VE studies, practical issues relating to time, data handling, equipment, and cost may prevent such research from being conducted. VE interviews should be carried out as soon as possible after the DPI has taken place (Lyle, 2003). However, doctors’ busy schedules often prevent this. Moreover, VE interviews are time consuming to conduct. For example, Larsen et al. (2008) report that it is common for a 50 minute long interaction to result in VE-interviews lasting for two-to-three hours. Analysis of videos and interview is likely to take at least twice as long. With three data sources to analyse, the study will require a substantial time commitment from researchers and participants. Moreover, a single case generates huge amounts of data, which must be systematically stored and analysed. This problem is exacerbated as there is no standardised procedure.

Equipment is also important in VE studies. As has been noted in section 3. 3, the video-recording should be high-quality and capture the behaviour of both participants to provide participants with many cues to stimulate recall. But this is not always achieved in practice (Haw & Hadfield, 2011). Researchers should also make provisions for the possibility of equipment failure, such as noise within the video-recording or digital analysis software crashing. Overall, these practical issues mean that the VE studies would be financially
costly. Nevertheless, the potential of such studies to gain an insight into the nature of an effective DPI is a good incentive for researchers to overcome these practical limitations.

3.4.4. ethical issues.

Any research study will need to gain ethical approval before it commences. However, those conducting VE studies may need to pay special attention to three issues highlighted within the British Psychological Society, *Code of Ethics and Conduct* (Ethics Committee of the British Psychological Society, 2009). Firstly, informed consent. This means that researchers should ensure that individuals understand the purpose and possible consequences of their participation. All participants must then agree to take part in the research. It is also desirable for researchers to request permission to use DPI-videos and VE interviews in secondary analyses, medical training, and conferences (Roberts, 2010). This will extend the utility of the data and can enable researchers to answer new questions using existing data sources. Secondly, video-recordings are hard to de-identify, causing the potential for issues regarding privacy. This may be addressed to some extent by storing videos in a secure location, separate from the participant’s details (Henry & Fetters, 2012). Lastly, the content of medical consultations may be upsetting or embarrassing for participants to discuss in VE interviews, for example, those involving treatment for a terminal illness. Thus, interviewers should approach these topics sensitively and honour their responsibility not to cause participants distress.

4. Conclusion

VE studies offer the opportunity to study multiple perspectives on the DPI, which may be integrated to form a rich data source. Given the complex nature of dyadic, face-to-face interactions in medical settings, integrative research is often required (Neumann et al., 2011). Nevertheless, the benefits of VE must be weighed against the practical issues surrounding such research, resulting from the wealth of data to be collected and analysed. When interpreting the data researchers should also consider the impact of contextual factors and the quality of the information obtained from VE interviews.

Furthermore, the ideas presented in this paper raise the question of what is an effective DPI? It has been explored that this question may be answered from the
perspective of an observer, the doctor, the patient, or based on clinical outcomes. In addition, this paper has proposed a research methodology to be conducted in pursuit of discovering the ‘perfect’ DPI, which satisfies on all accounts. However, research using VE methodology suggests that disparity is more common than convergence of these perspectives (Saba et al., 2006). Moreover, there does not appear to be a systematic link from objective or subjective features of the DPI to consequences of the interaction (Silverman, 1987; Young et al., 2011). This may be because contextual factors not identified through application of the VE methodology can influence how participants approach the DPI and respond to their partner, and thus the outcomes. As a result, it would be a philosophical question as to which perspective should be regarded as the most important. However, adoption of this idea would negate the need for multiple approaches since only one would be of value.

Irrespective of the difficulties in exploring the nature of DPI, VE can make a valuable contribution to research, psychological theory and medical practice. VE provides an opportunity for the development of integrative approaches in research, which has been recognised as important for the progression of science (Neumann et al., 2011). The findings of research may also be used to inform existing theoretical approaches to the study of health care communication and DPI (e.g. Rao et al., 2010). Importantly, it can be used to support the move from the uni-dimensional, ‘authoritarian doctor’ perspective to one in which the behaviour of both the patient and doctor are seen as integral to the medical consultation and its outcomes (Marks et al., 2011). Research findings may also be translated into recommendations for medical training and policies.

It is doubtful that application of VE methodology will reveal the screenplay for the ‘perfect’ DPI. However, VE studies have highlighted the complex, multi-dimensional and inter-subjective nature of DPI interactions. This finding is important in itself, but has also influenced health care research and practice, with changes implemented to increase the effectiveness of DPI.
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