Doctor-parent-child communication
A multi-perspective analysis

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Doctor-parent-child communication
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(met een samenvatting in het Nederlands)

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door

Henderike Tates

geboren op 3 september 1955, te Capelle aan den IJssel

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We become and are ourselves only in relation to others.
J. Shotter

To Sanne, Floris en Femme

Acknowledgements

My interest in medical interaction began over twenty years ago when I was working as a physiotherapist with physically retarded children and their parents. In my years with the Discourse Studies Group at Tilburg University, I became acculturated into the challenging world of scientific research. In 1996 I was given the opportunity to combine these interests in a research project on doctor-parent-child communication, which resulted in this thesis.

In retrospect, this may sound as if it was a smooth development, but I am fully aware that the realization of this thesis has only been possible thanks to the support and encouragement of many people. Although I do hope that I did not fail to express my appreciation over the years, it is appropriate here to acknowledge these people explicitly.

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and they made writing this book less of the overwhelming task it otherwise would have been. Therefore, this book is dedicated to my own favourite triad, our children Sanne, Floris and Femme. I am extremely proud that Sanne, as their representative, will also be assisting me in presenting this thesis.

Kiek Tates
Boxtel, July 2001

Contents

Chapter 1
Introduction

Introduction

This thesis focusses on doctor-parent-child communication at the general practitioner's surgery in the Netherlands. The origin of the study was the observation that although the first studies on doctor-patient communication took place in a pediatric setting (Korsch et al., 1968; Freemon et al., 1971; Korch & Negrete, 1972), little attention had been given to the specific role of the child in medical communication, or to the implications of a child's presence, as illustrated by Korsch et al. (1968, p.865):

> *In paediatrics patient refers to the patient's parent, mostly the mother. Hence the patient and parent will be referred to interchangeably*

Korsch probably set the tone for this by identifying the parent as the patient, implicitly conceptualizing children as passive participants in their own medical encounters. This view sharply contrasts with the tenor of an article three decades later, that advocates the child's right to share in health decisions:

> *Decisions affecting children and young people are much more complex, involving parents as a third party* (Rylance, 1996, p. 794)

The discrepancy between these quotations raises several questions: Are children credited a valuable position in medical encounters, and what is their specific role? How are children approached in medical encounters? What efforts do the physician and parent make to involve the child in the medical interview? Have any changes taken place in the communication between doctor, parent and child during the past decades?

Reasons for studying doctor-parent-child communication

There are theoretical as well as clinical indications that the implications of a child's presence in medical conversation deserves special attention. Over the past three decades a number of important changes have taken place in doctor-patient communication in general. The development of the patient-centred approach and demands regarding shared decision-making and informed consent have evoked a shift in the participant roles in medical consultation (Stewart et al., 1995; Blaauwbroek, 1997; Van den Borne, 1998; Verhaak et al., 1998). As a result, the doctor-patient relationship has developed from being very asymmetrical towards being a more egalitarian one, and patients have become more emancipated and autonomous over the years (DiMatteo & DiNicola, 1982; Ong et al., 1995; Roter, 2000). With the development of patient-centred medicine, research on medical communication has focussed particularly on the beneficial effects of active patient participation in processes of information- sharing and decision-making and on the changing participant roles in medical encounters (Stewart et al., 1995; Ong et al., 1995; Blaauwbroek, 1997; Van den Borne, 1998; Verhaak et al., 1998; Roter, 2000). In line with the changed position of the patient, it is increasingly being ac-

knowledged that children too should be involved in decisions about their own health care (Alderson & Montgomery, 1996; Rylance, 1996; Hart & Chesson, 1998). A strong argument for child participation in medical encounters is that more direct communication between doctor and child improves health care in terms of satisfaction, compliance, and a better understanding (Pantell et al., 1982; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998; De Winter et al., 1999). From the perspective of patient-centred care, with an emphasis on the child's own responsibility, one might hypothesize that these changes would also affect the interaction in the doctor-parent-child triad.
Changes in doctor-patient communication, and the specific role of the child in medical interaction can also been seen as an expression of major social changes that have taken place. Parenting has become less controlling and authoritarian, and adult-child interactions are increasingly characterized by a greater openness towards the child (De Swaan, 1988; DuBois- Reymond, 1993). This change has been confirmed in developmental cognitive studies which underline that children are able to take a far more active role in interaction with adults than has been assumed until now (Elbers et al., 1992; Hoogsteder, 1995).

Aim of the study

A first orientation showed that the existing literature on doctor-parent-child communication focussed on the doctor-parent dyad, rather than the communication between physician, parent and child. Most studies aim at describing one aspect of the interaction, viz. the structural or relational aspects of the communication or the content of the interaction. As a result, knowledge of these different aspects of communication seems to be highly fragmented and poorly integrated.
To narrow this gap in knowledge of the child's role in medical conversation, the present study explicitly takes the doctor-parent-child triad as the focus of analysis and aims to give a better insight into the characteristics and dynamics of the communication between doctor, parent and child communication at the general practitioner's surgery in the Netherlands. A number of basic assumptions have been formulated as a necessary condition for a better understanding of doctor-parent-child communication. First, the need to study various aspects of the interaction in relation with each other. Only by applying a multi-perspective focus can a comprehensive view of the communication within this triad be gained. Secondly, we claim that for a full account of the interaction a triadic analysis is a prerequisite i.e. an analysis of the interaction between all three participants. In addition, as children's perceptual, cognitive and social skills develop with age, we opt for a developmental perspective in our analyses of the communication between doctor, parent and child. Finally, in line with the changes in doctor-patient communication and adult-child interaction described above, we look for changes in doctor-parent-child communication over the years.

To summarize, the aim of this thesis is fourfold:

1. To evaluate the state of the art of research into doctor-parent-child communication, and to explore the specific role of the child in medical conversation;
2. To provide a detailed description of the interaction in the doctor-parent-child triad with reference to the structural, relational and content aspects of the communication;
3. To examine the influence of the child's age on the communication;
4. To look for changes in the communication over the years.

Sample

The four empirical studies presented in this thesis are based on 106 video recordings of medical interviews at the general practitioner's surgery. In the Dutch health care system, the general practitioner (GP), who is comparable to a family physician, has a gatekeeping role: patients may only consult a specialists after referral by a GP, and 90% of all complaints are treated by GPs (Van Suijlekom-Smit & Crone-Kraaijeveld, 1994; De Melker, 1997). Thus the GP is the first responsible health care provider, including primary care and preventive care. About one in six consultations involves a child under the age of 16. The videos were drawn from a large collection (n=2500) of medical interviews with patients of all ages, which have been collected since 1975, and held by the Netherlands Institute of Health Services Research (NIVEL). The validity of this data-set has been documented elsewhere (Bensing, 1985; Boink, 1996; Van der Pasch & Verhaak, 1998). A selection was made based on rigorous demands of technical quality. This was necessary since many of the earlier videos were of poor quality. The application of these and other relevant criteria (a triad doctor-parent-child, and the age of the child: 4-12 years), supplemented by matching for age, gender and type of complaint of the child patient, resulted in a data-set of 36 videos for the period 1975-1978, 36 videos for 1988-1989, and 34 videos for 1993. The unequal distribution of time between the three periods is a consequence of the availability of data at the start of the project. Data from these three periods allowed a comparison to be made cross-sectionally, but not longitudinally, while the participants differed over the three periods (Hertzog, 1995; Schaie & Baltes, 1996). In the majority of the consultations selected (n=88), the child was accompanied by its mother. All children had previously seen the GP and were visiting the GP for minor complaints, classified by the GP as either somatic (such as bronchitis, earache or stomach-ache) or psycho-social (such as headache, rash or bed watering). When a second child was present, verbalizations to this other child were not included as part of the data. Fifty-eight GPs participated in the study: 22 in period 1 (mean 1.6 consultation), 15 in period 2 (mean 2.4 consultation), and 21 in period 3 (mean 1.6 consultation). Because the majority was male (n=53), it was not possible to assess the effect of physician's gender on the communication patterns in the triad. The mean duration of the consultation was 6'54" and increased over the years (5'33" vs 7'22" vs 7'44"; F=5·69, p L.01). Table 1 presents an overview of the sample characteristics.

Table 1 **Sample profile (n=106)**

	Period 1 1975-1978 n=36 N %	Period 2 1988-1989 n=36 N %	Period 3 1993 n=34 N %	Total n=106 N %
Age:				
4-6	10 (28)	14 (39)	13 (38)	37 (35)
7-9	11 (30)	11 (30)	11 (32)	33 (31)
10-12	15 (42)	11 (31)	10 (30)	36 (34)
Sex:				
male	19 (53)	18 (50)	14 (41)	51 (48)
female	17 (47)	18 (50)	20 (59)	55 (52)
Complaint:				
somatic	25 (70)	22 (61)	17 (50)	64 (60)
psychosomatic	11 (30)	14 (39)	17 (50)	42 (40)

Structure of this thesis

This thesis consists of five studies: a review study and four empirical studies, each capturing a different aspect of doctor-parent-child communication. Chapter 2 presents a review of the literature, with the aim of evaluating the state of the art of research into doctor-parent-child communication. Chapter 3 focusses on the structural characteristics of the communication, by applying the Turn allocation System (based on Aronsson & Rundström, 1988). By analysing the interaction in terms of affective (socio-emotional) and instrumental (task-related) behaviour, the analysis presented in chapter 4 captures the relational aspects of the interaction, using an adjusted, triadic version of the Roter Interaction Analysis System (Roter, 1989). The finding that the extent to which both adult participants differed in their facilitation of child participation was the rationale for a sociolinguistic study on the participation framework in the triad, and focussed on the content of the communication. The results of this analysis are presented in chapter 5. The final study presented in chapter 6, builds on the study on participant roles and aims at further characterizing doctor-parent-child relationships, especially from a pedagogic perspective. This thesis concludes with chapter 7, which summarizes the research findings and presents a general discussion.

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Chapter 2

Doctor-parent-child communication: A (re)view of the literature

Tates, K. & Meeuwesen, L. (2001). Doctor-parent-child communication: A (re)view of the literature. Social Science and Medicine, 52, 839-851

Abstract

Studies on doctor-patient communication focus predominantly on dyadic interactions between adults; even when the patient is a child, the research focus is usually on doctor-parent interaction. The aim of this review study is to evaluate the state of the art of research into doctor-parent-child communication, and to explore the specific role of the child. Researchers have focussed on diverse aspects of the communication in this triad, and, as a result, knowledge gained from studies in this area is poorly integrated. Most of the studies have ignored the implications of a child's presence in medical encounters. Although all studies claim to examine the interaction in the doctor-parent-child triad, most research methodologies used are based on dyads. Our claim, however, is that because the interactional dynamics of a triad differ fundamentally from those of a dyad, triadic analyses are a prerequisite for a full account of the communication between doctor, parent and child. Suggestions are formulated for an adequate research frame regarding triads.

2.1 Introduction

Although the first studies on doctor-patient communication took place in a pediatric setting (Korsch et al., 1968; Freemon et al., 1971; Korsch & Negrete, 1972), it is surprising that the specific role of the child in medical conversation has not been considered a point of interest. Research focuses mainly on dyadic interactions between adults. Even in the case of a doctor- parent-child triad, the child's contribution is frequently ignored (Pantell et al., 1982; Tannen & Wallat, 1983; Aronsson & Rundström, 1988,1989), as is illustrated by Korsch et. al. (1968, p 865):

> *'In paediatrics patient refers to the patient's parent, most commonly the mother. Hence the patient and parent will be referred to interchangeably.'*

Korsch probably set the tone for this by identifying the parent as the patient, implicitly disregarding the child. Review studies hardly pay attention to doctor-child communication or to the influence of the presence of a third participant (Roter et al., 1988; Waitzkin, 1990; Charon et al., 1994; Ong et al., 1995; Boon & Stewart, 1998).
There are, however, theoretical as well as clinical indications that the child's role in medical conversation deserves special attention. Children appear to be able to understand more about concepts of health and illness than generally has been assumed (Lewis et al., 1984; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998). It has been demonstrated repeatedly that a more direct communication between physician and child contributes to an improved relationship in terms of satisfaction with care and adherence to treatment, and to better health outcomes (Pantell et al., 1982; Colland, 1990; Holtzheimer et al., 1998). Furthermore, the development of a patient-centred approach and increased demand for shared decision-making, disease prevention and health pro-

motion have led to a shift in the doctor- patient relationship from extremely asymmetrical towards more egalitarian (Davis & Fallowfield, 1991; Roter & Hall, 1992; Stewart et al., 1995; Van den Borne, 1998). In addition, parenting has become less controlling and authoritarian (De Swaan, 1988). Moreover, recent developmental cognitive studies have shown that children play a far more active role in the interaction with adults than has been assumed until now (Elbers et al., 1992; Hoogsteder, 1995). Consequently, the child's role in the medical consultation should be as important as the parent's, and it is increasingly acknowledged that children themselves should be involved in decisions about their own health care (Alderson & Montgomery, 1996; Rylance, 1996; Hart & Chesson, 1998).

The objective of or study is to evaluate the state of the art of research into doctor- parent-child communication, and to explore the role of the child. Before tuning to the specific research questions, we will define three aspects that we expect to play a key role in doctor- parent-child communication.

Relational aspects

With regard to the medical interview, two types of patient needs are generally distinguished; being the cognitive need to be informed (the need to know and understand), and the emo tional need to be taken seriously (the need to feel known and understood) (Engel, 1988). In response, the physician is assumed to possess two types of relational skills; instrumental, or task-related behaviour, and affective, or socio-emotional behaviour. Instrumental behaviour involves skills such as asking questions and providing information, while affective communication aims at reflecting feelings and showing empathy and concern (Roter, 1989; Bensing, 1991). Effective communication between doctor and patient is characterized by a balance between instrumental and affective behaviour, depending on the specific needs of the patient and the goal of the interview at the time.

Structural aspects

The issue of asymmetry is one of the key themes in studies on doctor-patient relations (Linell & Luckmann, 1991; Ong et al., 1995). In the case of a child patient, the issue of asymmetry is expected to play a crucial part, because of the child's position of double asymmetry, with the physician embodying both institutional and adult authority. The asymmetrical character is reflected in the way the communication is organized and structured in terms of sequences of initiatives and responses (Linell & Luckmann, 1991; Van Dijk, 1996; Drew & Sorjonen, 1997). Turn-taking in conversation is an important element in defining and establishing relationships, and presents the opportunity to explore the degree of asymmetry between participants (Linell & Luckmann, 1991).

Content of the interaction

Compared with the relational and structural aspects, little attention has been paid to the actual content of the participant's linguistic behaviour in medical encounters (Ong et al., 1995). During a consultation, the participants use medical and psychological

terms appropriate in that context, but it appears that doctor and patient may assign different meanings to the same term. Health terminology is moving towards everyday language use, and the meanings that become ascribed might lead to misunderstanding of which the parties involved are unaware (Ley, 1988; Hadlow & Pitts, 1991). We use the term 'interactive frame' to refer to the participant's sense of what activity is being engaged in (Tannen & Wallat, 1983, 1987; Tannen, 1993) Depending on the linguistic features of the speaker's contribution, the hearer can assign a particular interpretative frame to the speaker's contribution (e.g. an utterance is understood as a request or as a joke). Interactive frames are related to 'knowledge schemas'; structures of knowledge about situations, actions and actors, simply because such schemas provide expectations not only about what can happen, but about how to interpret what is said and done. In medical communication the participant's knowledge schemas may represent conflicting information about the ongoing activity. As a result of this mismatch of knowledge schemas, participants are oriented towards different frames of reference, which may result in mis-communication and conflicts (Tannen, 1993).

Our reasons for distinguishing the above mentioned three aspects of communication were purely analytical. In practice, these aspects may be intertwined, and not always discernable as such.

Finally, we are interested in *methodological issues* regarding the way the studies reviewed dealt with the consequences of a third participant's presence. A pivotal question is whether a choice was made for a dyadic analysis of the interaction between doctor-parent and doctor-child, or for a triadic analysis of the contribution of all three participants.

To summarize, this review seeks to address the following questions:

1. Which aspects of the interaction between doctor, parent and child play a prominent part in research on doctor-parent-child communication?
2. Has any attention been paid to the specific role of the child in medical encounters, and what are its characteristics?
3 To what extent are the methodologies used suitable for analysing triadic medical conversation?

2.2 Data collection and analysis

The procedures used for finding eligible studies included on-line database searches e.g. PsycLit, Sociofile and Medline, and searching for references in scientific papers and books on doctor-patient communication. The following terms were used: physician/doctor-parent-child communication, physician/doctor-patient communication, physician/doctor-child communication, adult-child communication, medical consultations, child discourse, medical discourse, medical interviews, language and medicine, pediatric encounters, triadic encounters. Publications were included if they met the following criteria:

1. The study was directed at the verbal and/or nonverbal communication between

doctor, parent and child in a medical setting, with the child being the patient.
2. The study involved research from the last thirty years, published in English.
3. The study involved audio or video recordings of consultations.

These search procedures produced twelve articles published between 1968 and 1998, which formed the basis of the current review study. A further eight more studies were restricted to the interaction between doctor and parent and were excluded from analysis, although selected results from these studies, if relevant, will be mentioned in the discussion section.

The sample characteristics, the design of the study, and the questions and findings of the twelve studies were evaluated in turn. The description of the *sample profile* provided an overview of the background variables and included information about the research setting, physician-parent-child familiarity (first or repeat visit), characteristics of the physicians (number, gender, specialization, and experience), characteristics of the parents (number, gender, education), characteristics of the children (number, age, gender, and diagnosis) and the sample size. To answer the methodological question, the *design* study included defining the nature of the study (in terms of quantitative versus qualitative research), comparing the observational strategy (coding from video, audio tape, direct observation or transcript), the communication channel (analysis of verbal or nonverbal communication), the observational instrument, and whether the communication was analysed as two dyads (analysing the interaction between doctor-parent and doctor-child) or as a triad (analysing the interaction between all three participants). The question of which aspects of communication had been analysed was answered in the review of the *questions and findings* of the studies.

2.3 Results

2.3.1 Sample characteristics

Table 1 presents a profile of the background variables of the studies reviewed, in terms of setting, familiarity, characteristics of the physician, parent and child, and the sample size.

Most studies on doctor-parent-child communication were carried out within the setting of a (children's) hospital, mostly within pediatrics. The extent of prior relationship was reported in nine studies. The studies were most frequently concerned with repeat visits or a mixture of first and repeat visits; three studies concerned only first visi t consultations (Korsch et al., 1968; Freemon et al., 1971; Korsch & Negrete, 1972). The physician's specialization was stated in every study; most studies concerned pediatricians, whereas three studies involved a family physician or a general practitioner (Pantell et al., 1982; Meeuwesen & Kaptein, 1996; Meeuwesen et al., 1998). The physician's gender was reported in seven studies, the majority being male. Experience and age of the physician were hardly ever mentioned. Nine studies reported the parent's gender (mainly mothers), whereas only four studies gave the parent's educational background (parents with secondary or higher education were over-represented). The sample size

(the unit of analysis being the medical interview) varied from n=1 (Tannen & Wallat, 1983,1987) to n=800 in the Korsch studies. The age of the child was reported in all studies; with most research involving children aged from 5 to 13 years. Three studies predominantly concerned infants and toddlers (Korsch studies: 75% under the age of 5). Half of the studies mentioned the gender of the child patient. All studies reported the primary diagnosis, which ranged from preventive health care through acute somatic symptoms, aller gies and lung diseases to severe developmental disabilities.

2.3.2 Design of the studies reviewed

Table 2 presents an overview of the design of the studies reviewed, in terms of qualitative versus quantitative research, observational strategy, communication channel, observational instrument, and whether the observation system was designed for analysing two dyads (doctor-parent and doctor-child) or a triad (interaction between all three participants).

Six studies were based on tapes and transcripts, the other half of the studies reviewed made use of video recordings (four video studies additionally made use of transcripts). Most research was restricted to the participants' verbal behaviour; only four studies also took nonverbal communication into account (Tannen & Wallat, 1983,1987; Worobey et al., 1987; Van Dulmen, 1998).

Regarding the observational instrument, seven quantitative studies applied category systems in order to code the verbal behaviour of the participants. The most commonly used methods were Bales' Interaction Process Analysis (IPA) (1950) (Korsch et al., 1968; Freemon et al., 1971; Korsch & Negrete, 1972; Pantell et al., 1982), and derived systems such as the Roter Interaction Analysis System (RIAS) (Roter, 1989) (Van Dulmen, 1998; Meeuwesen et al., 1998). The RIAS is a modification of the Bales system adapted for doctor-patient communication. This system distinguishes between instrumental and affective utterances by doctors and patients. Instrumental clusters refer to problem-solving (giving information, asking questions and counselling); affective clusters refer to aspects for establishing a good relationship (such as giving comfort, reassurance and showing empathy). A comparable classification method was used by Worobey et al. (1987), who focussed on form and content of the pediatrician's utterances, by analysing intonation, sentence type, and the person addressed.

In three quantitative studies, investigators employed a turn-taking system designed for triadic medical communication; Aronsson and Rundström (1988) made use of the Child Allocated Turns System (CAT), while Meeuwesen and Kaptein (1996) and Meeuwesen et al. (1998) applied a modified version of the CAT, the Turn Allocation System (TAS). The CAT focussed on the child allocated turns of the doctor, whereas the TAS explicitly aimed at describing the turn-taking patterns of all three participants, by analysing all turns in terms of initiative, allocation and response.

Two qualitative studies made use of conversation-analytical micro-analyses (Tannen & Wallat, 1983, 1987). Another qualitative study applied Brown and Levinson's Politeness

Table 1 **Sample characteristics: setting and characteristics of doctor, parent and child**

study	*setting and familiarity*	*characteristics doctor*	*characteristics parent*	*characteristics child*
Korsch et al. 1968	pediatric emergency clinic first visits	pediatrician n=64; 1-5 years' experience	n=800 interview n=293 mainly mothers different educational levels	n=800 0-10 years old 75% under 5 mainly acute somatic complaints
Freemon et al. 1971	see Korsch et al.	see Korsch et al.	n=285 from data Korsch et al.	n=285 from data Korsch et al.
Korsch & Negrete 1972	see Korsch et al.	see Korsch et al.	see Korsch et al.	see Korsch et al.
Pantell et al. 1982	family medical centre 72% repeat visits	family physician n=49; mean 2.3 consultation (range 1-9	n=115 educational level: 7% low; 50% medium; 43% high	n=115; 60 girls 55 boys age 4-14 mean age 8.5 health maintenance + acute illness
Tannen & Wallat 1983,1987	interdisciplinary clinic/ children's hospital	pediatrician n=1 female	n=1 mother	n=1 9 year-old girl physical and mental retardation
Worobey et al. 1987	pediatric consultation	pediatrician n=4	n=11	n=11 age 4-6 lung diseases
Aronsson & Rundström 1988,1989	allergic outpatient clinic 97% repeat visits	pediatrician n=5 1 female 4 male	n=32 25 mothers; 3 fathers; 4 both parents	n=32 age 5-15 allergy
Meeuwesen & Kaptein 1996	general practitioner's surgery repeat visits	general practitioner n=39 majority male	n=59 mainly mothers	n=95 49 girls 46 boys mean age 7.8 comparable acute complaints
Van Dulmen 1998	outpatient consultations general hospital 87% repeat visits	pediatrician n=21 9 female 12 male mean 15.5 consultation	n=302	n=302 mean age 5.3 60% boys 40% girls diverse diagnoses
Meeuwesen et al. 1998	general practitioner's surgery repeat visits	general practitioner n=17 majority male	n=20 18 mothers 2 fathers	n=20 age 6-13 mean age 9 13 girls 7 boys comparable acute complaints

Table 2 Design of the studies reviewed

study and nature	*observational strategy*	*communication channel*	*observational instrument*	*2 dyads / triad*
Korsch et al. 1968 quantitative	audio + transcripts + interview	verbal	Interaction Process Analysis Bales satisfaction ratings	2 dyads
Freemon et al. 1971 quantitative	audio + transcripts + interview	verbal	Interaction Process Analysis Bales satisfaction ratings	2 dyads
Korsch & Negrete 1972 quantitative	audio + transcripts + interview	verbal	Interaction Process Analysis Bales satisfaction ratings	2 dyads
Pantell et al. 1982 quantitative	video	verbal	Interaction Process Analysis Bales	2 dyads
Tannen & Wallat 1983,1987 qualitative	video + transcripts	verbal + nonverbal	micro-analysis	2 dyads
Worobey et al. 1987 quantitative	audio + transcripts	verbal + nonverbal	Schenkein	2 dyads
Aronsson & Rundstr̂m 1988 quantitative	audio + transcripts	verbal	Child Allocated Turns system	triad
Aronsson & Rundstr̂m 1989 qualitative	audio + transcripts	verbal	Politeness Theory Brown & Levinson	2 dyads
Meeuwesen & Kaptein 1996 quantitative	video + transcripts	verbal	Turn Allocation System	triad
Van Dulmen 1998 quantitative	video	verbal + nonverbal	Roter Interaction Analysis System	2 dyads
Meeuwesen et al. 1998 quantitative	video + transcripts v	erbal	Turn Allocation System Roter Interaction Analysis System	triad

Theory (1987) (Aronsson & Rundström, 1989), which focusses on the field of tension between the need for clarity on the one hand, and the need for politeness on the other. Brown and Levinson discuss 'politeness' in terms of respect behaviour and solidarity behaviour. Positive politeness strategies, such as expressions of solidarity and familiarity, appeal to the other's need for solidarity, whereas negative politeness strategies, such as expressions of restraint and distancing, appeal to the other's need to be respected. Sociological variables such as 'social distance' and 'power' predict the way participants phrase their utterances in terms of politeness. Where there is a large power difference between speaker and the person addressed, the speaker will phrase his message in an indirect and respectful way, whereas smaller power differences are associated with directness and clarity. For a critical overview of the strengths and limitations of recent methods of analysis, see Charon et al. (1994), and Boon and Stewart (1998).
Although all twelve studies claimed to analyse the interaction between doctor, parent and child, only three studies (Aronsson & Rundström, 1988; Meeuwesen & Kaptein, 1996; Meeuwesen et al., 1998) explicitly focussed on the communication between all three participants (doctor-parent, doctor-child and child-parent). The remaining ten studies restricted their analysis to the doctor-parent and doctor-child dyads.

2.3.3 Questions and findings of the studies reviewed

Table 3 presents an overview of the research questions and the findings of the twelve studies reviewed, as well as the aspects of communication focussed on.
Six of the seven studies focussing on the *relational* aspects of the communication between doctor, parent and child yielded information on the conversational contribution of the participants. The studies reviewed proved tolerably consistent in their findings on the conversatio nal contribution of the physician (about 60%). However, they differed substantially in the reported contribution of the parent and the child (parent: 26-39%; child: 2-14%) (Freemon et al., 1971; Pantell et al., 1982; Aronsson & Rundström, 1988; Meeuwesen & Kaptein, 1996; Van Dulmen, 1998; Meeuwesen et al., 1998). Although there is some variation, the conversational contribution of the child is very small or even absent; Van Dulmen (1998) reported that in 36% of the pediatric consultations the child did not participate at all verbally. Two studies reported differences in the child's conversational contribution in terms of an increase with age (Pantell et al., 1982; Van Dulmen, 1998). Meeuwesen et al. (1998) described an increase of the conversational contribution of the child between the seventies and the eighties. When focussing on the doctor-child (including child-doctor) interaction, there was a considerable variance in the results reported; ranging from 12% (Freemon et al, 1971) to 45% (Pantell et al., 1982) and even 63% (Worobey et al., 1987).
With respect to the distinction between affective and instrumental behaviour, there seemed to be remarkable differences in the doctor's role depending on who was addressed. In interaction with the parent, the doctor showed the commonly described physician role profile, characterized by a good deal of instrumental behaviour: the doctor provided information and instruction and asked for information, while the parent

Table 3 Questions and findings of the studies reviewed

study and aspect	*research question*	*findings*
Korsch et al. 1968 relation	relationship nature communication doctor and parental satisfaction + compliance	* positive relationship affective behaviour doctor and parental satisfaction * 76% of parents were satisfied * 24% of main worries was mentioned * a fifth of parents did not receive clear information * doctor should pay attention to parent's need for reassurance and explanation * use of medical jargon does not always lead to miscommunication
Freemon et al. 1971 relation	relationship attributes to doctor-parent interaction and parental satisfaction + compliance	* conversational contribution; doctor 59%, parent 39%, child 2% * communication doctor-parent[1] 88%, doctor-child 12% * role profile doctor-parent: doctor asks for information, gives instruction / mother gives information and expresses tension * role profile doctor-child: doctor 50% affective behaviour, 25% instructions /child answers questions and follows instructions
Korsch & Negrete 1972 relation	relationship attributes to doctor-parent interaction and parental satisfaction + compliance	* content analysis supports findings Korsch et al: doctor's attention to worries correlates with high parental satisfaction * affective behaviour doctor towards child only slightly influences parental satisfaction * in more than 50% of the cases the doctor uses medical jargon
Pantell et al. 1982 relation	relationship nature communication and characteristics children + parents	* conversational contribution: doctor 60%, parent 26%, child 14% communication doctor-parent 50%; doctor-child 45%, parent-child 5% * role profile doctor: relies on the child for obtaining information + shows affective behaviour, whereas the doctor provides the parent with medical information
Tannen & Wallat 1983, 1987 content	how does a doctor cope with conflicting demands during consultation	* the doctor addresses each audience from a different frame: towards child: motherese frame, towards mother: consultative frame, towards video-audience: reporting frame * conflicting frames may lead to miscommunication
Worobey et al. 1987 relation+content	how does a doctor accommodate form and content to addressee	* conversational contribution: the doctor addresses the child more than he does the parent (63% vs 37%) * doctor directs most questions towards child * doctor uses 3 different styles of conversation: towards child friendly talk (50%) and gentle, authoritative talk (13%); towards the parent consultative talk (37%)
Aronsson & Rundström 1988 structure	who controls the child's contribution in a pediatric consultation	* conversational contribution: doctor 58%, parent 34%, child 8% * parents are responsible for excluding the child from conversation: parental interference in 52% of the turns allocated to the child by the doctor * parents differ in type and degree of control

Aronsson & Rundström 1989 content	in what way does the presence of a third party affect the doctor's facework	* doctors operate within different politeness strategies: the parent is approached with indirectness and respect behaviour, whereas the child is approached with directness and solidarity behaviour * doctors criticize the parent through the child (strategic exploitation of a third-party presence) * doctors tend to soften the direct approach of the child by using a joking mode
Meeuwesen & Kaptein 1996 structure	description and comparison of doctor-parent-child communication over a period of 15 years	* conversational contribution: doctor 52%/50%, parent 41%/39%, child 7%/11% * communication doctor-parent: 75.6%/65.8% communication doctor-child: 12.4%/19.9% communication parent-child: 7%/7.2% * the conversational contribution of the child has increased over the years as the result of the child taking more initiatives and the GP addressing the child more frequently
Van Dulmen 1998 relation	what is the extent and nature of children's contributions to pediatric outpatient consultations	* conversational contribution: doctor 59%, parent 37%, child 4% * 1 out of 4 doctor's statements was directed to the child * role profile: although doctors ask the child a lot of questions (26%), only a small part of the medical information is directed to the child (13%) * the amount of doctor-child communication increased with the child's age (whereas the proportion of affective behaviour remained constant)
Meeuwesen et al. 1998 relation+structure	description and comparison of conversational patterns in doctor-parent-child communication over a period of 15 years	* conversational contribution: doctor 55%/50%, parent 40%/36%, child 5%/14% * communication doctor-parent 68.6%/54.2% communication doctor-child 22.7%/27.8% communication parent-child 4.7%/9.9% * the conversational contribution of the child has increased over the years as a result of the child taking more initiatives * the child gave more information, while the GP's instrumental behaviour and parental affective behaviour diminished

1 *The notation 'communication doctor-parent' and 'communication doctor-child' implies reciprocity*

gave information and asked a few questions (Freemon et al., 1971; Korsch & Negrete, 1972; Pantell et al., 1982). On the other hand, the doctor's role profile in interaction with the child was by and large restricted to affective behaviour, such as social behaviour and joking (Freemon et al., 1971; Pantell et al., 1982; Van Dulmen, 1998). Freemon et al. reported 50% of the doctor's behaviour to be affective, while another 25% consisted of instructions. Although doctors relied on the child for obtaining information (Worobey et al., 1987, even found that doctors questioned the child more than they questioned the parent), the greater part of medical information was directed at the parent (Pantell et al., 1982; Worobey et al., 1987; Van Dulmen, 1998).
Two relational studies reported the effects communication on outcome variables such as satisfaction and adherence to treatment (compliance). Parents who had not been given the opportunity to express their concern about their child or who did not receive the information they expected were less satisfied and showed less compliance (Korsch et al., 1968; Korsch & Negrete, 1972). The Korsch studies showed that only 24% of the parents indeed made their worries explicit and stressed the positive relationship between affective behaviour of the doctor towards the parent and parental satisfaction. Affective behaviour of the doctor towards the child only slightly influenced the satisfaction of the parents (Korsch & Negrete, 1972). None of the studies reviewed addressed the effects of relational aspects of the communication on outcome variables from the perspective of the child.

The three studies that paid attention to the *structural aspects* of doctor-parent-child communication revealed that in terms of turn-taking, it was mainly the parent who was responsible for excluding the child from medical conversation by interfering in 52% of the turns the doctor directed to the child. The extent of the doctor's control, however, was almost constant (Aronsson & Rundström, 1988). In the course of time there was an increase in the conversational contribution of the child, mainly attributable to an increase in the number of initiatives on the part of the child itself (Meeuwesen & Kaptein, 1996; Meeuwesen et al., 1998), and to the doctor addressing the child more directly (Meeuwesen & Kaptein, 1996).

The relational studies of Korsch et al. (1968) and Korsch and Negrete (1972) revealed that in more than 50% of the cases the physician made use of medical jargon towards the parent.
Research into the *content of the communication* aimed at describing the potential discrepancies between this medical jargon and everyday language, and patterns of mutual influence in terms of accommodation of conversational style. Accommodation of conversational style was studied in terms of frames of reference by Tannen and Wallat (1983, 1987). They reported how the doctor found a balance between such conflicting demands as consulting the mother, examining the child and reporting to the video audience, by switching frames, depending on the person addressed. In interaction with parents the doctor mainly used a consultation frame, in which task-related instrumen-

tal behaviour dominated the conversation. When talking to the child, the physician switched to a 'motherese' frame, which was characterized by an affective, teasing conversational style. This dichotomy is consistent with the findings of Worobey et al. (1987), where the doctor mainly used an affective conversational style towards the child, whereas the mother was addressed in a consultation frame. Aronsson and Rundström (1989) approached the same problem in another way, by focussing on the field of tension between the doctor's need for clarity on the one hand, and the need for politeness on the other. They analysed physician's questioning in terms of directness/indirectness and the person addressed, and found that the parent was addressed indirectly or respectfully, whereas the child was addressed rather directly. Their findings also demonstrated how the doctor used the child as a third party in order to formulate his criticism towards the parent in a mitigated way. The doctor's direct approach was compensated for by an excess of affective behaviour towards the child (joking relationship). Pantell et al. (1982) showed that accommodation to the person addressed in terms of instrumental versus affective behaviour also included the topic of conversation.

2.4 Discussion

The aim of this review study was to evaluate the state of the art of research into doctor-parent- child communication, and to explore the role of the child in medical interaction. We are led to the conclusion that doctor-parent-child communication is a subject that has been insufficiently studied; most of the studies reviewed ignored the consequences of the child's presence in medical communication as well as the need for triadic analyses. The communication in the doctor-parent-child triad possesses distinguishing features that differ fundamentally from dyadic doctor-patient interactions, and therefore must be studied as a unique subset of the medical encounter. We will elaborate on this conclusions by returning to the research questions.

2.4.1 Aspects of doctor-parent-child communication

The first question concerns the different aspects of doctor-parent-child communication which have been highlighted in the studies reviewed. Obviously, studies on the *relational* aspects of the interaction are dominant in this field of research. By drawing attention to the gap in doctor-patient communication (in terms of affective and instrumental behaviour), the Korsch studies have set the trend for a long-lasting tradition focussing on this aspect of medical interaction. In the first place, this type of quantitative research yields information on the conversational contribution of the participants. The studies reviewed reported the physician's contribution to the consultation at about 60%. This is consistent with general studies on doctor-patient communication, with patients contributing 40% to the conversation (Roter et al., 1988), and in accordance with Arntson and Philipsborn (1982) in their description of doctor-parent communication. The child's participation obviously seems to occur at the expense of

the parental contribution to the conversation. The most important conclusion, however, is that the conversational contribution of the child is very slight. The variance in the restricted child participation (2-14%) can be explained by regarding the background variables. The studies of the Korsch group mainly examined infants and toddlers[2], whereas the mean age in the other studies ranged from five to ten. The plausibility of this explanation is sustained by the findings of Pantell et al. (1982) and Van Dulmen (1998), who stress the positive correlation between the child's age and conversational contribution. A second possible explanation is that the Korsch research was carried out in the late sixties, a period in which children did not have much of a say. The presupposition that the child's contribution has increased over the years is supported by Meeuwesen & Kaptein (1996) and Meeuwesen et al. (1998). A third factor might be a difference in doctor-parent-child familiarity; in the Korsch studies participants met for the first time, whereas other studies mainly involved repeat visits.
Secondly, relational research draws attention to differences in the physician's role profile, depending on the person addressed. Whereas in interaction with the parent the doctor mainly shows instrumental behaviour, the communication between doctor and child seems to be restricted to the affective domain. In this respect the interaction between physician and child can indeed be typified as a 'joking relationship' (Aronsson & Rundström, 1989). Although doctors rely on the child for obtaining information, diagnostic and treatment information are primarily directed to the parent. In terms of the various goals of the medical consultation, the physician largely restricts the medical interaction with the child to the creation of a good interpersonal relationship. However, restricting doctor-child interaction to the affective domain precludes two other important goals of medical communication, viz. exchanging information and medical decision-making (Ong et al., 1995).
Finally, this field of research stresses the positive relationship between affective behaviour of the doctor and parental satisfaction and compliance. This is in line with studies on doctor-parent communication that reveal a higher correlation between parental satisfaction and physician's affective behaviour for worried parents, and a higher correlation between satisfaction and physician's informativeness for repeat visits (Street, 1991,1992). Surprisingly, the issue of the child's satisfaction and compliance in relation to the process of medical communication is not a topic of interest. One might expect, however, that the way the physician interacts with the child will influence the outcome of the consultation in terms of satisfaction, adherence, recall and understanding (and probably health outcomes).

By focussing on the *structural* aspects of doctor-parent-child interaction, linguistic-oriented research extends and specifies the findings of relational studies. Whereas the latter pictures the small conversational contribution of the child, structural research illustrates how the child by and large is excluded from medical communication by a controlling parent. On the other hand, the child itself can potentially exert influence on the organization of the communica tion. The increase of the child's contribution in the

2 *This puts the Kersch-quotatem into perspective*

course of time seems to be the result of an increase in the number of initiatives by the child itself (Meeuwesen & Kaptein, 1996; Meeu wesen et al., 1998), as well as the doctor giving more room to the child (Meeuwesen & Kaptein, 1996). Information on the dynamics of communication can become manifest only by investigating the sequential patterns of turn-taking in this triad.

The four studies addressing the *content* of doctor-parent-child interaction strongly support the difference in the physician's behaviour in terms of affective versus instrumental behaviour depending on the person addressed. This dichotomy in the doctor's verbal behaviour applies both to the topic of discussion (Pantell et al., 1982), and to accommodation in terms of frames or politeness strategies applied (Tannen & Wallat, 1983,1987; Worobey et al., 1987; Aronsson & Rundström, 1988,1989). These studies easily demonstrate how the presence of a child influences the physician's verbal behaviour. In this context Stiles (1989) stresses the error of the presupposition that process variables on patients are constant. Stiles criticizes the fact that the patient's demands and the doctor's responsiveness are often ignored in studies on doctor-patient interactions. This is consistent with the comments of Tannen and Wallat (1983) and Street (1992), who point out the importance of research on interactional influences in medical consultations. Research on the content of medical conversation is vital for exposing such processes, and, in the case of a doctor-parent-child triad, this type of interactional research underlines the difference between a triadic and a dyadic conversation.

To summarize, we have to conclude that researchers have focussed on diverse aspects of doctor-parent-child interaction, with the result that knowledge on the different aspects of communication is highly fragmented and poorly integrated. We would like to draw attention to the complementary nature of the various aspects of medical doctor-parent-child communi cation, and the need to study all these aspects of the interaction in relation with each other.

2.4.2 The child's role in medical communication

This study supports the assumption that the role of the child in medical communication is a subject that has been insufficiently studied. Even when the patient is a child, the focus of research is usually doctor-parent interaction, rather than the communication between doctor and child, and little attention is given to the specific role of the child. In so far as the studies reviewed deal with the specific contribution of the child, they picture the stereotype of child participation being restricted to the provision of medical information and to the maintenance of a 'joking relationship' with the physician. In addition, the studies reveal that the child's control in medical conversation is rather limited. We have to conclude that, as far as the doctor is concerned, it is a matter of quantitative control (in terms of conversational contribution), turn- taking control (in terms of allocation) and semantic control (in terms of topic control) (Linell & Luckman, 1991). The strategic control of the parent appears from the fact that the parent

claims a lot of the child's turns in speaking. This is consistent with Pantell and Lewis (1993), who stress that although physicians direct a considerable amount of speech towards the child, they seldom discuss management issues with the children, not even with older children or adolescents.

This negation of the child as an active participant does not seem to be consistent with the development of the patient-centred approach and the increased demand for shared decision making and informed consent (Stewart et al., 1995; Van den Borne, 1998). As we stated in the introduction, it is increasingly being acknowledged that children too should be involved in decisions about their own health care. From the perspective of patient-centred care, the child's role in the consultation should be as important as the parent's.

On the other hand, the findings of this review study demonstrate that the child can potentially exert influence on both relational and structural characteristics of the communication, as well as on the content of the interaction. However, there is still a lack on extensive data on this subject. One possible explanation for this gap between the expectations concerning the child's role in medical communication and the results of this review study could lie in the methodologies used in the studies we reviewed.

2.4.3 Design of the studies reviewed

The majority of research methodologies used are based on analysing dyad. Although all studies claim to examine the interaction between doctor, parent and child, most studies have not dealt with the implications of a third participant's presence. A consequence of this prevailing dyadic approach is that valuable information on the interactional dynamics of triadic communication, in terms of influences and role attributions, remains underexposed. By restricting the focus of research to the dyadic interaction doctor-parent and doctor-child, a phenomenon such as parental control (the parent taking over the turns the doctor directed to the child) would not have been revealed. It is not surprising that, especially in studies focussing on the structural aspects of communication, the necessity of adapting the coding schemas to include all participants in the analysis is rather strong. In these sequential analyses, one is forced to take into account the implications of a third participant's presence, e.g. by including a category such as allocation of turns, because of the impossibility of regarding the utterances of participant B as a direct consequence of the verbal behaviour of participant A.

As stated above, research into the content of interaction supports the need for triadic analyses by revealing the interactional influences of communication in the doctor-parent-child triad in terms of accommodation of conversation style. So far, however, this type of research has been restricted to doctor-parent and doctor-child communication, and therefore cannot be typified as triadic by nature. The prevailing doctor perspective in this type of research is probably responsible for the parent-child interaction being overlooked.

We have to conclude that because the interactional dynamics of a triad differ fundamentally from those of a dyad, triadic analyses are a prerequisite for a full account of the communication in the doctor-parent-child triad.

2.5 Recommendations

As we have shown that triadic analyses are indispensable for exposing the dynamics of triadic medical communication, future research should focus on the implications of a third participant's presence on the methodology used, and should attempt to develop a conceptual framework for analysing triadic medical communication such as the doctor-parent-child triad.

In order to conduct triadic analyses, researchers should develop adaptive coding schemes to take into account a third participant's presence by including the allocation of utterances (who the speaker is addressing), and by analysing the communication between all three interlocutors. In addition, research methodologies should employ a cognitive develop mental perspective, because children's communication skills and their understanding of diseases may change with age (Hart & Chesson, 1998), and with type of illness. As the samples of the studies reviewed reflect a dissimilarity of practice settings, different age limits, and a broad diversity of complaints, there should be more consistency in future research with respect to sample and method of analysis. Samples should be more balanced in terms of background variables such as setting, sample size, type of illness, the child's age and gender, socio-economic characteristics, and cultural background.

In view of the emphasis in this review study on the complementary nature of research focussing on various aspects of medical doctor-parent-child communication, future studies should further explore a number of underexposed characteristics. A deeper understanding of the relationship between interactional style and outcome variables, such as satisfaction and adherence, could have considerable potential for health education with respect to children developing a sense of responsibility for their own health care. Future research should explore the influences on the turn-taking patterns in this triad, e.g. the child's age, the type of complaint, and the segment of consultation. Triadic analyses on the content of interaction would reveal whether accommodation of conversational style also applies to the parent and the child. In addition, content analysis may yield valuable information in terms of topic initiations, topic shifts and topic avoidance in this triad.

We would like to stress that, for a full account of the communication, all aspects of the interaction should be studied in relation with each other. This case for a combined approach is equally applicable to the combination of quantitative and qualitative research. Although most research on doctor-patient communication is quantitative by nature, qualitative research is vital for exposing processes of responsiveness and accommodation of conversational style. The argument in favour of a combined approach is consistent with Wasserman and Inui (1983), Roter et al. (1988), Waitzkin (1990), Roter and Frankel (1992), and Charon et al. (1994), who stress the complementary nature of qualitative and quantitative research and the rich potential for cross-method collaboration. Finally, it is strongly recom mended that future research focus on nonverbal behaviour during medical consultations involving a child patient. Although several re-

searchers have acknowledged the importance of nonverbal behaviour (Roter et al., 1988; Ong et al., 1995; Boon & Stewart, 1998), this is still an underdeveloped area in research into doctor-parent-child communication.

The physician's perspective was dominant in the studies reviewed, and thereby most research implicitly aims at improving physician's behaviour. From the perspective of patient education and counselling, of both child and parent, future research should not be restricted to the doctor's perspective. Only by using a plural perspective, i.e. by dealing with the perspecti ve of all three participants, can the processes of mutual influence of the interactants be fully examined (Stiles, 1989; Street, 1992).

By using a plural perspective, future research should aim at gaining knowledge on the implicit and explicit role attributions of all three participants. The role of the child in medical communication is particularly deserving of more attention. The child itself has to be taken seriously and should be considered as an intelligent, capable and cooperative participant, with its own cognitive and emotional needs. The question of when a child can be considered a full participant in medical communication has to be answered in relation to the child's age, the type of complaint, and the parent-child relationship. Children may become more or less empowered by different discursive practices of both parent and doctor. Therefore, future research should also focus on the various roles of the parent in medical interaction, e.g. representative, mediator, or activator. This type of research could shed light on the back grounds of parental control; e.g. in terms of parental responsibility and concern or the child's lack of familiarity with the medical setting. Finally, the role of the doctor deserves further attention; it is the physician who has to deal with two interlocutors with potentially different needs and goals. In the case of the doctor-parent-child triad the development towards patient-centred medicine may be more problematic than hitherto assumed. On the one hand, the doctor should teach the child to cope with questions on health and illness, while on the other hand the physician has to be sensitive to the account of events and questions of the parent. Physicians ultimately have to cope with this 'pas de trois':

> *'Pediatric visits are particularly challenging in requiring that the physician engage in a dance with not one but at least two partners -parent and child- and that the physician be able to lead at times and follow at others.'*
> (Pantell & Lewis, 1993, p. 7)

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Chapter 3

"Let mum have her say" Turn-taking in doctor-parent-child communication

Tates, K. & Meeuwesen, L. (2000). "Let mum have her say": Turn-taking in doctor-parent- child communication. Patient Education and Counseling, 40, 151-162

Abstract

Recent legislation in the Netherlands requires that children should also play a part in decision-making regarding their own health care. So far, however, little attention has been given to the child's participation in medical interviews. In order to get a grip on aspects of asymmetry and control in doctor-parent-child communication, the present study explores the turn-taking patterns in this triad at the general practitioner's surgery, and makes a comparison over the years. Videotaped observations of 106 medical interviews taken over a period of almost 20 years have been analysed by means of the Turn Allocation System. The most important finding is the difference in the way GP and parent accommodate their turn-taking patterns to the child. The GP is considering the child's age, by addressing the older child more directly in the course of time, and allocating fewer turns to the parent as the child's age increases. Parental control however, appears to be constant over the years, and is not related to the age of the child. The results are discussed in terms of implications for medical practice and health education.

3.1 Introduction

Traditionally, children did not used to have a say in medical consultations. Most studies on medical communication have concentrated on the dyad doctor-adult patient, and the child's contribution to the medical encounter has hardly been considered a point of interest (Arntson & Philipsborn, 1982; Pantell et al., 1982; Tannen & Wallat, 1983; Aronsson & Rundström, 1988; Aronsson & Rundström, 1989). However, recent legislation, such as the Medical Treatment Agreement (WGBO) in the Netherlands, requires patients to participate actively in decision-making concerning illness and treatment (Blaauwbroek, 1997; Van den Borne, 1998), and it is increasingly acknowledged that children too should be involved in decisions about their own health care (Rylance et al., 1995; Alderson & Montgomery, 1996; Rylance, 1996; Hart & Chesson, 1998).

The issue of asymmetry in doctor-patient interactions is one of the key-themes in the field of medical discourse (Byrne & Long, 1976; Mishler, 1984; Linell & Luckmann, 1991; Ong et al., 1995). The asymmetrical character is reflected, amongst other things, in the way the communication between doctor and patient is structured in terms of conversational contribution and processes of turn-allocation (Wiemann, 1985; Linell et al., 1988; Linell & Luckmann, 1991; Van Dijk, 1996; Drew & Sorjonen, 1997). In the case of a juvenile patient, it is a matter of double asymmetry, the physician embodying both institutional and adult authority. Adult-child discourse is inherently not symmetrical, because of differences in status and in domain specific knowledge, including communicative competence (Ervin-Tripp, 1985; Siegal, 1997).

During the past three decades some important changes have taken place in doctor-patient communication in general. The development of the patient-centred approach and demands regarding shared decision making and informed consent, evoked a shift in the participant roles in medical consultations (Kaufmann, 1983; Stewart et al., 1995;

Blaauwbroek, 1997; Bury, 1997; Van den Borne, 1998; Brown, 1998). As a result, the nature of the doctor-patient relationship has developed from a very asymmetrical towards a more egalitarian relationship, and patients have become more emancipated and autonomous over the years (DiMatteo & DiNicola, 1982; Davis & Fallowfield, 1991; Roter & Hall, 1992; Roter, 2000). One might hypothesize that these changes would also affect the interaction in the doctor-parent-child triad.

The few studies that did pay attention to doctor-child communication, suggest that the child's control in medical conversation is rather limited (Tates & Meeuwesen, 2001). During medical encounters children only occupy a small portion of the discourse space (Freemon et al., 1971; Pantell et al., 1982; Aronsson & Rundström, 1988; Van Dulmen, 1998), although the child's contribution seems to increase over the years (Meeuwesen & Kaptein, 1996; Meeuwesen et al., 1998). Physicians tend to elicit information from children, but exclude them from diagnostic and treatment information (Worobey et al., 1987; Pantell & Lewis, 1993; Grover, 1996). The doctor's conversational style in interaction with the child is, by and large, restricted to the affective domain, such as social behaviour and joking (Freemon et al., 1971; Pantell et al., 1982; Aronsson & Rundström, 1989; van Dulmen, 1998). In addition, children often seem to be excluded from direct interaction with the doctor by a controlling parent (Aronsson & Rundström, 1988). This negation of the child as an active participant does not seem to match with the development towards 'shared decision making', with an increased preference for the child's participation in treatment decisions (Rylance et al., 1995; Alderson & Montgomery, 1996; Rylance, 1996; Hart & Chesson, 1998).

Changes in doctor-patient communication, and the specific role of the child in medical interaction can also be seen as an expression of major social changes that have taken place. Parenting has become less controlling and authoritarian, and adult-child interactions are increasingly characterized by a greater openness to the child (De Swaan, 1988; DuBois- Reymond, 1993). The preference of a growing participation of the child is in line with the development of children as fellow citizens (De Winter, 1996).

This change has been confirmed in developmental cognitive studies that underline that children can play a far more active role in taking initiatives when negotiating the aim and process of the interaction with adults than has been assumed (Elbers et al., 1992; Hoogsteder, 1995). Further, children also appear to be able to understand more about health and illness concepts (Lewis et al., 1984; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998). A more direct communication between physician and child would contribute to a better relationship in terms of satisfaction and compliance, and a better health experience (Pantell et al., 1982; Colland, 1990; Holtzheimer et al., 1998).

This study focusses on the child's participation in doctor-parent-child interactions during the medical interview. Since little is known yet about the specific role of the child in this triad, our first objective is to provide a detailed description of the turn-taking patterns in doctor-parent- child communication. Turn-taking in conversation is an important element in defining and establishing relationships, and presents the opportunity to explore the amount of asymmetry between participants (Wiemann, 1985; Linell

et al., 1988; Linell & Luckmann, 1991). A useful distinction for conversational practice is made by Linell et al. (1988) and Linell and Luckmann (1991), by formulating four categories of control or dominance: 'quantitative control' (in terms of conversational contribution); 'turn-taking control' (in terms of turn-allocation and turn-taking); 'semantic control' (in terms of the topic of conversation); and 'strategic control' (in terms of strategical interruptions). In this study we will focus on aspects of quantitative control, turn- taking control, as well as strategic control.

Our second aim is to look for changes in the turn-taking patterns. Considering the developments in doctor-patient communication in general, and the changes in adult-child interaction during the last decades, it seems relevant to make a comparison over the years. One might expect a less controlling GP and parent in the course of time.

In addition to the difference in participant status, the child's communicative competence may influence the extend of his/her participation in medical conversation. Communicative competence, or pragmatic competence, implies conversational logic and the understanding of conversational structure, especially the ability to respond to questions and directives (Lakoff, 1996). These conversational skills develop with age, and school-age children gradually learn the appropriate use of turn-taking devices (Romaine, 1984; Garton, 1992; Ervin-Tripp, 1995; Siegal, 1997). As conversational skills increase with age, as well as children's concepts of health and illness, one might expect older children to participate more substantially in the medical interview.

Summarizing, the following research questions will be addressed in this study:

1. How can the turn-taking patterns in doctor-parent-child communication be characterized in terms of quantitative, turn-taking, and strategic control?
2. Have any changes taken place in these turn-taking patterns over the years?
3. How does the child's age affect turn-taking in this triad?

3.2 Method

Sample characteristics

This study is based on 106 video recordings of medical interviews in the GP's surgery. All selected interviews concerned the triad doctor-parent-child, with the child visiting the GP for minor complaints, classified as either somatic (such as bronchitis, earache or stomach-ache) or psychosocial (such as headache, rash or bed-wetting). In the Dutch health care system, the general practitioner (GP), comparable to a family physician, has a gatekeeping role; patients do not have access to specialists or hospital care without referral, and 90% of all complaints is treated by GPs (De Melker, 1997). One in six consultations of a GP concerns a child under the age of 16, and in the Netherlands the GP is the first responsible health care provider for children, including primary care and preventive care (Van Suijlekom-Smit & Crone-Kraaijeveld, 1994; De Melker, 1997). The videos were drawn from a large collection (n=2500) of medical interviews, collected since 1975, held by the NIVEL (Netherlands Institute of Health Services Research). In 425 cases a child was involved; a first selection was made based on rigorous demands of technical

quality. This was necessary since many of the earlier videos were of poor quality. The application of these and other relevant selection criteria (a triad of doctor-parent-child, and the age of the child: 4-12 years), supplemented by matching type of complaint, resulted in a dataset of 106 consultations, containing a comparison over three periods: 1975-1978 (n=36), 1988-1989 (n=36), and 1993 (n=34). As none of the participants participated in more than one period, this study can be typified as a comparative study, though not longitudinally in the strict sense. All participants involved had a Dutch origin. In the majority of the consultations (n=88), the child was accompanied by the mother. The child's age was between 4 and 12 years (mean age 8), and boys and girls were equally represented. All consultations concerned a new complaint, and all children had previously seen the GP. When a second child was present, verbalizations to this other child were not included as part of the data. Fifty-eight GPs participated in the study; 22 in period 1 (mean 1.6 consultation), 15 in period 2 (mean 2.4 consultation), and 21 in period 3 (mean 1.6 consultation), the majority being male (91%).

Duration

The duration of the consultation was measured in seconds. Consultations were deemed to start and finish upon the initiation and cessation of the verbal interaction between participants. Interruptions, such as phone calls, or practice staff entering the consulting room were considered to be components of normal consultation and thus included. Not included was time spent on complaints of the parent or siblings.

Coding system

The sequential patterns of turn taking were analysed using the Turn Allocation System (TAS), based on the work of Aronsson and Rundström (1988). The unit of analysis was the 'turn', generally defined as 'what one says between two moments of silence' (Sacks et al., 1974; Huls, 1989). Along this definition, a turn can comprise one or more utterances; an utterance is defined as the smallest distinguishable speech segment, varying from a single word, a clause, or a complete sentence. All verbal turns of the three participants, like questions, remarks, or directions, have been analysed in terms of their initiatory and responsive character, i.e. in terms of initiative, allocation, and response. For example, for all responses to the initiatives the GP explicitly directed to the child (the 'child allocated turns': CAT's), an analysis was made of who responded to the GP's initiatives. Aronsson and Rundström were merely interested in the child allocated turns of the physician. However, in our study, the TAS analysis has been expanded to cover all participants: 'parent allocated turns' (PAT's), 'doctor allocated turns' (DAT's), and to 'both participants allocated turns' (BAT's). The BAT's were added to the observation system in those cases where the speaker addresses both other participants simultaneously, or in cases where it is not clear to whom the speaker is talking. The combination of three possible initiators (GP, parent, child), and three possible allocators (each of the two others of the triad separately or both together), results in a coding system of nine categories (see table 2a).

For assessing the sequential patterns with the TAS, all 106 medical interviews were transcribed in extenso, according to ethno-methodological rules, and adapted for the aim of this study (West, 1984; Meeuwesen, 1988). Non-verbal communication was noted as far as it was relevant to the coding (especially eye-contact). Before coding all utterances of doctor, parent and child, the medical interview was divided into three segments: the medical history, the physical examination, and the conclusion segment (diagnosis and treatment information). This sequential pattern is characteristic of medical interviews (Byrne & Long, 1976). In addition, the transcripts were segmented into turns, in accordance with the definition above. Turns included all talk explicitly directed at a specific person as indicated by e.g. first-naming and second-person singular form of address, the politeness form (the French 'vous', in Dutch 'u'), and eye-contact. This resulted in a dataset of 8373 units. The intercoder reliability, based on ratings of ten interviews by two independent raters, assessed by Cohen's kappa was sufficient (0.69 on average; items more than 5% present).

Statistical techniques

First, descriptive statistics were used to measure the conversational contributions of the three participants, in terms of initiatives, allocations and responses. Means of the dependent variables were calculated per consultation and consultation segment. Next, Oneway's and multiple range tests (Bonferroni) on the dependent variables were performed, breaking down results by period, type of complaint, child's age, and participant's gender.

3.3 Results

Duration

The mean duration of the 106 consultations was 6.53 minutes (std.=2.48), and increased over the years (5.33 vs 7.22 vs 7.44; $F=5.77$, $p<.01$). Only in the first period the somatic consultations took significantly less time than the psychosocial consultations (4.42 vs 7.24; two-sided t-test $t=-2.81$, $p<.01$). The increase in duration over the years was associated with a longer duration of the somatic consultations in the course of time (4.43 vs 6.53 vs 7.21; $F=6.37$, $p<.01$). With respect to the child's age and the participant's gender, no major differences in the mean duration were found.

Initiatives

First, the particpants' relative conversational contribution during a consultation was measured. As table 1 shows, the physician and the parent took the greater part of the initiatives; the child's contribution was restricted to 9.4%. A closer look at the segments of the consultation revealed that the physician took most initiatives while examining the child (medical history: 48.6% vs medical examination: 55.8% vs conclusion: 53.2%; $F=5.63$, $p<.01$), whereas the parent took most initiatives during the phase of medical history (42.2% vs 36.0% vs 38.2%; $F=4.25$, $p<.05$). The number of child initiatives was

about the same in the three segments of the consultation.
Over the years, there was an increase in the child's initiatives, especially between the first and the second period (7.9% vs 11.7% vs 8.5%; F=2.99, p<.05), mainly during the physical examination.

Table 1 Percentage of verbal turn initiatives (std.) per participant

	Period 1 1975-1978 N=2214		Period 2 1988-1989 N=3149		Period 3 1993 N=3010		Total N=8373		F-value	p
Child	7.9	(7.1)	11.7[1]	(7.6)	8.5	(6.6)	9.4	(7.3)	2.99	.05
Adult	92.1	(7.1)	88.3[2]	(7.6)	91.5	(6.6)	90.6	(7.3)	2.99	.05
Adults split up:										
Doctor	51.1	(10.5)	50.1	(8.2)	52.4	(8.1)	51.2	(9.0)		
Parent	41.0	(9.3)	38.2	(9.6)	39.1	(7.3)	39.4	(8.8)		

[1] period 1/2: p=.07

The age of the child appeared to be positively related to the child's conversational contribution, although not significant at 5% level; (age 4- 6: 7.4%, age 7-9: 9.9%, age 10-12: 10.9%; F=2.98, p=.09). No main or interaction effects were found regarding the number of initiatives of the participants and the type of complaint, nor with the participant's gender.

Initiatives combined with allocation

The next step was to determine the patterns of turn-allocation: who was talking to whom? The linking of the initiatives to the allocations of the turns, provided a picture of the amount of communication between the three interlocutors. Table 2a shows the results of this linking, specified for each participant over the three periods.

The *GP* allocated most turns to the parent (mean 35.6%), especially during the conclusion segment of the consultation (medical history: 28.5%, medical examination: 28.5%, conclusion: 42.2%; F=22.73, p<.001). In only 12.9% of the turns did the GP directly address the child, mainly during the physical examination (segment 1: 14.0%, segment 2: 23.8%, segment 3: 9.6%; F=20.60, p<.001). In 5 out of 106 consultations the GP did not allocate a single turn to the child. In only 2.7% of the turns parent and child were addressed simultaneously by the GP. Most of them during medical history taking. Over the years, there was a tendential decrease of GP's turns allocated to the parent in the second period, followed by an increase in the third period (36.8 vs 32.4% vs 37.8%; F=2.56, p=.08). On average, the proportion of child allocated turns of the GP hardly changed

Table 2a Percentage of verbal turn initiatives combined with allocation over the years

Initiator	Allocation	Period 1 1975-1978 N=2214	Period 2 1988-1989 N=3149	Period 3 1993 N=3010	Total N=8373	F-value	p
Doctor	Parent	36,8	32,4	37,8	35,6	2.56	.08
	Child	11,4	14,6	12,6	12,9		
	Both	2,9	3,1	1,9	2,7		
Parent	Doctor	35,3	32,4	35,0	34,2		
	Child	5,2	5,2	3,9	4,7		
	Both	0,5	0,6	0,3	0,5		
Child	Doctor[1]	3,7	6,6	5,4	5,3	3.66	.05
	Parent	2,4	2,3	2,3	2,3		
	Both[2]	1,8	2,8	0,8	1,8	4.90	.01

[1] significant at .05 level: period 1/ 2
[2] significant at .05 level: period 2/ 3

over the years. Only in the group children aged 10-12, there was a significant increase in the GP's CAT's in the second period (period 1: 11.4%, period 2: 21.5%, period 3: 18.1%; F=3.29, p<.05).
Most turns of the *parent* were directed at the GP (mean 34.2%), especially during the segment of medical history-taking. Only in 4.7% of the turns did the parent directly address the child, mainly during the conclusion segment. Over the years, the patterns of turn allocation of the parent appeared to be very constant.
The *child* allocated most turns to the GP, mainly during the medical history segment (segment 1; 6.7%, segment 2: 5.1%, segment 3: 3.8%; F=3.91, p<.05). The child addressed the parent in 2.3% of the turns, mainly during the last segment of the consultation. Only in 1.8% of the turns did the child direct both adult participants simultaneously. In the second period, the child addressed the GP more directly, and directed more turns at GP and parent together. The child's turn-allocations to the parent did not change in the course of time.

The turn-allocations of doctor and child were strongly associated with the child's age. Table 2b shows an overview of the turn-allocations in relation to the child's age.
The child's age appeared to be a strong indicator for the GP's allocation of turns: the older the child, the more the GP addressed the child directly, or together with the parent. In addition to this, the GP directed fewer turns at the parent as the child's age increased.

Table 2b Percentage of verbal turn initiatives combined with allocation by the age of the child

Initiator	Allocation	Age 4-6	Age 7-9	Age 10-12	F-value	p
Doctor	Parent[1]	39.7	35.0	32.1	4.85	.01
	Child[2]	10.1	12.1	16.4	4.98	.01
	Both[3]	1.2	3.3	3.5	7.66	.001
Parent	Doctor	35.8	33.8	32.9		
	Child	5.3	5.5	3.6		
	Both	0.5	0.3	0.5		
Child	Doctor[4]	3.3	4.9	7.6	8.52	.001
	Parent	2.1	2.8	1.9		
	Both	1.9	2.2	1.3		

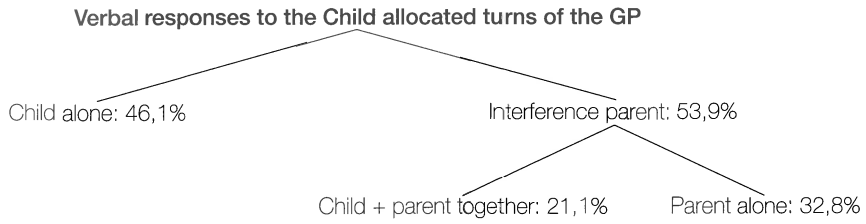
[1] significant at .05 level: group 1/ 3
[2] significant at .05 level: group 1/ 3
[3] significant at .05 level: group 1/ 2 and group 1/ 3
[4] significant at .05 level: group 1/ 3

Contrary to the expectations, the parent did not seem to take the child's age into account; the number of child allocated turns did not vary with the child's age.
The proportion of doctor allocated turns of the child varied with the child's age; the older the child, the more directly s/he addressed the GP). The above mentioned increase of the child's doctor allocated turns in the second period was found only to be significant with the children aged 10-12 (period 1: 4.7%, period 2: 9.8%, period 3: 9.5%; $F=5.18$, $p<.01$).
No main or interaction effects were found regarding any of the participant's turn- allocations and the type of complaint, nor with the participant's gender.

Sequential patterns

The final step in the analysis was to look at the reaction patterns: how were the responses to the different types of turn allocation? Figure 1 shows the verbal responses to the turns the GP directed at the child.

Figure 1



As stated above, the proportion of the GP's child allocated turns was limited to 12.9%. However, in 53.9% of these turn allocations it was the parent who interfered by giving a response to the doctor. The next fragment provides an example of parental interference:

Fragment 1

the GP explicitly addresses a 10-year old girl, and the mother repeatedly tries to take over the turn

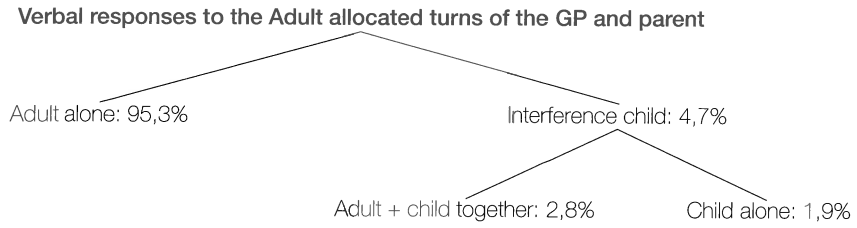
(GP= general practitioner, P=parent, C=child)

GP→C: Hello Rose, tell me what's up
C→GP: (.)
P→GP: well (.), Rose has not been feeling well for quite a long time
GP→C: oh ((is looking at Rose))
P→GP: she has a sore throat
C→GP: I have a sharp PAIN over here
P→GP: yes (.), and last week she ((interrupted))
C→P: last WEEK?
P→C: let MUM have her say!

In 21.1% of these interferences both parent and child responded to the GP's CATs, and in 32.8% the parent reacted alone. Over the years there were no changes in these sequential patterns. Again, the child's age appeared to be an important factor; in the group children aged 10-12 years, the pattern of the parent responding alone was limited to 23.2% (age 4-6: 36.3%, age 7-9: 39.8%, age 10-12: 23.2%; $F=3.05$, $p<.05$). In addition, the older child tried to enlarge its contribution by more responding itself to the GP (age 4-6: 42.1%, age 7-9: 43.4%, age 10-12: 52.3%; $F=2.34$, $p=.09$). There were no changes in the response patterns of the GP's child allocated turns, nor variation related to the segment of the consultation, the type of complaint, or the participant's gender.

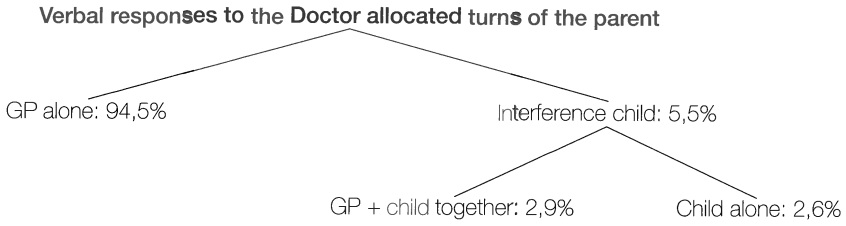
Looking at the reaction patterns to the turns the GP and parent allocated to each other (the adult allocated turns), quite a different picture emerged (see figure 2).

Figure 2



In these adult interactions, the dominant reaction pattern was that the adult is responding alone; the child only interfered in 4.7% of these turn allocations. In the course of time, the number of child interferences increased significantly in the second period (3.9% vs 6.9% vs 3.2%; F=4.58, p<.01), especially by responding alone (.9% vs 3.2% vs 1.5%; F=5.81, p < .01). These interferences were strongly associated with the child's age; older children interrupted more than the younger ones (age 4-6: 2.1%, age 7-9: 5.6%, age 10-12: 6.6%; F=6.63, p<.01), especially by responding together with an adult participant.
A more detailed analysis showed that the child was more likely to interfere during the doctor allocated turns of the parent. As figure 3 shows, the dominant reaction pattern to the doctor allocated turns of the parent was that of the GP responding alone.

Figure 3



The child interfered in about 5.5% of these turn-allocations. The next fragment refers to a protesting interference by a child:

Fragment 2

the child believes that the reason for consulting the GP has to do with her knee, which is damaged (GP=general practitioner, P=parent, C=child)

P→GP: She is down again, the headmaster of her school came over to complain
GP→C: Gee (.)
P→GP: and when ((interrupted))
C→P: Oh, nice to hear THAT now!

Over the years, the child's interference increased significantly in the second period (period 1: 4.5%, period 2: 8.4%, period 3: 3.3%; $F=4.88$, $p<.01$), mainly by responding alone. The two older groups were more interfering than the group aged 4-6 (age 4-6: 2.7%, age 7-9: 6.2%, age 10-12: 7.7%; $F=4.70$, $p<.01$), mainly by responding together with the GP.

3.4 Discussion

The first objective of this study was to characterize the turn-taking aspects in the doctor-parent-child triad. The results show that the child's control in the medical interview at the general practitioner's is rather limited. In terms of Linell and Luckmann (1991), we have to conclude that both adult participants possess the quantitative as well as the turn-taking control in this kind of medical encounter, whereas the parent seems to be in strong strategic control. The results regarding *quantitative control* differ somewhat from the findings of previous studies on the distribution of conversational participation in medical encounters. Regardless of the dyadic or triadic character of these studies, the physician's contribution was about 60% (Tates & Meeuwesen, 2001), whereas in our study the GP's participation is about 51%. The child's conversational contribution to the medical encounter is limited to 9.4%, whereas the communication between doctor and child (including child-doctor communication) is about 18.2% (see table 3a). This amount of child participation is in accordance with previous studies (Meeuwesen & Kaptein, 1996; Meeuwesen et al., 1998), and somewhat lower than the reported 4% in Pantell's study (1982), but higher than the reported 8% of Aronsson and Rundström (1988), and the 4% of Van Dulmen (1998). These differences can possibly be explained by differences in the setting of the studies (pediatric consultation versus general practitioner's practice), and the mean age of the children involved (Van Dulmen: mean age 5.3; Pantell et al, Aronsson & Rundström, and present study: mean age about 8). By allocating most turns to each other, both adult participants are in strong *turn-taking control*. Analysis of the responses to the various forms of turn allocation, reveals that it is especially the parent who is held to be responsible for the exclusion of the child. Evidently, it is the parent who is in *strategic control* by interfering in more than half of the turns the GP explicitly directs at the child. In the mean time, the child, and especially the older child, tries to enlarge its contribution by interfering in the doctor allocated turns of the parent.

The results reveal a strong relationship between the segment of the consultation and the turn-taking patterns of the participants. Our findings are in line with previous research (Pantell & Lewis, 1993), and show that, although the GP addresses the child frequently in the segment of medical history taking for obtaining information, during the conclusion segment the discussion and advice regarding the treatment are primarily directed at the parent. The physical examination occupies a special place; it is during this segment that the GP most directly addresses the child (e.g. by giving directives such as: 'well, show me your nasty ear'). At the same time, the increase of the child's conversational contribution mainly took place during this phase of the consultation. Ob-

viously, the GP is in strong control during the physical examination, which forces the parent to step aside. This may provide the child more room to communicate directly with the GP. The discrepancy, however, of the GP considering the child old enough for providing information, but not capable of discussing treatment decisions, does not seem to have diminished over the years. This contrasts noticeably with recent research that states that children understand more about medical issues than has generally been assumed, and that even young children are capable of understanding health and illness concepts (Lewis et al., 1984; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998). Nor does this discrepancy seem to match the demands regarding shared decision-making and informed consent (Stewart et al., 1995; Blaauwbroek, 1997; Hart & Chesson, 1998). From the perspective of patient-centred care, the child's voice in the consultation should be as important as the parent's.

This study began with the premise that, in accordance with general developments in doctor-patient communication and changes in adult-child interaction, turn-taking patterns in the doctor- parent-child triad would have changed *over the years.* Our data show that, in the course of time, the (older) child is more actively participating in the medical interview by taking more initiatives towards the GP or GP and parent together, and by more interfering in adult interaction In spite of these changes, the child's participation level in the medical interview is not very high. At the same time, the GP tends to allocate fewer turns to the parent. Contrary to the expectations, these changes were, by and large, restricted to the first two periods. Only the older children showed an increased participation in the third period. We cannot fully account for the decrease in the child's conversational contribution between period 2 and 3. Probably the fact that only 4 years have passed between period 2 and 3 is to be held responsible. We might expect that when period 2 and 3 differ more in time, the development of an increased participation of the child would have been persevered. As our study contains secondary analyses on the data, extended information on variables such as the GP's age or GP's communication-training activities are not available. Consequently, it is impossible to give our opinion upon the possible effects of content and duration of GP's medical education. Contrary to the expectations, the turn-taking patterns of the parent appear to be very constant over the years.

In line with the expectations, the child's *age* appears to be a very strong predictor for the child's participation; older children are taking more initiatives themselves, and at the same time the GP addresses the child more directly as the child's age increases, by allocating fewer turns to the parent. These results sustain previous findings (Pantell et al., 1982; Meeuwesen & Kaptein, 1996; Meeuwesen et al., 1998; Van Dulmen, 1998). Obviously, the variable 'age' tones down the effects of the variable 'time'; the changes over the years apply above all for the group of children aged 10-12.
An important finding of this study is the remarkable difference in the way the adult participants are taking into account the child's age. Apparently, the GP and the parent

differ fundamentally in accommodating their conversational contributions to the child. The GP is considerate to the child's cognitive development, by more directly addressing the older child and allocating fewer turns to the parent as the child's age increases. As for the parent, the child's cognitive development does not seem to play a part at all; parental control is constant over the years, regardless of the child's age.
The increase in the GP's child-orientation is in accordance with a general shift to more patient-centredness in doctor-patient communication, and in line with recent legislation that puts great emphasis on children's active participation in medical encounters. A more direct communication between physician and child contributes to a better relationship in terms of satisfaction and compliance and a better health experience (Pantell et al., 1982; Holtzheimer et al., 1998). In terms of health education too, it is important that the GP guides the child towards management of illness and care; GP's should stimulate children to develop a sense of responsibility for their own health care.
The results concerning the parental control are in line with the findings of Aronsson and Ründstrom (1988), who found examples of strong parental control too. But how are we to explain the lack of change in parental control over the years? One may speculate about the reasons for these parental interferences. There is reason to believe that parental concern plays a key-role. Through the years it has repeatedly been stated that the failure of the doctor to address parental concern may lead to dissatisfaction and poor communication (Korsch et al., 1968; Freemon et al., 1971; Roter, 1989;). Recently, a nation-wide study in the Netherlands revealed that the greatest influence on the decision as to whether to consult a GP for their child was parental concern (Bruijnzeels, 1997). Another explanation is that GP and parent enter the consultation with different expectations and purposes. The GPs aim at acquiring reliable and relevant information and are, in general, aware why children should be consulted directly. The parents, on the other hand, feel responsible for their child, and expect the GP to rely on them in obtaining information about their child's well being. This mismatch of expectations may effect the turn-taking patterns of GP and parent in terms of accommodation.

In evaluating the results of this study, firstly some remarks should be made on the representativeness of the number of selected interviews per period, and on the fact that only four years have passed between period 2 and 3. At the start of this study, only these data were available. It would be important to replicate and extend our findings. More firm differences may be expected when period 2 and 3 differ more in time, and with larger number of interviews.
Second, as this study focussed on quantitative, turn-taking, and strategic control, a number of interesting questions remain unanswered, e.g. the question about the nature and the topic of the turn allocations, and the function of the interferences.
Finally, as in this study only indigenous children were involved, we did not address the issue of ethnicity. In the Netherlands the number of children from ethnic minorities is set to grow (Bruijnzeels, 1997), and one might hypothesize that the observed parental control might be less strong when the child has more command of the language spoken

during the medical encounter than the parent.
Despite these limitations, the results presented in this study, may provide a starting point for a better understanding of triadic medical communication. The Turn Allocation System is specially designed to map sequences of initiatives and responses in the doctor-parent-child triad. Whereas most research on doctor-parent-child communication neglects the implications of a third particiants' presence by restricting the analysis to dyadic interactions between doctor and parent or doctor and child, our study explicitly aims at describing the sequential turn-taking patterns between all three participants. By restricting the analysis to two dyads, the phenomenon of parental control could not have been explored. Our findings show that for a thorough examination of triadic conversations one should not limit the analysis to (one of) the composing dyads.

3.5 Practice implications

The findings of this study do have a number of major implications for medical practice and for health promoting activities advocating improving appropriate behaviour patterns in dealing with illness in children. The challenge facing the physician in triads like this, is to balance the needs of both children and parents. On the one hand, the GP should try to develop appropriate and correct management practices regarding child patients in order to enable them to increase control over their health and medical care. On the other hand the GP is forced to address parental concern, given its vital importance in establishing a good relationship with the parent, and because parental concern seems to be a major trigger for consultation. In addition, the GP should give parents the opportunity to express their expectations, which are likely to differ from children, and will be based on many years experience of health services. Parent's knowledge may also be important for the GP to understand how the child may best be approached (Hart & Chesson, 1998). This requires the GP to provide clarity, for the child as well as for the parent, about the desirable participant roles in triadic consultations. As asymmetry and participant status are not given or constant features of conversation, but open to negotiations between the participants (Roter, 1989; Ten Have, 1991; Van Dijk, 1996; Drew & Sorjonen, 1997), the GP should explain why it is important that the child itself should participate actively in the medical interview. It needs no explanation that in this movement towards an active participation of the juvenile patient the child's developmental stage has to be taken into account. From the perspective of health education and counselling, both parents and children should be informed on the need for children to develop responsibility for their own health and health care. In addition, parents need to be encouraged to stand back and enable their child's voice to be heard.

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Chapter 4

Joking or decision-making? Affective and instrumental behaviour in doctor-parent-child communication

Tates, K., Meeuwsen, L., Bensing, J.M. & Elbers, E.P.J.M. (Submitted for publication). Joking or decision-making? Affective and instrumental behaviour in doctor-parent-child communication.

Abstract

Advocating active child participation in medical encounters is in line with demands for shared decision-making and informed consent. The sparse literature on doctor-child communication, however, conceptualizes children as passive participants and depicts the stereotype of a 'joking' relationship, which is limited mainly to affective behaviour. This descriptive study explores the nature of communication in the doctor-parent-child triad at the general practitioner's surgery. Video-taped observations of 106 medical interviews were analysed in terms of affective and instrumental behaviour. An adjusted version of the Roter Interaction Analysis System (RIAS) was used to analyse the doctor-parent-child triad. The videos, taken over a period of almost twenty years, made it possible to look for the presence of effects over time. The results show that the stereotype of doctor-child interaction as a joking relationship does not hold true. In fact, besides affective behaviour, there was more exchange of instrumental behaviour. The age of the child was positively related to child participation. Time appears to have had a rather limited effect. Whereas GPs accommodated their behaviour to the child's age by displaying more instrumental behaviour towards older children, the nature of parental behaviour appeared to be almost constant. The results are discussed in terms of the relevance for shared decision-making in medical consultations regarding children, and recommendations are given for medical practice and health education.

4.1 Introduction

The development of a patient-centred approach and processes of shared decision-making are central themes in research on medical communication (Stewart et al., 1995; Blaauwbroek, 1997; Van den Borne, 1998; Verhaak et al., 1998). It is increasingly acknowledged that children should also be involved in decisions about their own health care (Alderson & Montgomery, 1996; Rylance, 1996; Hart & Chesson, 1998). Until recently however, children have been mainly conceptualized as passive participants, and their role in medical communication has largely been ignored in research (Tates & Meeuwesen, 2001). This contrasts with studies emphasizing the capability of children to play an active and negotiative role in interaction with adults (Elbers et al., 1992) and their understanding of medical issues (Colland, 1990; Alderson & Montgomery, 1996). More direct communication between physician and child, including discussion about the treatment plan, contributes to greater patient satisfaction and better health outcomes (Colland, 1990; Boon & Stewart, 1998; Holtzheimer et al., 1998). From the perspective of patient-centred care, the interaction between physician and child deserves special attention. While it has been common to restrict the analysis mainly to the doctor-parent dyad, the present study explicitly takes the doctor-parent-child triad as the unit of analysis, and attempts to describe the nature of the communication between doctor, parent, and child at the general practitioner's surgery in the Netherlands.

When seeing a general practitioner (GP), patients have two basic needs: there is the

cognitive need to be informed (the need to know and understand), and the emotional need to be taken seriously (the need to feel known and understood) (Engel, 1988). In concordance with this, the GP is assumed to possess two types of skills: instrumental, or task-related behaviour, and affective, or socio-emotional behaviour. Instrumental behaviour involves problem-solving skills such as asking questions and providing information, while affective communication refers to those aspects needed to establish a therapeutically effective relationship, such as reflecting feelings and showing empathy and concern (Roter, 1989). Depending on the specific needs of the patient and the goal of the interview, a balance between instrumental and affective behaviour characterizes effective communication between doctor and patient (Bensing, 1991; Bensing et al., 1996).

The few studies that have been conducted largely depict the stereotype of doctor-child communication as being restricted to affective behaviour, especially joking and social talk (Freemon et al., 1971; Pantell et al., 1982; Aronsson & Rundström, 1989; Van Dulmen, 1998). Although physicians tend to rely on the child for obtaining information, diagnostic and treatment information are primarily directed to the parent (Pantell et al.,1982; Worobey et al., 1987; Van Dulmen, 1998). In general, the conversational contribution of the child is very limited, between 2% and 14% (Tates & Meeuwesen, 2001). The child's conversational contribution appears to be strongly related to his/her age (Meeuwesen et al., 1998; Van Dulmen, 1998). Older children take more initiatives themselves, and interrupt adult interactions more frequently. In addition, GPs appear to take the child's age into account by addressing an older child more directly and by allocating fewer turns to the parent as the child's age increases (Tates & Meeuwesen, 2000).

Over the past three decades a number of important changes have taken place in doctor-patient communication in general. The development of the patient-centred approach and demands regarding shared decision-making and informed consent evoked a shift in the participants' roles in medical consultation (Stewart et al., 1995; Blaauwbroek, 1997; Van den Borne, 1998). As a result, the doctor-patient relationship has developed from being highly asymmetrical towards being more egalitarian, and patients have become more emancipated and autonomous over the years (DiMatteo & DiNicola, 1982; Ong et al., 1995; Roter, 2000). A parallel can be seen in the interaction between parent and child, in that parenting has become less controlling and authoritarian, and adult-child interactions are increasingly characterized by a greater openness towards the child (De Swaan, 1988; DuBois-Reymond, 1993). Results of a previous study show that the child's control in the medical consultation is rather limited, although, over the years, the participation of the child has become more active (Tates & Meeuwesen, 2000).

This study addresses the following research questions:

1. How can the nature of doctor-parent-child communication be characterized in terms of affective and instrumental behaviour, and in terms of child-centredness and parent-centredness?

2. Does the child's age affect the communication patterns within the doctor-parent-child triad?
3. Have any changes in doctor-parent-child communication taken place over the past few decades?

Regarding the first question, it may be expected that doctor-child interaction is more affective in nature, and is primarily directed at establishing a good relationship. Communication with parents is likely to be more task-related and is assumed to involve more instrumental behaviour, such as information exchange and decision-making. As the child's age increases, an increase in instrumental behaviour is expected between the participants. Regarding the third question, it is expected that in the course of time GPs might have become more child-centred, by taking more account of the child's view. One might assume that there has been an increase in instrumental behaviour between GP and child, e.g. by the GP including the child more in the diagnostic process and the decision-making about choice of treatment.

4.2 Method

Sample characteristics

This study is based on 106 video recordings of medical interviews at the GP's surgery. In the Dutch health care system the GP, who is comparable to a family physician, has a gate-keeping role: patients may only consult a specialist after referral by a GP, and 90% of all complaints are treated by GPs (Van Suijlekom-Smit & Crone-Kraaijeveld, 1994; De Melker, 1997). Thus the GP is the first responsible health care provider, including primary care and preventive care. About one in six consultations involves a child under the age of 16. The videos were drawn from a large collection (n=2500) of medical interviews with patients of all ages, which have been collected since 1975, and held by the Netherlands Institute of Health Services Research (NIVEL). A selection was made based on rigorous demands of technical quality. This was necessary since many of the earlier videos were of poor quality. The application of these and other relevant criteria (a triad of doctor-parent-child, and the age of the child: 4-12 years), supplemented by matching for age, gender and type of complaint of the child patient, resulted in a dataset of 36 videos for the period 1975-1978, 36 videos for 1988-1989, and 34 videos for 1993. The unequal distribution of time between the three periods is a consequence of the availability of data at the start of the project. Data from these three periods allowed a comparison to be made cross-sectionally, but not longitudinally, while the participants differed over the three periods (Hertzog, 1995). In the majority of the consultations selected (n=88), the child was accompanied by the mother. All children had previously seen the GP. Fifty-eight different GPs participated in the study: 22 in period 1 (mean 1.6 consultations), 15 in period 2 (mean 2.4 consultations), and 21 in period 3 (mean 1.6 consultations). Because the majority was male (n=53), it was not possible to assess the effect of physician's gender on the communication patterns in the triad. The mean duration of the consultation was almost 7 minutes.

Coding system

The verbal and nonverbal communication between doctor, parent and child was measured directly from the video recordings. Before coding, the medical interview was divided into segments, viz. 1: the medical history, 2: the physical examination, and 3: the conclusion segment (diagnosis and treatment information). This sequential pattern is characteristic of medical interviews (Byrne & Long, 1976; Roter & Hall, 1992).

Affective and instrumental behaviour

The verbal communication was analysed using an adjusted version of the Roter Interaction Analysis System (RIAS), a well-documented, widely used system in the USA and the Netherlands for coding both doctor and patient communication (Roter, 1989; Bensing & Dronkers, 1992). This system distinguishes instrumental (task-focussed) and affective (socio-emotional) verbal behaviour in doctors and patients, reflecting the two main purposes of the medical consultation: information exchange and the creation of a good interpersonal relationship. The unit of analysis is the verbal utterance, defined as the smallest discernable segment of speech to which a coder can assign a classification. An utterance may vary in length from a single word or clause to a complete sentence. All utterances are categorized in a mutually exclusive way. All behaviour is merged into 16 categories, almost identical for doctor, parent and child (Van Dulmen, 1998). The affective dimension includes social behaviour, agreement, paraphrase, verbal attention, showing concern, reassurance and disagreement (for parent, child and doctor). The instrumental dimension contains asking for clarification, asking questions (medical/ therapeutic), asking questions (psychosocial), giving information (medical/therapeutic), giving information (psychosocial), counselling (doctor), other.

As RIAS was designed and applied to measure the communication of dyads, the application of RIAS in triadic communication was hitherto restricted to the analysis of two dyads, e.g. doctor-parent and doctor-child (Van Dulmen, 1998; Wissow et al., 1998). Since the aim of the present study was to focus explicitly on the triadic communication between doctor, parent and child, a number of adjustments were made, the most important being the notation of the initiative and the allocation of each utterance and for each participant. Additionally, a category 'both' was included, for those cases where the speaker addresses both the other participants simultaneously, or in cases where it is not clear to whom the speaker is talking.

All 106 consultations were coded by two trained observers. The interrater reliability (Pearson's correlation coefficient) of physician categories was between 0.73 and 0.96 (mean 0.89), and of parent categories between 0.66 and 0.98 (mean 0.84). No interrater reliability could be calculated for child categories, because none of these occurred in more than two percent of cases, which is the criterion for calculating the IRR. Factor Analysis of the RIAS categories revealed six clusters, two of which were affective in nature and four instrumental.

Affective behaviour:

1. Social behaviour and partnership building (based on social behaviour, agreements, showing concern, reassurance and paraphrasing)

2. Involvement (verbal attention, disagreement)

Instrumental behaviour:

3. Counselling and advice (medical counselling, psychosocial counselling, other)
4. Medical information exchange (medical questions, information on medical condition and treatment)
5. Psychosocial information exchange (psychosocial questions, information on psychosocial condition and treatment)
6. Consultation structuring and clarification (directions and instructions, requests for repetition of previous statements).

Global affect ratings

In addition to the above-mentioned verbal categories, the affective context of the video-taped interviews, beyond the significance of the words spoken, was rated by means of three affect scales (Roter, 1989; Bensing, 1991). The general affective climate of the medical interview seems to be positively related to good communication and patient satisfaction. The affect scales are warmth, nervousness, and irritation. They were rated on six-point scales (1=low, 6=high) for each participant separately. The interrater reliability of a total of 18 scales (see table 3) was high (ranging from 0.83 to 0.99).

Patient-centredness

GP's child-centredness and parent-centredness were measured separately using five-point Likert scales (1=not at all, 5=very) in order to obtain a global indication of the extent to which the GP took the child's or the parent's view into consideration during 1) the medical history-taking, 2) the conclusion segment, and 3) the extent to which the GP responded adequately to the contributions of child and parent, respectively (Bensing et al., 1996; Van der Pasch & Verhaak, 1998). The interrater reliability (Pearson correlation coefficient) was good (GP's child-centredness 0.79; GP's parent-centredness 0.83).

Statistics

Descriptive statistics were used to report the affective and instrumental behaviour. The RIAS categories were each analysed separately for GP, parent and child as percentages of all utterances and the ratios of affective/instrumental utterances were calculated. This descriptive analysis indicated that the distribution of the data was non-normal. The Kolmogorov-Smirnov Goodness of Fit Test revealed that the variables were equally positively skewed. In addition, non-parametric Kruskal-Wallis analyses yielded the same results as multivariate analyses. While considering the data as near-normally distributed, one-way analyses were performed, breaking down results by period and age. Additionally, multiple range tests (Bonferroni) were performed to compare the groups.

4.3 Results

Affective and instrumental behaviour

Table 1 presents an overview of the participants' contribution in terms of affective and instrumental behaviour as well as allocation. The GPs' contribution to the consultation was 52%, whereas parental and children's contribution were 38.4% and 9.6%, respectively. In general, the ratio of affective versus instrumental behaviour was 41% and 59%. Most of the GPs' behaviour was instrumental, both in interaction with the parent (21.2/33.9*100=63%) and the child patient (8.4/14.4*100=58%). Of the parental behaviour, 56% was instrumental, irrespective of the addressee. The child displayed relatively more instrumental behaviour towards the GP (60%) than towards the parent (51%). About two thirds (65%) of the affective and instrumental verbal interaction occurred between GP and parent, 21% between GP and child, 7% between parent and child. The other behaviour was not directed explicitly to one of the others (7% both directed).

The affective cluster 'social behaviour and partnership building', (social conversation, agreements, concern, reassurance and paraphrasing) occurred the most frequently (39.2%), followed by the instrumental cluster 'medical information exchange' (29.8%). 'Counselling/ advice' and 'consultation structuring and clarification' were represented modestly (13.8% and 12.4%), while 'psychosocial information exchange' and 'involvement' rarely occurred (3.1% and 1.7%).

A closer look at the separate clusters revealed that the GP directed 'social behaviour and partnership building' twice as much to the parent as to the child. Most of the GP's child-directed social behaviour and partnership building took place during the physical examination segment of the interview (1st segment 6%, 2nd segment 7%, 3rd segment 5%, $F=4.19$, $p<.05$). whereas GPs' social behaviour and partnership building towards the parent were relatively more frequent in the other two segments (1st segment 14%, 2nd segment 9%, 3rd segment 13%, $F=15.68$, $p<.001$). The parent directed most of the social behaviour and partnership building to the GP in the conclusion segment (1st segment 10%, 2nd segment 9%, 3rd segment 18%; $F= 45.24$, $p<. 001$).

The greater part of instrumental behaviour involved medical information exchange (29.8%), and counselling and advice (13.8%), and mostly took place between the two adult participants. The GP addressed 76% of medical information exchange to the parent, and mainly during the last two segments (1st segment 7%, 2nd segment 10%, 3rd segment 12%; $F=7.45$, $p<.001$). In addition, 81% of GPs' statements concerning counselling and advice were parent-directed and mainly given in the conclusion segment (1st segment 3%, 2nd segment 3%, 3rd segment 10%; $F=51.36$, $p<.001$). In contrast with the medical information exchange between GP and parent, most exchange of medical information between GP and child took place at the beginning of the consultation, during the medical history-taking and physical examination (1st segment 3%, 2nd segment 4%, 3rd segment 1%; $F=8.48$, $p<.001$). In parallel with this, the child also directed medical information to the GP mostly during these two segments (1st segment 4%, 2nd segment 3%, 3rd segment 1%; $F=13.63$, $p<.001$). With regard to the structure of the con-

Table 1 Affective and instrumental behaviour of GP, parent and child in percentages (17.924 utterances in 106 visits)

	GP ↓ P	GP ↓ C	GP ↓ B	GP total	P ↓ GP	P ↓ C	P ↓ B	P total	C ↓ GP	C ↓ P	C ↓ B	C total	Total
Affective behaviour													
Social behaviour and partnership-building	12.3	5.7	1.0	19.0	14.2[2]	1.8	0.3	16.4[2]	2.5	0.9	0.5	3.9	39.2
Involvement	0.4[2]	0.3	0.1	0.8	0.3	0.4	0.0	0.6	0.1	0.2	0.0	0.3	1.7
Affective total	12.7	6.0	1.1	19.8	14.5	2.2	0.3	17.0	2.6	1.1	0.5	4.2	41.0
Instrumental behaviour													
Counselling/advice	6.7[1]	0.1	0.6[1]	8.3	2.9	0.7	0.3	3.9	0.6	0.6	0.4	1.5	13.8
Medical information exchange	10.4	2.6[1]	0.6[1]	13.7	12.3	0.5	0.1	12.9	2.7[1]	0.3[1]	0.2	3.2[1]	29.8
Psychosocial information exchange	0.7	0.2	0.0	0.9[1]	1.8	0.1	0.0	1.9	0.3	0.1	0.0	0.4	3.1
Consult structuring and clarification	3.4	4.7	1.2	9.3	1.0	1.6	0.1	2.7	0.2	0.1	0.0	0.3	12.4
Instrumental total	21.2	8.4	2.5	32.4	18.0	2.9	0.5	21.4	3.8	1.1	0.6	5.4	59.0
Total GP, parent and child				52.0				38.4				9.6	

Legend: GP=general practitioner; P=parent; C=child; B=both other participants

[1] Effect of age (see table 4)
[2] Effect of time

sultation, half the amount of GPs' structuring utterances were directed at the child, mainly during the physical examination (1st segment 2%, 2nd segment 18%, 3rd segment 2%; F=91.93, p<.001). More than 60% of the parental utterances regarding consultation structuring and clarification were directed to the child.

Global affect ratings

A focus on the affect ratings (table 2) revealed that the GPs showed a fair amount of warmth towards the parent and the child. The parents and children also showed warmth, but less than the doctor.
The participants displayed little nervousness and irritation towards each other.

Patient-centredness

Table 3 shows the means of the global ratings of the GPs' child-centredness and parent-centredness in the medical history segment, in the conclusion segment, and as an overall rating on adequate response.
On all three measures, the GPs' child-centredness was rather low, although in the medical history-taking segment it was higher than in the conclusion segment. The GPs' parent-centredness was on all scores significantly higher than the child-centredness (p<.001), especially in the conclusion segment.

The effect of age

The child's age and the period during which the consultations were recorded showed significant effects on the nature of the medical communication. This did not hold true for participants' gender or type of complaint. An overview will be given of the most salient effects.
Regarding the age of the child, it turned out that the older the child, the more the GP directed instrumental behaviour to the child itself (4-6 years 6.%, 7-9 years 8.5%, 10-12 years 10.5%; F= 4.43, p<. 01), or to child and parent together (both), and less to the parent (4-6 years 25%, 7-9 years 20%, 10-12 years 18.5%; F=5.19, p<.01). In return, older children themselves displayed more instrumental behaviour towards the GP (4-6 years 2%, 7-9 years: 3%, 10-12 years 6%; F=13.50, p<. 001). The nature of the parental behaviour did not appear at all to be affected by the child's age.

Table 4 contains data of the clusters showing significant differences as an effect of the child's age. These effects were constrained to the instrumental categories, and to doctor and child. The exchange of medical information between GP and child intensified as the child's age increased. The older the child, the more GPs' exchange of medical information was directed to the child alone, or to child and parent together. Conversely, older children intensified the exchange of medical information with both the GP and the parent. In addition, the GP directed less counselling and advice to the parent as the child's age increased, and more to child and parent together. The amount of GPs' psy-

Table 2 Global affect ratings (scale 1-6)

	Mean	(std)
Warmth		
GP → child[2]	4.0	(1.2)
GP → parent[2]	4.1	(1.0)
Parent → GP[1]	3.5	(0.9)
Parent → child	3.6	(1.1)
Child → GP	3.0	(1.1)
Child → parent	3.1	(1.1)
Nervousness		
GP → child	1.0	(0.3)
GP → parent	1.0	(0.2)
Parent → GP	1.5	(0.9)
Parent → child	1.2	(0.6)
Child → GP[1]	1.3	(0.8)
Child → parent	1.1	(0.6)
Irritation		
GP → child	1.0	(0.2)
GP → parent	1.1	(0.4)
Parent → GP	1.1	(0.3)
Parent → child	1.2	(0.5)
Child → GP	1.1	(0.5)
Child → parent	1.1	(0.5)

[1] Effect of age
[2] Effect of time

Table 3 GP's child-centredness and parent-centredness (scale 1-5)

	Mean	(std)
Child-centredness		
During segment of medical history-taking [1, 2]	2.5	(1.3)
During segment of diagnosis and treatment information [2]	2.0	(1.2)
Adequate response [2]	2.9	(1.3)
Parent-centredness		
During segment of medical history-taking [2]	3.4	(0.8)
During segment of diagnosis and treatment information [2]	3.8	(0.8)
Adequate response [2]	3.7	(4.0)

[1] Effect of age
[2] Effect of time

cho-social information exchange appeared to be negatively associated with the child's age. Although the exchange of psychosocial information is rare, as we have seen, it seems to be seldom discussed when children become older.

The amount of parental physician-directed warmth was associated with the child's age: parents displayed less warmth towards the GP as their child's age increased (4-6 years X=3.8, 7-9 years X=3.4, 10-12 years X=3.4; F=2.99, p<.05). Younger children expressed more nervousness than older children in interaction with the GP (4-6 years X=1.6, 7-9 years X=1.2, 10-12 years X=1.1; F=4.63, p<.01). The amount of irritation displayed in the doctor-parent-child triad was very low and was not age-dependent.

The degree of GPs' child-centredness during the medical history-taking appeared to be

positively associated with the child's age: the older the child, the more child-centred the GP (4-6 years X=2.2, 7-9 years X=2.5, 10-12 years X=2.9; F=2.95, p<.06).
The length of the interview was not affected by the age of the child (4-6 years 6'38"; 7-9 years 7'04"; 10-12 years 6'56"; n.s.).

Table 4 Instrumental behaviour and age of the child

	Age 4-6 mean	Age 7-9 mean	Age 10-12 mean		
Counselling and advice					
GP →parent	8.6	6.3	5.2	F=5.96	p<.01[1]
GP → both others	0.3	0.3	1.3	F=8.09	p<.001[2]
Medical information exchange					
GP → child	1.5	2.1	4.3	F=10.89	p<.001[3]
GP → both others	0.1	0.6	1.1	F=7.41	p<.001[4]
Child → GP	1.1	2.5	4.7	F=13.58	p<.001[5]
Child →parent	0.1	0.4	0.5	F=3.83	p<.05[6]
Total child	1.3	2.9	5.4	F=14.83	p<.001[7]
Psychosocial information exchange					
Total GP	1.4	0.7	0.5	F=3.67	p<.05[8]

[1] significant at .05 level: age 4-6/age 10-12
[2] significant at .05 level: age 4-6/age 10-12 and age 7-9/age 10-12
[3] significant at .05 level: age 4-6/age 10-12 and age 7-9/age 10-12
[4] significant at .05 level: age 4-6/age 10-12
[5] significant at .05 level: age 4-6/age 10-12 and age 7-9/age 10-12

[6] significant at .05 level: age 4-6/age 10-12
[7] significant at .05 level: age 4-6/age 10-12 and age 7-9/age 10-12
[8] significant at .05 level: age 4-6/age 10-12

The effect of time

The length of the interview increased over the years (5'33" vs 7'22" vs 7'44", F=5.69, p<.01). The participants' overall rate of affective versus instrumental behaviour did not change fundamentally over the years. Only in the second period did parents express less affective behaviour towards the GP (1st period 16%, 2nd period 11%, 3rd period 16%; F=10.59, p<.001). As far as the distinguished clusters are concerned, parents displayed less social behaviour and partnership-building towards GPs over the years, especially in the second period (1st period 16%, 2nd period 11%, 3rd period 3:16%; F= 11.62, p<.001). Conversely, GPs directed less involvement to the parent (period 1: 0.7%, period 2: 0.1%, period 3: 0.2%; F=3.25, p<0.05).
A focus on the group of children aged 10-12 revealed a higher exchange of medical information between GP and older children during the second period. These older children directed more medical information towards the GP (1st period 3%, 2nd period 6%, 3rd period 5%; F=4.98, p<.05). While at the same time the GP intensified the exchange of medical information with the child (1st period 3%, 2nd period 6%, 3rd period 5%; F=5.23, p<.05) and directed more consultation-structuring utterances to the child (1st period 4%, 2nd period 7%, 3rd period 3%; F=3.31, p<.05). All the other categories or age groups showed no changes over time.

The GP demonstrated more warm feelings towards both child (1st period X=3.5, 2nd period X=4.5, 3rd period X=4.0; F=6.09, p<.01) in the second period, and parent (1st period X=3.5, 2nd period X=4.3, 3rd period X=4.4; F=10.22, p<.001) in the second and third period. Also the parent showed more warmth to the GP over time (1st period X=3.1, 2nd period X=3.6, 3rd period X=3.9; F=7.27, p<.001). Regarding the other feelings, no changes occurred over the three periods.
On all measures (see table 3), the GP became significantly more child-centred and parent-centred in the second period, compared with the first period (level of significance varying from p<.05 to p<.001).
Overall, there seemed to be a number of changes in the second period, but they were mostly not consolidated later on. In sum, the effect of time on the nature of the medical communication was fairly small.

4.4 Discussion

Affective and instrumental behaviour in doctor-parent-child communication

Detailed analysis of the doctor-parent-child communication of 106 medical interviews confirms that child participation in medical encounters is rather limited. The interaction in the doctor-parent-child triad is dominated by both adult participants, which is in line with previous findings (Meeuwesen & Kaptein, 1996; Tates & Meeuwesen, 2000). Contrary to the hypothesis, all three participants involved display mainly instrumental behaviour. Physician-child interaction appears not to be primarily restricted to the affective domain. Both GP and child display mainly instrumental behaviour towards each other, and the greater part of GPs' affective behaviour appears to be directed to the parent. This contrasts with previous findings that stated that most of physicians' affective behaviour appears to be child-directed, and that children's contribution to medical communication appears to be especially affective in nature (Freemon et al., 1971; Pantell et al., 1982; Aronsson & Rundström, 1989; Van Dulmen, 1998; Wissow et al., 1998).
The specific communication profiles of the participants in the three major segments of the interview varied according to their function. During medical history-taking, there is a great deal of social behaviour and partnership-building between the GP and the parent, and, in interaction with the child, the GP tells jokes and laughs in order to relieve tension. As for discovering the reason for the child's attendance, there is a fair amount of exchange of medical information between physician, parent and child. By directly addressing the child, the GP is apparently considering the child patient capable of providing medical information. In the physical examination segment the exchange of medical information between GP and child, as well as between child and GP, is intensified. The GP also directs a fair amount of consultation-structuring utterances in terms of directions and instructions to the child ('Well, show me your nasty ear'). Conversely, in the conclusion segment, the GP resumes his orientation towards the parent by exchanging more medical information and by displaying social behaviour and partnership-building. By directing more than 80% of the counselling and advice to the

parent, the GP obviously does not consider the child capable of discussing decisions on treatment. The results of these segment-related profiles are validated by the demonstrated increase in parent- centredness of the GP, and are consistent with earlier findings (Pantell & Lewis, 1993; Van Dulmen, 1998; Wissow et al., 1998), which state that the dominant communication pattern in pediatric visits is one that includes children in information gathering, but excludes them from management and diagnostic information.

In line with the second hypothesis, the older the child, the more instrumental the behaviour of both GP and child. Parental behaviour and the affective behaviour of GP and child appeared to be unaffected. The GP involves the older child more directly in the medical encounter by an increased exchange of medical information towards the child alone or towards child and parent together, and by a decrease of parent-directed counselling. The older child itself enlarges her contribution to the consultation by intensifying the exchange of medical information with both the GP and the parent. The increase of GPs' overall child-centredness in the case of older children validates these RIAS results. Our findings of intensified communication between GP and child as children grow older are supported by earlier studies (Pantell et al., 1982; Meeuwesen & Kaptein, 1996; Van Dulmen, 1998; Tates & Meeuwesen, 2000), and show that children can play a far more active role in taking initiatives when negotiating the aim and process of the interaction than has previously been assumed (Elbers et al., 1992; Hoogsteder, 1995). This is an important finding from the perspective of child-centred care and increased demands for shared decision-making and informed consent.

The hypothesis that, because of the growing emphasis on the child's own responsibility, the GPs would have become more child-centred as an effect of time, was confirmed when comparing the first and second period. As far as changes in specific communication behaviour took place, they were restricted to the group of older children, where more exchange of medical information was initiated by both GP and child during the second period (the eighties). In addition, the GP directs more consultation structuring utterances to the child. These changes do not continue in the third period (the nineties).

Stereotype

Considering the results, we are led to the conclusion that the stereotype of doctor-child interaction as a joking relationship implies an underestimation of the differentiated nature of doctor-parent-child interaction. Evidently, the child's age appears to have a substantial effect on child participation. In the case of 10-12 year old children in particular, the interaction between GP and child has the potential to develop from a joking relationship towards a situation in which shared decision-making might no longer be a misnomer. These age-related results stress the importance of taking into account the child's cognitive development and not to generalize the findings from studies with different samples regarding the child's age.

We would like to put the stereotype of doctor-child interaction as a joking relationship

in a different perspective. Both affective and instrumental behaviour are exchanged between doctor and child (and parents, of course). Affective behaviour influences the quality of doctor-patient relationships and facilitates the mutual process of information exchange. In view of the considerable amount of GPs' child-directed instrumental behaviour, especially in older children, it is concluded that doctor-child communication implies more than the maintenance of a joking relationship. GPs' communication style in interaction with the child may best be described as both caring (creating a good relationship by affective behaviour) and curing (helping the child to solve his health problem by instrumental behaviour) (Bensing, 1991). GPs are obviously striving for the goal of talking *with* children instead of talking *at* children. Treating the child as an active participant in medical communication is consistent with the increasing demands for shared decision-making and informed consent (Stewart et al., 1995; Blaauwbroek, 1997; Van den Borne, 1998). This preference of increased child participation is also in line with the development of children as fellow citizens (De Winter, 1996). GPs in our sample aspire to create a good interpersonal relationship and, in the case of older children, to exchange medical information. The aim of shared decision-making, however, is not attained. Sharing information and sharing decisions are not synonymous; they are separate goals within the consultation, with information sharing being prerequisite to shared decision-making (Ong et al., 1995; Charles et al., 1997). The age-dependent instrumental behaviour during the treatment phase of both GPs and children themselves emphasizes the potential for reaching the goal of shared decision-making. The older the child, the more the exchange of medical information is intensified by both GP and child, and the more the GP involves the child in the process of decision-making by directing counselling and advice to parent and child together instead of only to the parent.

A remarkable finding is that while the GP accommodates his/her behaviour to the child's age, the parental behaviour appears to be almost constant (see also Tates & Meeuwesen, 2000). The GPs' accommodative behaviour is in line with Street (1992) and Wissow et al.(1994), who stress that pediatricians do vary their communication style in response to patient characteristics. Why do parents seem to be insensitive to the changing needs and capabilities of older children? Parental concern may be a possible explanation for this non-accommodation. Lack of familiarity with the importance of active child participation in the medical interview might be another reason. Parents may regard themselves as the appropriate spokesman in medical communication, because they consider issues of children's health and illness as their parental responsibility. Possible different role expectations of GPs and parents and the consequences for active child participation in medical communication will be elaborated elsewhere (Tates et al., submitted).

Methodological reflections

This study gives rise to several methodological comments. Obviously, the strength of this study is that insight into the child's participation in the medical interview and the

results of differences in adult accommodation have only become manifest by adapting the RIAS observation system to *triadic* analysis. Conventional dyadic RIAS analyses are bound to fail in fully exposing the interactional dynamics of triadic interactions. Restricting the analysis to the dyadic interactions between doctor-parent and doctor-child, ignores the consequences of a third participant's presence. This study reveals the possibilities of extending the RIAS, as the system most frequently used to analyse doctor-patient communication, to triadic applications.

As far as the reliability of RIAS is concerned, we already mentioned that it was satisfactory to good. Referring to the validity it can be said that RIAS measures just one level of communication, the affective and instrumental behaviour, which is restricted to frequential analyses. It is advisable to present case studies in order to further unravel the specific interactional patterns of the complex triadic communication. RIAS could then be applied in combination with qualitative methods and/or sequential analysis (Roter, 2000). Results regarding turn-taking patterns and role identities are elaborated elsewhere (Tates & Meeuwesen, 2000; Tates et al., submitted). Referring to the validity of the measures of GPs' patient-centredness, Mead and Bower (2000) point to the complications and low validities, because patient-centredness can be operationalized in different ways. A degree of caution is called for in interpreting the results on these measures. But the fact that the results affirmed the RIAS findings can be taken as an indication of a quite acceptable validity level.

This study focused on a description of the details of verbal behaviour. The question of whether differences in verbal behaviour have an impact on the outcome of the consultations will have to be answered elsewhere. Stiles (1989) rightly warns about the pitfalls of process-outcome correlations. On the basis of this study, one can only conclude that RIAS offers a useful framework for describing the process of doctor-parent-child communication.

The disappointing result of the effects of time on the communication patterns may be due to the small number of consultations for each period and their unequal division. At the start of this project, other data were not available. Another explanation is that the declining attention to good communication in the educational programs for medical students in the eighties made its negative effect felt in the nineties. Whatever the case, we recommend that future research seeks to replicate with a greater sample, and more equally divided periods.

Practice implications

The present findings have several implications for medical practice. From the perspective of effective communication in the doctor-parent-child triad and in terms of education and counselling of both child and parent, GPs should provide information about the benefits of active child participation in medical communication. With information-sharing being a prerequisite to decision-making, GPs should strive to elicit children's perceptions of their illness and expectations associated with the disease in order to achieve an effective information exchange. As a more direct communication between

doctor and child improves care in terms of satisfaction, compliance, and better health experience (Pantell et al., 1982; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998), physicians should aim at enhancing child participation in the diagnostic and treatment phase. In addition, merely by addressing (older) children directly and encouraging child participation, physicians may provide both children and parents with an important message about the desirable mode of interaction in medical encounters, and emphasize the child's identity as an autonomous participant. A first step in reaching the goal of shared decision-making with children is to establish a conducive atmosphere in which both child and parent feel that their views are valued and needed. Paying attention to these issues will, hopefully, contribute to more effective communication between GP, parent and child.

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Chapter 5

'I've come for his throat': Roles and identities in doctor-parent-child communication

Tates, K., Meeuwesen, L., Elbers, E.P.J.M. & Bensing, J.M. (Accepted for publication pending minor revisions) "I've come for his throat": Roles and identities in doctor-parent-child communication. Child: Care, health and development.

Abstract

Our previous studies on doctor-parent-child communication at the general practitioner's surgery showed that GP and parent differ fundamentally in the way they enable or constrain child participation. Whereas GPs were obviously striving for active child participation in medical interactions, parents would appear to restrict child participation by interfering in doctor-child interactions, irrespective of their child's age. The question as to how to explain these differences is at the core of the present study. The aim of this study is to show how the participants in this triad display their orientation to their institutional roles and identities through verbal and nonverbal behaviour; how they collaboratively co-construct the course of action; and how these discursive constructions structure the ongoing interaction. Our analysis shows that although GP and parent initially show incongruent orientations toward child participation, in the further course of the encounter all three participants jointly establish a situation in which child participation appears to be rather an exception. We must therefore conclude that parental speaking for the child is, in a way, institutionally co-constructed; parents take their responsibility, which is hardly ever questioned by children, and GPs ratify this behaviour by refraining from meta-communicative comments and by aligning with the parent in the course of the interaction. The results are discussed in terms of possibilities for child participation and implications for medical practice.

5.1 Introduction

With the development of patient-centred medicine, research on medical communication has focussed particularly on the beneficial effects of an active patient participation in processes of information-sharing and decision-making and on the changing participant roles in medical encounters (Stewart et al., 1995; Ong et al., 1995; Blaauwbroek, 1997; Van den Borne, 1998; Verhaak et al., 1998; Roter, 2000). In line with the changed position of the patient, it is increasingly being acknowledged that children too should be involved in decisions about their own health care (Alderson & Montgomery, 1996; Rylance, 1996; Hart & Chesson, 1998). A strong argument for child participation in medical encounters is that a more direct communication between doctor and child improves health care in terms of satisfaction, compliance, and better understanding (Pantell et al., 1982; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998; De Winter et al., 1999). However, the sparse research on child participation in medical encounters states that in actual practice the child's contribution is rather limited, with the medical interaction being dominated by the physician and the accompanying parent (Tates & Meeuwesen, 2001).

In one of our studies on doctor-parent-child communication within the setting of general practitioner's surgeries in the Netherlands, we examined the turn-taking patterns in the doctor-parent-child triad, where children aged between 4 and 12 were the patients (Tates & Meeuwesen, 2000). The interaction appeared to be dominated by both

adult participants, and child participation was restricted to about 9%, which is in line with the image depicted in other research on child participation in medical encounters. One unexpected finding in this study was the difference in the way the GP and the parent accommodated their contributions to the child. Parents tended to control the interaction in the triad verbally by interfering in most doctor-child interactions, regardless of the child's age. The physicians, on the other hand, appeared to be more considerate to the child's cognitive development by addressing the older children (aged 10-12) more directly and allocating fewer turns to the parent as the child's age increased (Tates & Meeuwesen, 2000). A second study (Tates et al., submitted), exploring the nature of these doctor-parent-child interactions applying the Roter Interaction Analysis System (Roter, 1989), confirmed this difference in adult accommodation. Whereas the GP attempted to facilitate child participation by involving the older child more directly in the exchange of medical information, parents did not accommodate the nature of their contributions as the child's age increased. This parental authoritarian style in interaction with the child may be characterized as under-accommodated along definitions of control and discourse management (Giles & Coupland, 1991).

Viewed from the perspective of child participation, it is apparent that in our studies GP and parent differ fundamentally in the way they enable or constrain child participation. By taking into account the child's age, GPs are obviously striving for active child participation in medical communication. Parents, on the other hand, would appear to restrict child participation by interfering in doctor-child interactions, irrespective of their child's age. The question as to how to explain the differences in the way GP and parent establish a relevant context for child participation is at the core of the present study. It is hypothesized that dissimilarities in the participants' expectations and suppositions regarding the character of the medical interaction and the various participant roles explain the difference in the extent to which the physician and the parent enable child participation. The adult participants might differ in their orientations to tasks and roles they expect to be appropriate in this type of triadic medical interaction. Parents, for example, may feel responsible for their child, and expect the doctor to rely on them to obtain information about their child's well-being.

The participants' expectations and underlying motives can be analysed in different ways. The prevailing socio-psychological approach is to question people's views and expectations through questionnaires or interviews. In the present study, however, we take a interactional sociolinguistic approach and focus on the ways in which identity and roles are constructed through language and in social interaction (Goffman, 1981; Heritage, 1997; Antaki & Widdicombe, 1998; Zimmerman, 1998; Hall et al., 1999). We can gain access to the participant roles by analysing the participants' verbal and nonverbal interaction during the medical encounter. The aim of this study is to show how participants in the setting of the general practitioner's surgery display their orientation to their institutional roles and identities through verbal and nonverbal behaviour; how they collaboratively co-construct the course of action; and how these discursive constructions structure the ongoing interaction.

Co-construction of roles and identities

The theoretical background of the study derives from interactional sociolinguistics, a research tradition which combines a functional and structural approach to discourse with the emphasis on language as indexical to social, cultural, and personal meaning (Schiffrin, 1994). In his view on language as a socially and culturally constructed symbol system, Gumperz (1982) introduced the concept of *contextualization cues*; aspects of participants' verbal and nonverbal behaviour that function as signalling mechanisms about the framework within which messages are to be understood. Contextualization cues provide information allowing participants to interpret the meaning of what is said, and thereby display social identity and relationships between participants.

As in conversation analysis, interactional sociolinguistics focusses on turn-taking and sequence organization in order to expose how communication behaviour is produced and understood as responsive to the immediate course of interaction. Within this argument, all talk is *sequentially relevant* and *sequentially implicative*; the contributions of each participant to the interaction are shaped by what was just said or done, and are understood in relation to what came before (Roger & Bull, 1988; Pomerantz & Fehr, 1997; Silverman, 1998). Research on institutional interaction attempts to characterize how identity construction is accomplished interactionally and sequentially in a particular institutional context, such as the medical encounter (Goffman, 1981; Drew & Heritage, 1992; Drew & Sorjonen, 1997; Heritage, 1997; Silverman, 1998; Sarangi & Roberts, 1999). Participants display their orientations to institutional roles and identities through their use of linguistic devices. The selection of particular descriptive terms, such as person reference, lexical choice and grammatical forms is indicative of the participants' understanding of the situation they are in (Drew & Sorjonen, 1997). In their use of personal pronouns, people may produce a clue about participant roles and display inclusion or exclusion of a person, for example by using the first plural pronoun *we* to denote a joint responsibility. Another clue about participants' orientations to institutional talk is the use of meta-communicative expressions by which people refer overtly to the way they organise their interaction with the others. Thus, by analysing institutional talk it is possible to reveal how the participants orient themselves to their institutional roles and identities during the interaction (Grimshaw, 1994; Sarangi & Roberts, 1999). This dynamic view on roles and identities as discursively produced challenges traditional role theory, which ignores the interactional production and regards social roles and identities as exogenous and fixed properties of the participants (Widdicombe, 1998; Roberts & Sarangi, 1999). Instead of this deterministic view on roles, we want to stress the interactional and dialogic aspects of roles and identities, achieved and maintained through the details of language use.

Studies on institutional interaction have emphasized the goal-oriented character of medical interaction; participant roles are shaped by institutional procedures (Byrne & Long, 1976; Drew & Heritage, 1992; Roter & Hall, 1992; Drew & Sorjonen, 1997; Sarangi & Roberts, 1999). Therefore, in our analysis we follow the standard sequencing of the medical consultation, in terms of the three different phases (history-taking, physical

examination, diagnosis and advice). Within this argument a descriptive analysis is presented, focussing on three aspects of verbal behaviour in doctor-parent-child interactions. During the medical history-taking we focus on (1) discovering the reason for attendance, and on (2) the global and specific problem definition; in addition we focus on (3) the allocation of diagnosis and treatment information during the last segment of the consultation.

Discovering the reason for attendance

Usually, the medical encounter opens with an exchange of greetings, and an arrangement of the seating. Then the physician asks the patient to describe the reason for the attendance (Byrne & Long, 1976; Roter & Hall, 1992). Heath (1981) emphasizes the special character of openings in medical conversations; they are sequentially implicative (in the sense that invitations set the addressee's response) and relationally affirmative (in the sense that openings (re)define the relationships between participants). In addition, developmental studies have shown that implicit and explicit assumptions regarding the character of the interaction are quite a constitutive factor for child participation (Elbers & Kelderman, 1994; Elbers & Streefland, 2000). Children's participation does not only depend on their communicative competence, but also on their awareness of how the interaction will proceed. As we are interested in how identity alignment in the opening phase in triadic medical encounters is oriented to establish a relevant context for child participation, we examine to whom the GP addresses the invitation for describing the reason for attendance. The assumption is that the opening of the consultation is crucial for setting 'the mode of interaction' and the participants roles within the triad.

Global and specific problem definition

As we are interested in what way the allocation of the GP's invitation to describe the problem is related to the opportunities for the child to participate in the further course of the triadic interview, the next step of the analysis is to look at which participant responds to the invitation. When the child or the parent has established this 'global problem definition', the GP starts a chain of questions, elaborating on the formulation of the problem. In addition, we will analyse with which participant the doctor elaborates on the complaint. We chose the notion of 'specific problem definition' to denote the person who ultimately provided this information.

Diagnosis and treatment information

Our previous studies on doctor-parent-child communication revealed that physicians tend to rely on the child for obtaining medical information, but that they direct diagnostic and treatment information primarily at the accompanying parent (Tates & Meeuwesen, 2000; Tates et al., submitted). These findings are in accordance with research in other medical contexts where a child is involved, such as pediatrics and family care (Tates & Meeuwesen, 2001). In the present study, we are interested whether set-

ting the mode of interaction at the beginning of the encounter, by encouraging children to formulate the reason for attendance, leads to more active child participation in the course of the encounter, in terms of the GP more actively involving the child in the diagnosis and treatment segment.

5.2 Method

Sample characteristics

The study is based on 106 video recordings of doctor-parent-child interactions at general practitioner's surgeries in the Netherlands, with the child visiting the GP for temporary illness and minor complaints. The video recordings were drawn from a large collection (n=2500) of medical interviews, collected and held by the Netherlands Institute of Health Services Research (NIVEL), and contained a comparison over three periods: 1975-1978 (n=36), 1988-1989 (n=36), and 1993 (n=34). All participants differed over the three periods, were of Dutch origin and all children had previously seen the GP in question. In the majority of the interviews the child was accompanied by the mother (n=88). The child was between 4 and 12 years of age (mean age 8), and boys and girls were equally represented. Fifty-eight GPs participated in the study, the majority being male (n=53).

Coding procedures

The analyses were conducted on the basis of extensive transcripts of all 106 consultations. Non-verbal communication was noted as far as it was relevant for the coding (especially eye-contact). First, for each consultation we determined the exact formulation of the invitation to describe the reason for attendance. The sequential environment of the utterance was of vital importance; utterances were only labelled as invitations in those cases (one of) the other participant(s) responded with a problem formulation. This allowed us to distinguish between real invitations and so-called greeting substitutes (Schegloff, 1986). For example, when participants responded with 'I'm fine, thank you' to the utterance 'How are you?', this was regarded as a greeting substitute because the utterance did not initiate the medical interaction. We then determined which participant formulated the invitation and to whom the invitation was allocated, as indicated by e.g. first-naming, pronoun form and politeness form. It should be noted that the Dutch informal second person singular pronouns *je* and the formal form *u* (comparable to the distinction between the French *tu* and *vous,* and the German *Du* and *Sie*), as well as the second person plural form *jullie,* are all translated by *you* in English. In addition, we determined which participant responded to the invitation with the formulation of the global problem definition and the specific problem definition respectively. Finally, we determined to which participant the GP directed diagnosis and treatment information during the last segment of the consultation. Again, we made accurate notes on the characteristics of the formulations in terms of person reference, lexical and grammatical choice and politeness form.

The interrater reliability, based on ratings of 13 consultations by two independent raters, assessed by Cohen's Kappa was good (invitation: 0.88; global problem definition: 0.81; specific problem definition: 0.83; advice: 0.87).

5.3 Results

Discovering the reason for attendance

Our first focus of interest was to determine which participant the GP invited to describe the reason for attendance. As shown in table 1, in 79% of the 106 consultations the GP explicitly formulated an invitation to describe the reason for attendance. In 33% of the consultations the GP directly invited the child to formulate the reason for attendance, and in 16% the invitation was directed at the child and parent together. Therefore, in a total of 49% of the consultations the GPs actively attempted to involve children during the opening sequence. In addition, in 30% of the consultations the GP's invitations were explicitly parent-directed. In 5% of the consultations it was the parent who invited the child to formulate the complaint, and in 16% there was no invitation at all, due to the parent's self-initiated presentation of the child's health problem. The child's age appeared to be strongly related with the GP's allocation of the invitation; children aged 10-12 were invited to describe the reason for attendance more often, and fewer invitations were parent-directed (Spearman's rho: -.32, p<.01). Over the three periods investigated, children were more often invited by the GP (period 1: n=7, period 2: n=13, period 3: n=15; Spearman's rho: -.35, p<.01), and fewer invitations were directed at the parent.

Table 1 Invitations to formulate the problem definition

	Invitation GP → C		Invitation GP → P		Invitation GP → B		Invitation P → C		None		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Age 4-6	10	9	16	15	5	5	1	1	5	5	37	35
Age 7-9	8	8	11	10	6	5.5	2	2	6	5.5	33	31
Age 10-12	17	16	5	5	6	5.5	2	2	6	5.5	36	34
Total	35	33	32	30	17	16	5	5	17	16	106	

GP= general practitioner C= child P= parent B= both other participants

The allocation of the invitation was strongly reflected in the GP's lexical choice. When inviting the child to describe the reason for attendance, GPs often used the child's first name or the second person pronoun form. Some child-directed examples:

- *John, tell me why you're here* (you = 2nd person singular informal form *je*)
- *How are your ears?*

- *OK Susan, can you tell me what the problem is?* (you = 2nd person singular informal form *je*)

The parent-directed invitations were marked quite differently:

- *So, what can I do for you?* (you = 2nd person singular formal form *u*)
- *What seems to be wrong with her?*
- *So, you're here for Linda* (you = 2nd person singular formal form *u*)

Whereas the invitations directed at both child and parent reflected the ambiguity of the addressing:

- *Right, what seems to be the problem?*
- *Tell me then, why have you come to see me?* (you = 2nd person plural form *jullie*)

Remarkably, our data hardly contain any meta-communicative expressions regarding the desirable participant roles during the invitation. There were only a few examples of the GP's use of meta-communicative statements when inviting the addressee to describe the reason for attendance:

- *It's OK if your mum tells me*
- *Paul, do you want to tell me or shall we let your mum do it?* (you = 2nd person singular informal form *je*)

This finding contrasts sharply with the parental use of meta-communicative statements in 4 of the 5 consultations in which the parent invited the child to describe the reason for attendance:

- *Tell the doctor why we're here, Mark, tell him what's wrong with you*
- *You can tell him*

Responses to the invitations

As we were interested in whether the allocation of the invitation influenced the responses in terms of formulation of the global and specific problem definition, and the direction of GP's diagnosis and advice, our next step was to examine which participant responded to the GP's invitation and how the participants co-constructed the further course of the interaction. We describe these results in terms of patterns following the different types of invitations to describe the reason for attendance.

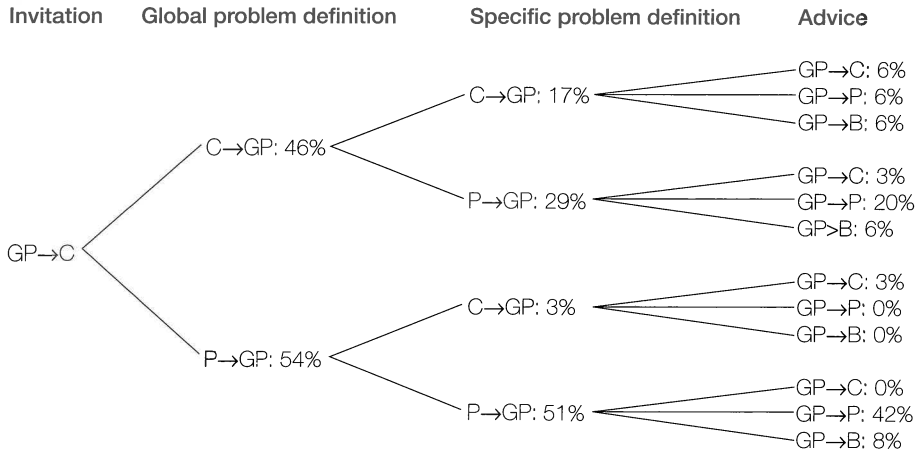
1) Patterns following GP's child-directed invitations

Firstly, we examined the responses to the child-directed invitations by the GP to describe the reason for attendance. Figure 1 shows that in 46% of those consultations the child responded with a global problem definition, and in 20% (17%+3%) with the specific problem definition. In only 6 consultations (17%) was it the child who ultimately formulated both the global and the specific complaint. As the child's age increased, children more frequently formulated the global problem definition themselves (Spearman's rho: -.39, $p<.01$), as well as the specific problem definition (Spearman's rho: -.30, $p<.01$) instead of their parents.

As we were interested in how the role constructions in the first segment of the consultation would guide the ongoing interaction, we examined to whom the GP finally di-

rected diagnosis and treatment information in the child-directed consultations. In only 12% of these consultations did the GP direct these statements explicitly to the child; all of them were aged 10-12 (Spearman's rho: -.25, p<.01). In 20% the GP directed diagnosis and treatment information to both child and parent together, whereas in the other 68% of the consultations all diagnosis and treatment information appeared to be parent-directed.

Figure 1 Patterns after GP's child-directed invitation (n=35)



As shown in figure 1, the most dominant pattern following the GP's child-directed invitations is that, although both child and parent had about equal opportunity to formulate the global problem definition, the specific problem definition as well as the information exchange concerning diagnosis and treatment were accomplished in the adult interaction between doctor and parent. This pattern appeared to be less dominant as the child's age increased (Spearman's rho: -.29, p<.01).

Fragment 1 shows an example in which the GP invites a 12-year old girl to formulate the problem definition:

Fragment 1

Consultation no: 53 (GP=general practitioner, P=parent, C=child; 12-year old girl)

1 GP→C: What have you come to see me about? (.) tell me (you= 2nd person singular informal form *je*)
2 C→GP: ((turns on her chair)) yes (.)
3 I've got a lump on my foot
4 GP→C: a lump on your foot
5 C→GP: yes (.) on the ALONG my foot

6 GP→C: sorry ?
7 P→GP: here, on the SIDE
8 C→GP: on the side
.....
10 GP→C: tell me something about this, eh, lump
11 C→GP: yes (.), ehh (.)
12 something suddenly started to hurt
13 and when I looked I saw this strange LUMP
14 GP→C: how long have you had it?
15 C→P: I think about a week, isn't it? ((looks at mother))
16 P→C: ((nods her head))
.....
GP→C: ((examines the foot and explains his diagnosis to the child))
29 GP→C: all you have to do is ((focusses only on the child when talking about the treatment))

In lines 2-5 the child defines the global problem definition, after the explicit invitation of the GP. The mother remains silently in the background, and it is only at line 7, when the GP does not quite understand the girl's utterance 'along', that the mother reacts to her child's lexical realisation and enters the conversation. After the mother's reformulation of her child's statement, the GP resumes his orientation to the child, and GP and child collaboratively construct the specific problem definition. After the GP's question about the duration of the complaints in line 14, the child seeks (non)verbal support from her mother (line 15). The mother nonverbally acknowledges her child's answer, and in lines 29 the GP directs all the information concerning diagnosis and treatment explicitly at the child. This child-directedness is reflected in the GP's lexical choice when addressing the child in line 29 with the second person singular informal pronoun form 'you' (*je*). Obviously, in this encounter GP and parent agree on the child's participant status; the GP actively tries to increase child participation by co-constructing the global as well as the specific problem definition and diagnosis and treatment information with the child, whereas the parent implicitly supports child participation by remaining silent in the background and providing support when necessary.
However, in our data this picture of both adult participants establishing a relevant context for child participation appeared to be something of an exception. A more recurrent example of how the course of interaction developed after the GP invited the child to formulate the problem definition is shown in the following fragment.

Fragment 2

Consultation no: 10 (GP=general practitioner, P=parent, C=child: 10-year old girl)
1 GP→C: Hello Rose, tell me what's up ((looks at Rose))
2 C→GP: (.)

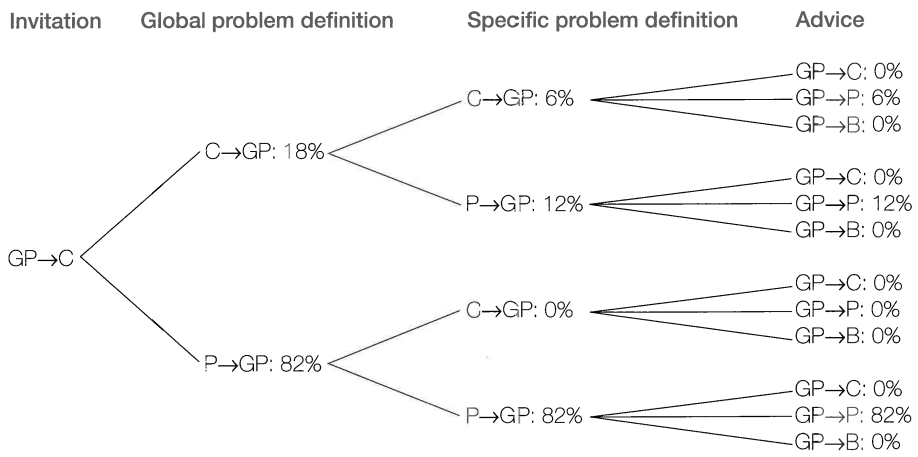
3	P→GP:	well (.), Rose hasn't been feeling well for quite a long time
4	GP→C:	oh ((is looking at Rose))
5	P→GP:	she has a sore throat
6	C→GP:	I have a sharp PAIN over here ((points to somewhere on her head))
7	P→GP:	yes (.) and last week
8	C→P:	last WEEK?
9	P→C:	Let MUM have her say!
10	GP→P:	((folds arms and smiles, looks at mother))
11	P→GP:	((continues with global problem definition))
12	GP→P:	And how long has it been like that?
13	P→GP:	those pains in her head, about two weeks
14	GP→P:	and has she had any high temperatures?
15	P→GP:	((goes on to formulate the specific problem definition))
16	GP→P:	has she got a cough as well?
.....		
19	GP→P:	well (.), I'd like to suggest the following (.)
20	GP→P:	I'll give her some nose drops for a week
21		and I'll also give her a tablet you can dissolve in water

This fragment shows how, right from the start of the GP's invitation to the child to formulate the problem, the parent intervened in the interaction. Despite the GP's initial effort to draw the child into the interaction (in line 1 by addressing her by her first name, and by the implicit acknowledgement towards the child to continue the global problem definition in line 4), the mother took over the role of respondent from the beginning of the encounter. The mother shows her reluctance towards child participation in line 9 by means of a sharp intervention, claiming that the girl should let her mum do the talking. Noteworthy is line 10; the nonverbal behaviour of the GP leaves the mother space to continue her global problem definition in line 11. Thereafter the GP accepts the parental role of speaking for her child; this shift in alignment is reflected in the GP's lexical choice; the use of the third person pronoun form to denote the girl (lines 14, 16, 20, and 21) establishes a new course of the interaction which emphasizes the mother's role as a respondent for her child. In the further course of the interaction, the child is cast as a non- addressed recipient, and parent and GP co-construct a dyadic interaction, with little space for the child to join the interaction.

2) Patterns following GP's invitations directed to child and parent together

In addition to the responses to the child-directed invitations to describe the reason for attendance, figure 2 shows the responses to the invitations the GP directed at both child and parent together.

Figure 2 Patterns after GP's both-directed invitation (n=17)

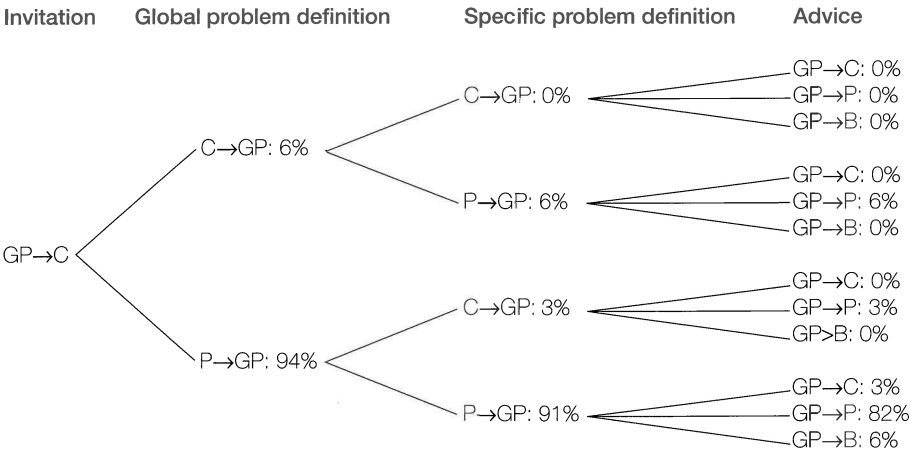


The ambiguity of this approach resulted in a lower degree of child participation; in 18% of the consultations the child formulated the global problem definition, and in only 6% of consultations did the child provide the specific problem definition. In all these consultations the GP explicitly addressed information regarding diagnosis and treatment solely to the parent. No correlation was found between both-directed invitations and the child's age or the periods investigated.

3) Patterns following GP's parent-directed invitations

The opportunities for child participation diminished in those cases where the GP explicitly invited the parent to formulate the problem, as shown in figure 3.

Figure 3 Patterns after GP's parent-directed invitation (n=32)



In these consultations 94% of the global problem definitions were established by the parent, as were 97% of the specific problem definitions, and 91% of the information concerning diagnosis and treatment appeared to be parent-directed. This dominant pattern diminished slightly over the three periods we investigated (Spearman's rho: -.30, p<.01) and with older children (Spearman's rho: -.29, p<.01). The following fragment provides an example of this pattern:

Fragment 3

Consultation no: 80 (GP=general practitioner, P=parent, the patient is a 5-year old boy)

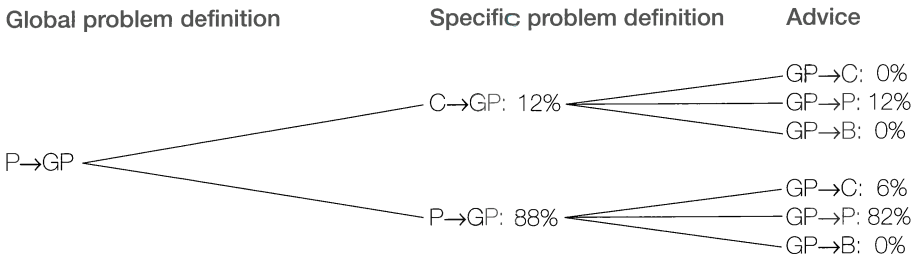
1	GP→P:	right (.) tell me
2	P→GP:	we won't be long (.) he's been really ill (.) FLU
3	GP→P:	right
4	P→GP:	and I've come for some kind of pick-me-up or something
5		we can't go on like this (.) YEH, he's just like some kid from the third world
6	GP→P:	right (.)
7	P→GP:	some minerals or vitamins or something
8		something you KNOW will do him good
9	GP→P:	can (.) may I take a look?
10	P→GP:	yes ((the mother lifts the boy's shirt up))
11		((GP examines the boy))
12	P→GP:	today's the first time in ages I've seen any colour in his cheeks
13	GP→P:	yes (.)
14	P→GP:	he's been so sick (.)really awful
15	GP→C:	((uses stethoscope to listen to the boy's chest)) couldn't you go skating?
16	P→GP:	but I think (.) you MUST have something for him
17	GP→P:	well (.) I think I've got something for him

In this fragment the GP sets the tone of an adult-centred interaction by explicitly inviting the parent to describe the reason for attendance. The parent immediately aligns to this type of participation framework by formulating the problem definition in lines 2-8. The parent's strong identification with the health problems of her child is expressed in her lexical choices; the use of the first person pronoun form in lines 4, 12, and 16, denotes that she conceives those health problems as her own responsibility. The GP implicitly agrees with this parental role by asking permission to examine the boy in line 9. Thus, both adults co-construct a situation in which the child is treated as a non-person; this is exemplified in line 10 where the mother lofts up the boy's shirt in order to let the doctor do his job. The only child-directed question by the GP in line 15 might be typified as small talk; the pseudo-question probably aims at putting the child at ease, and has nothing to do with the course of the medical interaction. At the end of this fragment of interaction the GP lexically emphasizes the child's (non)participant status by means of the third person pronoun form 'I think I've got something for him'.

Patterns following parental self-initiated problem definitions

Our data contain 17 consultations in which the parent immediately started with a presentation of the child's health problems, before the GP had the opportunity to invite one of the participants to do so.

Figure 4 Patterns after parent self-initiated problem formulation (n=17)



As illustrated in figure 4, after most parental self-initiated global problem definitions, it was the parent who also formulated the specific problem definition (82%). In addition, 94% of diagnostic and treatment information appeared to be parent-directed. In one consultation, the GP immediately started the physical examination after the parental global problem definition. No correlation was found between these patterns and the child's age or the periods investigated. Fragment 4 is an example of a parent-initiated problem definition.

Fragment 4

Consultation no: 113 (GP=general practitioner, P=parent, C=child; 10-year old boy)

1	P→GP:	I'm here for Peter (.) he's got a sore throat
2	GP→P:	something wrong with his throat (.)
3	P→GP:	((sighs)) yes ((sighs))
4	P→GP:	and quite a BAD one at that
5	GP→C:	hm (.) and can you yourself say anything about it? (.)
6		or does it hurt too much?
7	C→GP:	it does hurt quite a bit
8	GP→C:	(.) and (.) where (.) where doe it hurt?
9	C→GP:	((shrugs his shoulders))
10	GP→C:	where (.) here, more at the top ((points)) or more at the bottom
11	C→GP:	((coughs)) yes, here at the bottom ((coughs))
12	GP→C:	do you have to cough a lot?
13	P→GP:	((talks a great deal about the coughing and other symptoms))
.....		
19	P→GP:	is this one of those new viruses or something?
20	GP→P:	no

21 GP→B: no (.) there's a LOT of this about at the moment
22 GP→B: well, we can give him something for it
23 GP→C: you dissolve it ((looks at child)) and then drink it ((pretends to drink))
24 and if you have a lot of problems with your voice (.)
25 then steaming's the answer
26 it'll help you to get rid of any phlegm that's there
27 C→GP: ((nods))
28 P→GP: is it a good idea to let him stay at home for a few days? (.) or not

Despite the mother's firm display of speaking for her child (line 1: I'm here for Peter), the GP actively tries to establish a context for the boy to participate in the specific problem definition. In line 5 the GP explicitly asks the child to speak for himself, and even after the minimal answers the boy provides in lines 9-11, the physician appears to be oriented towards the child instead of to the accompanying parent. Line 23 is an interesting one; after the parental elaboration on the problem definition in line 13, line 23 displays a rapid shift in the GP's alignment from the parent to the boy by a shift from the first plural pronoun form *we* in line 22 to the second singular informal pronoun form *je* in line 23. By this switch, the GP resumes his orientation to the child as the actual patient within the encounter. The mother's statement in line 28 suggests that she does not seem to fully accept the child's participant status.

5.4 Conclusions and discussion

The rationale for studying the participation framework in doctor-parent-child triad was the finding that GP and parent frequently differ fundamentally in the degree to which they enable child participation. Our analysis reveals that these differences stem from dissimilarities in the participants' orientations regarding the desirable participation framework. In our data parents frequently take on the role of spokesmen; they speak on behalf of their child even when the child is explicitly addressed, as was the case in the responses to the GP's child-directed invitations. The patterns we described show that with every structurally important step in the consultation, such as the response to the invitation and the transition from global to specific problem definition, the parents validate their position as primary speaker and increasingly get the floor. Parents obviously regard matters of the child's health as their own responsibility and therefore they frequently treat their children in medical interviews as if they were absent. The parental identification with their child's health problems is reflected in their linguistic realisations. For example, the parental use of the first person singular in: 'I've come for Peter, he's got a sore throat' when formulating the global problem definition, may denote a strong identification with the child's health problems (one could say that the mother has come for her son's throat). We consider parental speaking for their child during medical interactions as a contextualization cue by which parents signal their view on the child's participant status, and as a display of their own institutional competence.

These manifestations of the parental participation framework contrast with the initial efforts of the GPs to involve children in the medical interaction. The fair amount of child-directed invitations to formulate the reason for attendance, illustrates the GPs' willingness to include the child in the first segment of the medical interview. Physicians express their orientation towards the desirability of child participation in the doctor- parent-child triad in their linguistic behaviour, by addressing children by their first name or by using the second person singular informal form *je*. However, the doctor's orientation toward child participation decreased considerably towards the end of the consultation, when most diagnosis and treatment information was directed at the accompanying parent.

Our conclusions should not be interpreted as if the opportunities for child participation in medical encounters are only uni-directionally defined by the behaviour of (one of) the adult participants. The patterns we described underline the interactionally constructed character of roles and identities. Participant roles established at the beginning of the encounter were redefined frequently in the course of the encounter. A clear example is the dominant pattern that follows the GP's child-directed invitation; the fact that the child frequently establishes the global problem definition, appears not to be a guarantee for increased child participation during the ongoing communication. Rather than blaming parents for interrupting doctor-child interaction, we can say that parents often reorient the participation framework to maintain their active role as spokesman. In a lot of these encounters the GPs verbally or nonverbally accept this parental role of speaking for their child, shift their alignment, and co-construct a dyadic interaction with the parent, which renders the child as a non-addressed participant. The absence of GP's use of meta-communicative statements regarding the participant roles desired in this triad is indicative in this regard. Most GPs adopt a neutral stance by refraining from aligning openly with either the parent or the child. As a result, mismatches in adults' orientations regarding triadic participation framework as in fragment 4 remain unaddressed and may lead to ineffective communication, especially between GP and parent. It should be emphasized in this respect that children too are co-constructors of the participation framework in this triad. In our data, children frequently withdrew from the interaction (by laughing, non-responding or looking at the parent) despite the GP's efforts to include them into the communication. Furthermore, children often responded to the GP's questions with one-word answers; they hardly ever spontaneously elaborated on their problem definition, in contrast to their parents. This forced the GP to formulate new questions in order to elaborate on the child's answers. In addition, children did not regularly produce response tokens, such as 'yes' and 'mm hm', which normally signals the hearer's attention and function as a signal to continue the conversation. Through this lack of display of recipiency children present themselves as being withdrawn bystanders in the interaction, which renders doctor-child interaction more difficult. In this line of reasoning, the parental eagerness to intervene in the child's problem definitions may be explained by their willingness to

elaborate on the child's concise problem definition in order to facilitate doctor-child communication. In addition, there were only a few examples of children competing with their parents in taking the active role of respondent. We must therefore conclude that parental speaking for the child is, in a way, institutionally co- constructed. Although GP and parent initially show incongruent orientations towards child participation, in the further course of the encounters all three participants jointly establish a situation in which child participation appears to be rather an exception. Parents take their responsibility, which is hardly ever questioned by children, and GPs ratify this behaviour by refraining from meta-communicative comments and by aligning with the parent in the course of the interaction.

The findings of our study underline the dialogically constructed character of roles and identities within the doctor-parent-child triad. Identities displayed and aligned in the opening of the consultation appear to be open for negotiation during the ongoing interaction. The patterns we described show how such 'redefinitions' of the interactional situation take place especially within the transitions of the consultation segments. For example, the pattern following the GP's child-directed invitations reveals how, with every new phase in the consultation, the parent more strongly casts the child as a side-participant, and how on the whole the GP's orientation towards child participation diminished. The adult participants' orientation to the various tasks that are inherent to the different segments of the medical encounter may explain these points of redefinition. In addition, we may conclude that our findings partially underline Heath's claim about the sequentially implicativeness of openings in medical interaction. On the one hand, our study emphasizes the importance of setting the 'mode of interaction' at the beginning of the encounter. Comparing the various patterns in terms of opportunities for the child to participate in the medical interaction, we conclude that inviting children to formulate the problem definition embeds the opportunities for child participation in the further course of the encounter. On the other hand, our data do not unconditionally prove the relationally affirmative character of these invitations. The potential effect of the GP's child-directed invitations appears to be minimized by the child's lack of display of recipiency. Obviously, children take it for granted that adults do most of the talking in medical interaction; children only took part in the medical exchange when they were explicitly invited to do so. The power of setting the mode of interaction also applies to the parental self-initiated problem definitions; these uninvited problem presentations grant parents the floor to continue the problem definition, and to cast the child as a side- participant. As in our study the focus was mainly on the adults' orientations regarding child participation, future research should develop a conceptual framework and further explore the various participant roles of all three participants in the doctor-parent-child triad. Once such participant roles are delineated it would be useful to determine how often roles change during the segments of the consultation, and longitudinally over many visits.

The present study emphasizes that the low degree of child participation in the doctor-parent-child triad should not be interpreted as a sign of incompetence on behalf of the children, but rather as a consequence of the participants' underlying participation framework. We have to conclude that the adult participants play a pivotal role in enhancing or restricting child participation. This conclusion is in line with Pyörälä (2000), who reported a fundamental difference between triadic dietician-parent-child encounters and dyadic encounters between the dietician and the diabetic child. In the dyadic encounters children assumed an actively-responding patient role, but in the triadic encounters the children turned into withdrawn bystanders. The passivity of the children in the triadic encounters was not due to not knowing or not understanding what was happening, but rather to the particular participation framework within that institutional setting. Although they do not discuss their findings in terms of roles and identities, Strong (1979), Tannen and Wallat (1983,1987), and Aronsson and Rundström (1989) also report the child's participant status as an unaddressed recipient of talk in their own consultations. However, in these studies the status of the parents as spokesmen for their children is hardly ever questioned, nor are the consequences of the participants' orientations regarding the child's participant status in terms of the opportunities for child participation.

Methodological reflections

In research on medical interaction the quantitative approach is predominant; doctor-patient communication is mostly studied from a top-down perspective, by means of validated coding systems (Verhaak et al., 1998). We started our research on doctor- parent-child communication with two quantitative analyses, studying the turn-taking sequences and the nature of the communication in this triad (Tates & Meeuwesen, 2000; Tates et al., submitted). Both studies emphasized the difference in the way the adult participants established a relevant context for child participation. By applying an interactional sociolinguistic perspective, the present study offers valuable insight into the ways through which GP, parent and child co-construct and display their participant roles and identities through their verbal and nonverbal behaviour. We claim that this qualitative bottom-up approach complements the aforementioned quantitative analyses in several respects. First, by applying the notion of participation framework, the present study explains the underlying rationale for the difference in the extent to which GP and parent enable child participation. Secondly, whereas children have traditionally been conceptualized as passive participants in medical encounters, our analysis emphasizes the interactionally constructed character of doctor-parent-child communication. All three participants jointly establish a context in which the potential triadic communication is reduced to a dyadic interaction between physician and parent. Finally, by focussing on the sequential implicativeness of the GP's invitations, we were able to show how these initial moves are crucial in defining the mode of interaction and in determining the opportunities for child participation. Quantitative coding systems, in spite of their usefulness in providing an overview of the medical communication, are

not sensitive to capturing the sequential embedding of the interactional moves. Thus, our conclusion must be that a multi-method approach, which combines and integrates quantitative and qualitative analyses, is necessary to capture the complex dynamics of doctor-parent-child communication.

Practice implications

In the Netherlands, the GP is the provider of first line health care, including primary care and preventive care, and one in six GP consultations involves a child under the age of sixteen. Given that young children visiting the doctor are always accompanied by (one of) their parents, it is important to realize how adult language behaviour socializes child participation in triadic medical interactions. Children are socialized indirectly in the ongoing verbal interactions with physician and parent, and therefore it is important in terms of health education that both GP and parent guide the child towards management of illness and health care. Learning by participation instead of being excluded from the interaction is to be considered as a powerful tool to promote self-confidence and a sense of control of one's own life. Antaki and Widdicombe (1998) pointed to the dual aspect of identity both as a tool and an achievement. In this line of reasoning, child participation should be both the objective and the means of child-health promotion (De Winter et al., 1999). Empirical studies emphasize the health promoting value of active child participation (Pantell et al., 1982; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998; De Winter et al., 1999). Therefore, physicians and parents should attempt to create a developmental environment which offers children the opportunity to participate actively in medical contexts. Our study exposes the differences in the participants' orientations regarding child participation; orientations that are taken for granted by GPs appear to be unknown to the parent and can be the source of mis-communication. Thus, the GP should provide clarity, for the child as well as for the parent, about the desirable participant roles in triadic medical encounters, and the importance of an active child participation. Enhancing child participation in triadic medical encounters may therefore force physicians, parents as well as children, to question their roles and become aware of their responsibilities and obligations.

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Chapter 6

Doctor-parent-child relationships: A 'pas de trois'

Tates, K., Elbers, E.P.J.M., Meeuwesen, L. & Bensing, J.M. (Submitted for publication). Doctor-parent-child relationships: A 'pas de trois'.

Abstract

While it has been common in research on medical communication to focus on the dyadic relationship between health care provider and (adult) patient, this study takes the triadic relationship between doctor, parent and child as the unit of analysis. Our previous studies emphasized the pivotal role of both adult participants in doctor-parent-child interactions at the general practitioner's surgery. The child's opportunities to participate in the medical encounter appeared to be strongly related to characteristics of the adult behaviour. This study built on these findings and aimed at further characterizing the relationships within this triad. Videotaped observations of 106 medical interviews, taken over a period of almost twenty years, were analysed. As a first step towards a typology of doctor-parent-child relationships, we classified adult behaviour along an interaction dimension in terms of supporting versus non-supporting of child participation. By emphasizing the interactionally constructed character of relationships, child behaviour was examined in relation to adult behaviour in terms of display of involvement and turning to the parent for support.

In most consultations, both GP and parent displayed non-supportive behaviour. Despite the GPs' initial efforts to involve the child in the interaction, 90% of the consultations ended up in a non-participatory way. During this last segment of diagnosis and treatment information, the child's voice was hardly heard, as reflected in the minimal involvement displayed and the absence of turning to the parent for support.

The perspective chosen in this analysis allowed for a better understanding of the underlying mechanisms leading to the stereotypical picture in both literature and actual practice of triadic medical interactions being dominated by both adult participants. The low degree of child participation should not solely be seen as a consequence of adult behaviour, but rather as a co-construction of all three participants.

The results are discussed from a pedagogic perspective, and implications for medical practice are formulated.

6.1 Introduction

Research into medical communication usually focussed on the dyadic relationship between health care provider and (adult) patient. The present study takes a triad as the unit of analysis, in order to analyse the medical interaction between doctor, parent and child within the setting of the general practitioner's surgery. Traditionally, children are conceptualized as passive participants, and their part in medical communication has largely been ignored in research (Tates & Meeuwesen, 2001). Our previous studies showed that the phenomenon of low child participation also applies to daily medical practice (Tates & Meeuwesen, 2000). The interaction in this doctor-parent-child triad appeared to be dominated by both adult participants and child participation was very limited. Viewed from the perspective of child participation, a noticeable finding was that GP and parent differed fundamentally in the degree to which they enabled or con-

strained child participation. Whereas parents, regardless of the child's age, tended to control the interaction by interfering in doctor-child interactions, physicians were more inclined to involve older children more directly in the medical interaction (Tates & Meeuwesen, 2000; Tates et al., submitted). This finding was the rationale for a subsequent study on the participation framework in this triad. By focussing on the discursive construction of participant roles we were able to show that these differences in adult accommodation were due to dissimilarities in the adults' orientations regarding the underlying participation framework (Tates et al., accepted).
The present study builds on this study of participant roles, and aims at further exploring the relationships between GP, parent and child. Relationships between people both shape and reflect the expectations each participant has about the conduct of the other (Roter & Hall, 1992). As relationships may have substantial implications for how the curing and caring process is to be accomplished and the extent to which needs and expectations will be met (Roter & Hall, 1992; Roter, 2000), more insight into the possible relationships between doctor, parent and child is imperative for the development of optimal medical care in this triad. The purpose of this paper is twofold: (1) To develop a typology of doctor-parent-child relationships; (2) To provide empirical validation for our data at the GP's surgery.

A typology of doctor-parent-child relationships

Our previous studies on doctor-parent-child communication emphasized the pivotal role of both adult participants in doctor-parent-child interactions. The child's opportunities to participate in the medical interview appear to be strongly related to characteristics of adult behaviour (Tates & Meeuwesen, 2000; Tates et al., submitted). In the past there was a tendency to rely on parents as sources of information about their child's health status. However, it is increasingly being acknowledged that children can provide information themselves and should be involved in decisions about their own health care (Alderson & Montgomery, 1996; Rylance, 1996; Hart & Chesson, 1998). In addition, empirical studies have shown the health-promoting value of active child participation (Colland, 1990; Holtzheimer et al.,1998; Hosli, 1998; De Winter et al., 1999).
We claim that doctor-parent-child interactions are to be understood both in terms of a pedagogic relationship, and in terms of a provider-patient relationship. Children must learn to manage their own disease, so part of the goal of medical interaction is to create a developmental environment which offers the child the opportunity to learn how to participate in medical encounters (Eiser, 1998; De Winter et al., 1999). The idea of guiding the child on his or her way to active participation matches the concept of guided participation (learning through participation; Rogoff, 1990), and implies a focus on the active role of children in medical interaction and on the enabling or constraining characteristics of adult behaviour. We therefore focus more extensively on the pedagogic relationship between doctor and child and parent and child by defining and characterizing adult behaviour in terms of the consequences for child participation.
With reference to two separate bodies of research, literature on parenting styles and so-

cialization on the one hand, and studies on doctor-patient relationships on the other, the first step towards a typology of doctor-parent-child relationships is to set out the adults' interaction style along an *interaction dimension*, in terms of supporting versus non-supporting the child to participate in the medical interaction. This distinction corresponds to contrasts in parental behaviour in terms of supportive, child-centred behaviour versus non-supportive behaviour and non-involvement of the child (Maccoby & Martin, 1983; Stafford & Bayer, 1993; Socha & Stamp, 1995; Smart et al., 1999). Models on doctor-patient communication denote this distinction in terms of a participatory relationship (in which patients are facilitated to assume a responsible role in the medical dialogue and in decision-making) as opposed to a non- participatory doctor-patient relationship (Roter & Hall, 1992; Stewart et al., 1995; Roter, 2000).

We characterized adult behaviour along the interaction dimension for GP and parent separately. The prototypical supportive triadic medical interaction is a situation in which both GP and parent encourage the child to take an active role in the medical encounter. The GP who assumes a supportive role displays child-oriented behaviour, e.g. by inviting the child to formulate the problem definition, by directing medical questions at the child, and by involving the child in the discussion of the diagnosis and treatment. Parental behaviour is characterized as supportive where the parent both verbally and as non-verbally encourages the child to take an active role in the medical interaction. In addition, a supportive parent strives for effective doctor-child communication by remaining in the background and leaving the child enough room to respond to the questions asked by the GP, and by acting as an information provider or translator should the child misinterpret a question or lack background information.

The opposite extreme to both adults assuming a supportive role is the situation in which no efforts are undertaken either by the GP or the parent to enable the child to join in the medical interaction. Both adult participants control the interaction and treat the child as a passive bystander in his or her own medical consultation. GPs who assume a non-supportive role display parent-oriented behaviour, e.g. by explicitly inviting the parent to formulate the problem definition, by directing most questions concerning the medical condition at the parent, and by discussing all diagnosis and treatment information only with the parent. Parents who assume a non-responsive role are mainly doctor-centred and tend to speak for the child, e.g. by ignoring the child's contributions or by interrupting doctor-child interaction. As a consequence, the child's voice is largely absent in non-supportive doctor-parent-child interactions; the child is not considered capable of discussing his or her health problems and is excluded from the interaction.

It is important to realize that the GP and parent may display either similar or conflicting behaviour in terms of supporting the child to participate in the medical interaction.

It should be emphasized from the outset that the behaviour of GP and parent as described above has been defined from the adults' perspective on child participation. Al-

though it is generally acknowledged that adults do have more influence on a child than vice versa, we opt for a bi-directional perspective, by emphasizing the mutually influential nature of relationships. Therefore, we combine a typological approach in characterizing adult behaviour along the interaction dimension, with an emphasis on the interactionally constructed character of doctor- parent-child relationships in our data. We view adult behaviour typified along the interaction dimension as offering the child a context in which the child as an actor itself can choose to accept or reject the opportunities for participation in the medical interaction. The child's behaviour was examined in relation to adult behaviour in terms of the child's display of involvement in the medical interaction and the extent to which the children turned to their parents for support during the encounters.

In our analysis of doctor-parent-child relationships we take into account the segment of the consultation since it is known that the opportunities for child participation are related to the segment of the encounter. Previous studies have shown that physicians tend to elicit medical information from children, but exclude them from diagnostic and treatment information (Tates & Meeuwesen, 2001). Studies on institutional interaction have emphasized the goal-oriented character of medical interactions and stress that participant roles are shaped by institutional procedures (Roter & Hall, 1992; Drew & Sorjonen, 1997; Sarangi & Roberts, 1999). In a previous study we found that redefinitions of roles take place in particular within the transition of the consultation segments (Tates et al., accepted). As we expect relationships not to be static across the encounter, we characterized the adult participants' behaviour during the segment of medical history-taking and during the segment of diagnosis and information on treatment. In line with the literature and the findings of our previous studies, we expect a decrease in the adults' supportive behaviour in the course of the encounter.

As our data relate to consultations from the seventies, eighties and nineties, our analysis includes the period during which the consultation was registered. Over the past three decades a number of important changes have taken place in doctor-patient communication and in adult- child interactions which might have influenced the doctor-parent-child relationship. First, the development of the patient-centred approach with an increasing emphasis on the patient's own responsibility, evoked a shift in the participant roles in medical consultation. As a result, patients have become more emancipated and autonomous over the years (Ong et al., 1995; Stewart et al., 1995; Roter, 2000). In addition, parenting has become less restrictive and authoritarian, and adult-child interactions are increasingly characterized by a greater openness towards the child (De Swaan, 1988; DuBois-Reymond, 1993). In view of these developments, it was hypothesized that the adults' supportiveness would increase over the years, and, at the same time, we expected an increase in the child's display of involvement.

Finally, we chose to imply a developmental perspective, as children progressively develop communicative skills, including meta-communication and domain-specific knowledge, as their cognitive and linguistic development progresses (Garton, 1992; Flavell et al., 1993; Siegal, 1997). As we expect GP and parent to align their behaviour to

the child's age, it is hypothesized that the GP and parent display supportive, child-centred behaviour in interaction with older children in particular.

6.2 Method

Sample characteristics

The study is based on 106 video recordings of doctor-parent-child encounters at general practitioner's surgeries in the Netherlands. In all selected interviews the child was seeing the GP for temporary illness and minor complaints. In the Dutch health care system, the GP, comparable to a family physician, has a gate-keeping role; patients do not have access to specialist or hospital care without referral, and 90% of all complaints are treated by GPs (De Melker, 1997). About one in six consultations with a GP involves a child under the age of 16, and in the Netherlands it the GP who is initially responsible for children's health-care, which includes primary care and preventive care (Van Suijlekom-Smit & Crone-Kraaijeveld, 1994). The video recordings were drawn from a large collection (n=2500) of medical interviews with patients of all ages, which have been collected since 1975, and held by the Netherlands Institute of Health Services Research (NIVEL). A selection was made based on rigorous demands of technical quality. This was necessary since many of the earlier videos were of poor quality. The application of these and other relevant criteria (a triad of doctor-parent-child, and the age of the child: 4-12 years), supplemented by matching for age, gender and type of complaint of the child patient, resulted in a dataset of 36 videos for the period 1975-1978, 36 videos for 1988-1989, and 34 videos for 1993. All participants differed over the three periods, were of Dutch origin and had previously seen the GP. In the majority of consultations the child was accompanied by the mother (83%). Fifty-eight different GPs participated in the study, the majority being male (91%). The mean duration of the consultation was about 7 minutes.

Coding procedures typology

The analyses were conducted on the basis of extensive transcripts of all 106 consultations. Nonverbal behaviour was noted as far as it was relevant for the coding (especially eye-contact). A qualitative overall impression of the supportiveness of both GP and parental behaviour was given separately on the basis of four criteria for the medical history-taking segment and for the segment incorporating diagnosis and treatment information:

Supportiveness of GP behaviour during the medical history-taking segment

	yes	no
Invites the child to formulate the problem definition		
Directs questions concerning the medical condition at the child		
Encourages the child to join in the medical dialogue, verbally as well as non-verbally (e.g. by seeking eye contact, smiling or nodding)		
Addresses the child by first name or second person pronoun form		
Overall impression: supportive		

Supportiveness of parental behaviour during the medical history-taking segment

	yes	no
Leaves the child room to respond to the GP's questions		
Stays in the background and acts as an information provider or translator should the child be unable to respond to the GP		
Encourages the child to join in the medical dialogue, verbally as well as non-verbally (e.g. by seeking eye contact, smiling or nodding)		
Addresses the child by first name or second person pronoun form		
Overall impression: supportive		

Supportiveness of GP behaviour during the diagnosis and treatment information segment

	yes	no
Directs counselling and advice at child or repeats information for the child		
Explains treatment information to the child, or repeats information for the child		
Encourages the child to join in the medical dialogue, verbally as well as non-verbally (e.g. by seeking eye contact, smiling or nodding)		
Addresses the child by first name or second person pronoun form		
Overall impression: supportive		

Supportiveness of parental behaviour during the diagnosis and treatment i nformation segment

	yes	no
Leaves the child room to discuss treatment information and to respond to the medical information given by the GP		
Stays in the background and checks for understanding or paraphrases the medical information for the child		
Encourages the child to join in the medical dialogue, verbally as well as non-verbally (e.g. by seeking eye contact, smiling or nodding)		
Addresses the child by first name or second person pronoun form		
Overall impression: supportive		

As our focus was on the interactionally constructed character of doctor-parent-child relationships, we also examined child behaviour. First, we examined the child's *display of involvement* in the interaction using of a 3-point scale (1=active involvement; 2=passive involvement, 3=no display of involvement). Child behaviour was labelled as an active display of involvement when the child took the initiative or actively responded to the adults. In those cases where the child's response to the adult was minimal (e.g. by means of back-channelling behaviour), or where the child only displayed nonverbally involvement in the interaction (e.g. by nodding when the parent answered the question, or by seeking eye-contact), we labelled child behaviour as a passive display of involvement. No display of involvement was noted in those consultations where the

child did not respond to adult behaviour, or displayed a nonverbal lack of involvement, e.g. by looking around when being addressed. In addition, we examined whether or not children turned to their parents for support, verbally (e.g. by asking 'isn't it?'), or nonverbally (e.g. by seeking eye-contact with the parent). The interrater reliability, based on ratings of 12% of the consultations by two independent raters, assessed by Cohen's Kappa, varied from good to excellent (Role GP segment 1: 0.84; role GP segment 3: 0.83 ; role parent segment 1: 1.00; role parent segment 3: 1.00; involvement child segment 1: 0.86; involvement child segment 3: 0.86; support seeking behaviour child segment 1: 0.84; support seeking behaviour child segment 3: 1.00).

6.3 Results

First, we characterized adult behaviour along the interaction dimension in terms of supporting versus non-supporting the child to participate in the medical interaction. This was done for GP and parent separately, by taking into account the segment of the consultation, the child's age and the period of registration. We then determined the occurrence of patterns of adult behaviour, with reference to the same independent variables. As our focus was on the interactionally constructed character of doctor-parent-child relationships, we finally examined the child's behaviour in relation to adult behaviour in terms of the child's display of involvement in the medical interview and the extent to which the child turned for support during the interaction.

6.3.1 Doctor-parent-child relationships during the medical history-taking segment

As shown in table 1, in most consultations both GP and parent assumed a non-supportive role towards the child during the medical history-taking segment. GPs, however, more frequently encouraged the child to take part in the medical interaction compared to parents (GPs 28% supportive consultations, versus parents 13%). As expected, both adults more frequently assumed a supportive role in interaction with older children (GPs: age 4-6: n=5, age 7-9: n=6, age 10-12: n=19; Spearman's rho .35, $p<.01$ / parents: age 4-6: n=2, age 7-9: n=1, age 10-12: n=11; Spearman's rho .30, $p<.01$). Only for the group of children aged 10-12, was there also a change in adult behaviour over the three periods we investigated; in the course of time, both GP and parent more frequently took a supportive role in interaction with older children (GPs: Spearman's rho .39, $p<.05$; parents: Spearman's rho .41, $p<.05$).

Table 1 Adult behaviour along the interaction dimension during the first segment of the consultation (n=105)

		Doctor					
		Supportive N	%	Non-supportive N	%	Total N	%
Parent	Supportive	14	13%	0	0%	14	13%
	Non-supportive	16	15%	75	72%	91	87%
	Total	30	28%	75	72%	105	

Patterns of doctor-parent-child behaviour during the first segment

I The most frequently occurring pattern of adult behaviour (72%) in our data was that both GP and parent assumed a non-supportive role during the first segment of the medical encounter. It is the prototypical paternalistic triadic medical interview in which both adults dominate the interaction and exclude the child by treating the child as a passive bystander. Parents spoke on behalf of their child and often tended give a monologue in their presentation of the child's complaints, as shown in the following fragment:

Fragment 1

Consultation no: 109 (GP=general practitioner, P=parent, C=child; 10-year old girl)

Segment 1 *GP and parent assume a non-supportive role*

1 GP→C: Who's first, you or your mum?
2 C→GP: I don't care ((shrugs her shoulders))
3 P→GP: Well, yesterday she was in bed with a headache ALL DAY LONG
4 (.) doing nothing but throwing up (.) and you told us to come back
5 if it happened more often (.)well (.) it is happening more often
6 she eh (.) that
7 gets those severe headaches
8 GP→P: mmh
9 P→GP: and eh she can't eat (.) she really can't do anything
10 when she's got those headaches
11 GP→P: sick and throwing up?
12 P→GP: yes

13 C→GP: yes
14 GP→P: well eh (.) how long does such an attack last?
15 P→GP: a day (.) a whole day long
16 GP→P: and then she has to rest?
17 P→GP: yes she's got to go to bed (.) otherwise then
.....
24 GP→P: the attacks last a day
25 P→GP: yes

The GP in this fragment displays non-supportive behaviour right from the beginning of the encounter. The GP co-constructs a dyadic interaction with the mother by accepting the parental formulation of the complaint, thereby emphasizing the mother's role as respondent for her child. No effort is undertaken to involve the child in the elaboration of the complaint. The child's position as a passive bystander is reflected in the adults' person reference; both GP and mother use the third person pronoun form to denote the girl (parent: lines 3,6,9 and 17; GP in line 16). This pattern of adult behaviour appeared to be strongly related to the child's age; GP and parent displayed this non-supportive pattern of behaviour in interaction with younger children in particular (age 4-6: n=32; age 7-9: n=26; age 10-12: n=17; Spearman's rho: -.36, p<.01). Overall, no correlation was found between this non-supportive pattern of adult behaviour and the period of registration; only in interaction with children aged 10-12 was this pattern less frequently displayed over the years (period 1: n=11, period 2: n=3, period 3: n=3; Spearman's rho: -.46, p<.01).

II The following fragment is an example of the opposite pattern (occurring in 13% of the consultations), in which GP and parent both display supportive behaviour by encouraging the child to participate in the medical interview.

Fragment 2
Consultation no: 95 (GP=general practitioner, P=parent, B= both parent and child, C=child: 10-year old girl)

Segment 1 *GP and parent both assume a supportive role*

1 GP→C: Carla, why have you come to see me?
2 C→GP: a bump in my neck
3 GP→C: a bump? And does it hurt?
4 C→GP: eh (.) sometimes
5 GP→C: sometimes (.) and how long have you had it?
6 C→GP: I found out eh
7 C→P: when did I find it?
8 P→C: last week wasn't it?

9 C→GP: last week
10 GP→C: hmm (.) and has anything else been bothering you? Your throat?
11 C→GP: yes
12 GP→C: yes?
13 C→GP: [nods]
14 C→GP: it's behind here (.) so eh
15 GP→B: yes that's possible (.) because this is where your drainage system for your
16 throat and nose is ((indicates the place in his own neck))
17 GP→C: did your ear trouble you too?
18 C→GP: ((shakes her head))
19 GP→C: no? Well (.) we'll just have a look

By inviting the child to formulate the reason for seeing the doctor, the GP displays his first orientation towards active child participation. In addition, the GP encourages the girl to participate in the medical information exchange in order to arrive at a formulation of the specific complaint. During the entire segment the GP explicitly addresses the child, either by her first name (line 1), or by using the second person singular pronoun form (lines 5,10 and 17). The mother displays her orientation towards active participation by her daughter by remaining in the background; it is only in line 8, after the child's direct question for support, that the mother mediates between the GP and the child by providing information the child herself was not able to.
This participatory pattern of adult behaviour was found in encounters with older children in particular (11 out of the 14 supportive patterns involved children aged 10-12; Spearman's rho: .36, $p<.01$). Overall, no correlation was found between this supportive pattern and the period of registration; only for the group of children aged 10-12, was there an increase over the years (period 1: n=1, period 2: n=5, period 3: n=5; Spearman's rho: .46, $p<.01$).

III During the segment of medical history-taking, in 15% of the consultations adult behaviour represents a moderate alternative between the non-participatory pattern and the participatory pattern described above. In this pattern the GP encourages the child to participate actively in the medical encounter, whereas the parent assumes a non- supportive role, as shown in the following fragment:

Fragment 3
consultation no: 123 (GP=general practitioner, P=parent, C=child; 12-year old girl)

Segment 1. *GP supportive; parent non-supportive*

1 GP→C: Melissa, can you tell me yourself?
2 C→GP: yes (.) my back has been bothering me recently
3 GP→C ((nods))

4 C→GP: yes (.) eh
5 P→C: tell him about the school doctor
6 C→GP: yes (.) the school doctor said that I should come back
7 after a few examinations
8 GP→C: yes
9 C→GP: I had to come back in October but now it is
10 bothering me even more
11 GP→C: can you tell me when it started?
12 C→P: no (.) I really don't know
13 GP→P: a year ago (.) half a year ((looks at her mother))
14 P→GP: in the sixth (.) in the sixth form
15 GP→P: yes
16 P→GP: the school doctor came
17 GP→P: yes
18 P→GP: and he eh (.) yes ((gestures))
19 GP→P: routine examination
20 P→GP: routine examination (.) and then her back proved to be a bit crooked ((gestures)) on one side
21 GP→P ((nods))
22 P→GP: one side was higher ((gestures)) than the other
23 GP→P: the other side
24 P→GP: and they would keep an eye on it (.) I think it was in October
..... ((parent goes into detail))
33 GP→C: and now it bothers you more
34 C→GP: yes
35 GP→C: and eh (.) are you keen on sports?
36 C→GP: tennis
37 GP→C: tennis [nods] does it trouble you then?
38 C→GP: no (.) not really
39 GP→C: then it's not necessary to stop
49 C→GP: no
50 GP→C: now a silly question (.) you'll say that has nothing to do with it (.)
51 I'll explain t to you (.) have you already started your period?
52 C→GP: no
53 GP→C: not yet (.) I asked you because you grow the most
54 in the year BEFORE your first period
55 then you grow explosively (.) so ehh

In this fragment the GP actively tries to establish a context for the girl to participate by addressing her by her first name when inviting her to describe the reason for attendance in line 1. When the girl cannot answer the GP's question on the duration of the complaints in line 12, the GP implicitly acknowledges the mother to elaborate on her

daughter's problem definition by seeking eye-contact. After the parent's extended answer, the GP resumes his orientation to the girl in line 33. In his elaborated explanation of the question about her period in line 50-55 the GP displays his orientation to guide the child towards active participation. One might argue about the facilitative status of line 5 when the mother presses her daughter to introduce the topic of the school doctor, but fundamentally the parental behaviour is non-supportive, especially in the extended formulation of the problem definition in lines 14-24. This pattern also appeared to be age-related, and occurred more frequently in interaction with older children (age 4-6: n=3, age 7-9: n=5, age 10-12: n=8; Spearman's rho: .36, p<.01). No correlation was found for the period of registration.

Child behaviour during the medical history-taking segment

As our focus was on the interactionally constructed character of doctor-parent-child relationships, we also examined the child's behaviour in relation to adult behaviour in terms of the child's display of involvement in the medical interview and the extent to which the child turned for support during the medical interaction.

During the first segment of the consultation most children showed involvement in the medical interaction, either actively (48%), or passively (19%), as shown in the bottom row of table 2. This display of involvement appeared to be strongly related to the child's age; older children displayed more active involvement, whereas younger children more frequently showed no involvement in the interaction at all (Active involvement: age 4-6: 16%, age 7-9: 30%, age 10-12: 54%; Spearman's rho: .44, p<.01; No involvement: age 4-6: 57%, age 7-9: 29%, age 10-12: 14%; Spearman's rho: -.44, p<.01). Over the three periods investigated, we found no significant changes regarding the child's display of involvement. In addition to child involvement, we examined the extent to which the child turned for parental support. Only in 22% of the consultations did children verbally or non-verbally turn for support, and these turns for support increased with the child's age (age 4-6: n=3, age 7-9: n=6, age 10-12: n=15; Spearman's rho: .33, p<.01). Over the years, the oldest children displayed no turns for support less frequently (period 1; n=12, period 2: n=5, period 3: n=4; Spearman's rho: -.36, p<.05).

Table 2 Child behaviour in relation to adult patterns during segment 1 (n=105)

	Child shows involvement						Child turns for support			
Pattern	Active		Passive		None		Yes		No	
	N	%	N	%	N	%	N	%	N	%
GP non-supportive + parent non-supportive (n=75)	28	37%	14	19%	33	44%	11	15%	64	85%
GP supportive + parent non-supportive (n=16)	13	81%	3	19%	0	0%	5	31%	11	69%
GP supportive + parent supportive (n=14)	9	64%	3	22%	2	14%	8	57%	6	43%
Total (n=105)	50	48%	20	19%	35	33%	24	22%	82	78%

Child behaviour in relation to patterns of adult behaviour

The supportiveness of the pattern of adult behaviour during the first segment appeared to be related to both the child's display of involvement (Spearman's rho: .37, p<.01) and to the child's turnings for support (Spearman's rho: .34, p<.01). Not surprisingly, children showed least active involvement in those cases where both adults assumed a non-participatory role in interaction with the child. In addition, in 85% of the consultations with a non-supportive pattern of adult behaviour, children did not turn to their parents for support. This passive, withdrawn child behaviour also co-constructed the dyadic character of this type of doctor- parent-child relationship, and emphasized the child's position as a marginal participant.

In encounters with both adult participants assuming a supportive role, children displayed more active involvement (64%) and turned the most frequently to their parents for support (57%). Over the three periods we investigated, children displayed more active involvement in consultations with this participatory pattern (Active involvement period 1: n=0, period 2: n=4, period 3: n=5; Spearman's rho: .60, p<.05).

In the moderate pattern with GPs assuming a supportive role and parents a non-supporting role, children displayed the most active involvement (81%) and turned to their parents for support to a moderate extent (31%).

6.3.2 Adult participant behaviour during the diagnosis and treatment information segment

As shown in table 3, in 89% of the consultations both GP and parent displayed non-supportive behaviour towards the child during the segment of diagnosis and treatment information; GPs adopted a supportive role in 10% of the consultations, and parents in only 7%. Unlike in the first segment of the consultation, adult behaviour appeared not to be age-related, nor was any correlation found between adult behaviour and the three periods we investigated. The adult participants displayed the same type of behaviour during the last segment of the consultation (first segment: consensus in 89 out of 105 consultations, last segment: consensus in 100 out of 105 consultations; Mann-Whitney $Z= -2.12$, $p<.01$).

Table 3 Adult behaviour along the interaction dimension during the segment of diagnosis and treatment information (n=105)

	Doctor					
	Supportive		Non-supportive		Total	
	N	%	N	%	N	%
Parent						
Supportive	6	6%	1	1%	7	7%
Non-supportive	4	4%	94	89%	98	93%
Total	10	10%	95	90%	105	

Patterns of doctor-parent-child behaviour during the last segment

I. Table 3 shows that during the last segment of the consultation the most prevalent situation was that in which both GP and parent assumed a non-supportive role in interaction with the child (89% of the consultations). The increase of non-supportive adult behaviour was mainly due to GPs changing from a supportive role during the first segment to a non-supportive role during the last segment of the consultation (Mann- Whitney $Z= -3.58$, $p<.001$). The following fragment is an example of this type of consultation; it is the continuation of fragment 3, in which the GP assumed a supportive role during the first segment. However, in the last segment both GP and parent displayed non-supportive behaviour:

Fragment 4
consultation no: 123 (continuation of fragment 3)
Segment 3 *GP and parent both non-supportive*

56	GP–P:	the best thing we can do is
57	GP–C	you can get dressed now (.) I've finished taking a look
58	GP–P:	so with all those pains she has ((points to himself)) I just think
59		she feels the vertebra against the chair
60	GP–P:	I just think her back shows a clear curvature
61		and eh the best you can do is to have an X-ray taken to measure
62		the angle (.) it's really important to know that
63	P–GP:	hmm
64	GP–P:	an X-ray shows the degree of angle
65		and if it diverges
66	P–GP:	yes
67	GP–P:	if it is within the limits (.) then you need not do anything about it

Despite the GP's initial efforts in the first segment to involve the child in the interaction, the GP takes a non-supportive role in the last segment by directing all treatment information to the parent. One could argue that this is a lost opportunity; by using the first person plural pronoun form 'we' in line 56 and by telling the girl to get dressed in line 57, the GP automatically changed the interaction into a dyadic encounter between GP and parent. When discussing the diagnosis and treatment the GP only addresses the parent (lines 61 and 67) and refers to the girl using the third person singular pronoun form (lines 58 and 59), thereby making the treatment decisions a joint responsibility of both GP and parent. No correlation was found between this pattern and the child's age, nor with the periods we investigated.

II. The opposite extreme pattern, in which GP and parent both assumed a supportive role during the last segment, occurred in only 6% of the consultations An example is the following fragment (the continuation of fragment 2), in which both adult participants did continue their supportive behaviour during the end of the consultation:

Fragment 5
Consultation no: 95 (continuation of fragment 2)
Segment 3 *GP and parent both assume a supportive role*

20	GP–C:	no (.) there's NO reason to worry ((takes a book out of the cupboard))
21		look I'll show you
22	C–P:	((smiles at her mother))
23	P–C:	((mother gives the child an encouraging smile))

24	GP–C:	where you've got all those glands (.) and there are quite a lot of them
25		(.) eh ((looks in the book))
26		look (.) here at the corner of the jaw you've got (.)
27		there they are ((points them out in the book))
28	P–GP:	oh yes ((also looks in the book))
29	C–GP:	you mean all that green?
30	GP–C:	yes (.) all those green little balls (.) and here they are behind your ear ((indicates in book))
31	C–GP:	so here
32	P–GP:	and here too ((fingers her own face)) good heavens
33	GP B:	and you don't notice them until they swell up

This fragment is a clear example of how the three participants jointly co-constructed a situation in which the child can actively participate in the medical encounter. The GP continues his supportive role towards the child by explicitly directing all diagnosis information toward the child. The GP reassures the girl (line 20) and provides additional information about the lymph glands by showing their location in a book. In addition, the mother encourages (and acknowledges) her child to participate in the interaction in line 23, remains in the background, and shows her involvement in the interaction in line 32. The child herself shows optimal active involvement in the interaction, as demonstrated in lines 29 and 31. Again, no correlation was found between this pattern and the child's age, nor with the periods we investigated

Child behaviour during the diagnosis and treatment information segment

During the last segment of the consultation most children showed no involvement in the medical interaction (58%), as shown in the bottom of table 4. This lack of display of involvement appeared to be strongly related to the child's age; younger children more frequently showed no involvement in the interaction (No involvement: age 4-6: 29%, age 7-9: 17%, age 10-12: 14%; Spearman's rho: -.34, $p<.01$). In 96% of the consultations children did not seek support from their parents. No correlations were found for the children's turns for support and the age of the child. Over the three periods we investigated, no significant changes were found regarding the child's behaviour during the last segment.

Table 4 Child behaviour in relation to adult patterns during the last segment (n=105)

	Child shows involvement						Child turns for support			
Pattern	Active		Passive		None		Yes		No	
	N	%	N	%	N	%	N	%	N	%
GP non-supportive + parent non-supportive (n=94)	16	17%	22	21%	56	53%	4	4%	90	96%
GP supportive + parent non-supportive (n=4)	0	0%	2	50%	2	50%	0	0%	4	100%
GP non-supportive + parent supportive (n=1)	0	0%	0	0%	1	100%	0	0%	1	100%
GP supportive + parent supportive (n=6)	1	17%	3	50%	2	33%	0	0%	6	100%
Total (n=105)	17	16%	27	26%	61	58%	4	4%	101	96%

Child behaviour in relation to patterns of adult behaviour

The supportiveness of the pattern of adult behaviour during the last segment appeared not to be strongly related with the child's display of involvement, nor with the child's turns for support. Only in consultations with the adults assuming both a non-supportive role, was there a slight effect for the age of the child. In those non-participatory consultations, older children displayed involvement in the interaction more frequently (No involvement age 4-6: n=26, age 7-9: n=15, age 10-12: n=13; Spearman's rho: .29, $p<.01$). In addition, the only children who sought support during this pattern were aged 10-12 (Spearman's rho: .21, $p<.05$).

Shift in GP supportiveness

Our analyses yielded a significant increase of non-supportive adult behaviour during the last segment of the consultation, due to a shift in the GPs' amount of supportive behaviour from 28% during the first segment to 10% in the last segment of the consultation. Despite the initial efforts by GPs to involve the child in the interaction, 90% of the consultations ended up in a non-participatory way. This finding was the rationale for an additional analysis of the twenty consultations concerned. In a number of these consultations the non-participatory behaviour of the physician could be traced back to factors such as the child's age or the child's behaviour. Four consultations involved chil-

dren aged 4-6 who verbally or nonverbally displayed their incapability or unwillingness to take part in the interaction by crying or refusing to answer when addressed. In another four consultations, non-responsive child behaviour, such as looking away when addressed, providing minimal answers or shrugging their shoulders was associated with a shift in the supportiveness of GP behaviour.
Characteristics of parent behaviour appeared to be another influencing factor. In six consultations parents emphatically expressed their concerns about their child's health, by directing a lot of questions at the GP after the segment of physical examination, or by discussing the various treatment options. In three encounters, the GP and parent had a different opinion about the necessity to consult a specialist.
A final factor was that sometimes, because the child was not in the immediate vicinity, it was impossible to involve the child in the interaction from the beginning of the last segment, because the child was still in the examining room or the child had been instructed to get dressed, as illustrated in fragment 4.

6.4 Conclusions and discussion

The rationale for this study was the finding from previous studies that GP and parent differ considerably in the extent to which they facilitate child participation in triadic medical encounters. In the present study we aimed to develop a typology for a more thorough analysis of the relationships between doctor, parent and child at the general practitioner's surgery. We will discuss the results of our analysis both in terms of a characterization of doctor-parent-child relationships, and in terms of the typology proposed.

Doctor-parent-child relationships at the general practitioner's surgery

This aim of this study was to characterize doctor-parent-child relationships within the general practitioner's surgery. On the basis of the interaction dimension as proposed, we first classified adult behaviour in terms of supporting or non-supporting the child to participate in the medical interaction. At first glance, most interactions within this triad can be typified as paternalistic and non-participatory for the child, with both adult participants dominating the interaction and excluding the child from the discussion on diagnosis and treatment. This picture is in line with the stereotype often depicted in research into doctor-parent-child communication which is restricted to the dyadic interaction between physician and parent (Tates & Meeuwesen, 2001). Our findings show that, although both GP and parent predominantly assume a non-supportive role in interaction with the child, GPs more frequently display supportive behaviour, especially during the medical history-taking segment. This difference in the extent to which both adults encourage child participation is in line with a previous study in which we explored the participation framework in the doctor-parent-child triad (Tates et al., accepted).
In addition to our typological approach, we used an interactional perspective, and by

thus emphasizing the interactionally constructed character of doctor-parent-child relationships, we were able to provide a more finely tuned characterization of the interaction in this triad. In line with the expectations, the child's age appeared to be a very strong predictor of child participation. During the medical history-taking segment, both adult participants more frequently display supportive behaviour in interaction with older children. At the same time, older children show more involvement than younger children, and turn for support more frequently, especially in supportive consultations. The participatory effect of GP behaviour appeared to be an important factor; children display most active involvement in those consultations where the GP assumes a supportive role. For the group of children aged 10-12, this participatory pattern of doctor-parent-child interaction increased over the three periods we investigated; both GP and parent less frequently assumed a non-supportive role during the first segment, and over the years children displayed more active involvement in consultations with a participatory pattern.

The results also show that doctor-parent-child relations are not static; there is a strong relationship between the segment of the consultation and the participatory effect of adult behaviour. Ninety percent of the consultations concludes in a non-participatory manner, partly due to a shift in the GPs' amount of supportive behaviour from 28% during the first segment to 10% in the last segment of the consultation. During this non-supportive phase of the consultation, the child's voice is not heard much, as reflected in the minimal involvement displayed and displayed in the fact that the child does not seek support. Even eleven and twelve-year-olds waited in silence when the GP and parent discussed the diagnosis and treatment information. Only very rarely did children comment on doctor-parent interactions, or initiate topics or questions themselves. By being passive and withdrawn, children presented themselves as subordinates, and as a result, the interaction could largely preserve its dyadic format. Evidently, children take it for granted that their parents act as their spokesman. Another remarkable finding, in this regard, is the limited degree to which children turned to their parents for support. The finding that GPs are less child-oriented towards the end of the consultation is in accordance with previous studies (Pantell et al., 1982; Worobey et al., 1987; Van Dulmen, 1998), which state that physicians seldom discuss treatment decisions with children, but contrasts noticeably with the demands of shared decision-making and informed consent. From a pedagogic perspective, the attitude of treating children as non-participants seems to undermine the developmental potential of learning through participation; by excluding children from important parts of the medical interaction, they miss the opportunity to gradually develop a sense of responsibility for their own health care and become a competent member in medical interactions. Our additional analysis of the factors associated with this shift in GP's supportiveness provides a better understanding of the causes of this phenomenon. In some consultations with very young children, the shift to non-supportive behaviour stemmed from the children's inability to comprehend the consequences of treatment decisions, as was the case in a discussion regarding housing improvement for an allergic child. As young children may lack suf-

ficient background knowledge to discuss topics like this, one can hardly dispute the dyadic nature of such a discussion. In those cases child-supporting behaviour was not possible because of the child was not in the vicinity. However, GPs failed to repeat the treatment information for the child or neglected to check whether the child had followed the conversation while getting dressed.

Finally, parental behaviour appears to be a qualifying factor in GPs shift from supportive to non-supportive behaviour in the course of the consultation. By asking a lot of questions, or by empathically expressing their concern about their child's well-being, parents often forced the GP to focus the attention on them, and as a consequence the GP was no longer able to give the child his undivided attention The parental need to express their concern and to be involved in treatment decisions was already emphasized in the first studies on doctor-patient communication, more than 30 years ago (Korsch et al., 1968; Freemon et al., 1971; Korsch & Negrete, 1972), as well as in recent studies on pediatric communication (Wissow et al., 1998). This parental control may explain the shifts in GP's supportive behaviour towards the child. Worthy of note here, is the fact that these shifts in GP behaviour were irreversible; the GP hardly ever resumed his or her supportive behaviour towards the child after the dyadic discussion with the parent. A remarkable finding is that GPs never argue with parents about the desirability and benefits of child participation. As a consequence, the non-complementary views on child participation remain implicit.

Towards a typology of doctor-parent-child relationships

The aim of this study was to contribute to the development of a framework for analyzing doctor-parent-child relationships. By combining a typological approach with an interactional perspective, we opted for a bidirectional view on adult-child relations and challenge the traditional, unidirectional approach. Bidirectional theories of adult-child relations have shifted attention from unidirectional, impositional models to frameworks that highlight the two-way, mutual, and reciprocal influence in adult-child interactions (Stafford & Bayer, 1993; Socha & Stamp, 1995; Berardo & Shehan, 1999; Knapp, 1999). The perspective of the child as an active agent makes it possible to consider how children act as agents and broadens the focus of research into doctor-parent-child relationships to include the influence of children. This approach is in line with the growing recognition of the need to consider children to be active contributors in their own socialization, both within the context of parent-child interactions (Hogan et al., 1999; Knapp, 1999), as well as within a medical context (De Winter et al., 1999).

We started our analysis by setting out adult behaviour along an interaction dimension in terms of supporting versus non-supporting the child to participate in the medical encounter. By emphasizing the interactional and dialogical aspects of adult-child interactions, we were able to refute the traditional view of children as passive participants in their own medical consultations. Although limited in scope, children appear to be able to exert an influence on the doctor-parent-child relationship. We claim that for a full understanding of the dynamics of doctor-parent-child relationships, it is necessary to rec-

ognize the interdependency of the roles and functions of all three participants.
Future research should detail how doctor-parent-child relationships change longitudinally, over many visits. It is challenging to investigate the relation between different types of doctor-parent-child relationships and outcome variables, such as satisfaction, and adherence to treatment. Due to the fact that we conducted secondary analyses, we were unable to question the participants on their assumptions regarding child participation, nor could we relate their satisfaction ratings with behaviour variables. It is important to address these issues in future research, because non-complementary role expectations within the triad may interfere with the child becoming a competent member in medical interactions.
A closely related theme involves the validation of the typology proposed in various medical settings. Our data contain less severely ill children, and one may hypothesize that different relationships may be appropriate in different clinical situations.
Since our study only involved indigenous children, we were not able to address the issue of cross-cultural differences in doctor-parent-child relationships. Currently, there is an increased awareness of the importance of cross-cultural studies, as it is evident that generalizations from a single culture may not be valid in other cultural contexts. Since the number of children from ethnic minorities is set to grow in the Netherlands, future research should focus on the diversity of doctor-parent-child relationships across ethnic groups.

Practice implications

The findings of the present study have several implications for triadic medical practice with a child involved. Our data show that these kinds of triadic encounters entail specific difficulties for physicians. On the one hand, GPs seem to be oriented towards facilitating child participation, while on the other, GPs are confronted with parents who largely advocate a passive child role. This may place the physician in a dilemma; holding on to his or her own professional opinion regarding child participation may conflict with the parental orientations. The adults' non-complementary views on child participation prevent the child from taking an active part in the medical encounter, and may lead to sub-optimal treatment in triadic interactions. Therefore, we claim that physicians should more explicitly explain to both the child and the parent beforehand why active child participation is important and desirable. It may be the case that the parent and child advocate a passive child role, not fully aware of the alternatives.
Developmental studies have shown that implicit and explicit assumptions regarding the character of the interaction are quite a constitutive factor for child participation (Elbers & Kelderman, 1994; Elbers & Streefland, 2000). The low degree of child participation can result from children not being aware of how the interaction will proceed. When children are not told explicitly to speak for themselves in a medical context, they obviously take it for granted that their parents to do the talking. Therefore, the physician should try to break this passive attitude by making the desirability of an active contribution to the child itself more explicit. Since the development of new participant

roles takes place through processes of socialization, children should be acknowledged as an active party in triadic medical encounters, in order to develop a sense of responsibility for their own well-being.

Clarity about the desirability of child participation should be coupled with attention to parental concerns and communication needs. We focussed on parental concern as a possible cause for the break in GPs' supportive behaviour. The need for parents to express their concerns about their child's health was documented long ago (Korsch et al., 1986; Freemon et al., 1971), as well as recently (Wissow et al., 1998). In addition, it has been shown that parents expect the physician to use their expert knowledge in making the diagnosis (Roberts, 1996; Östergaard, 1998). As these parental communication needs may interfere with the opportunities for child participation, physicians should discuss the benefits of child participation with parents, and in addition address the parents' own needs. This recommendation is in line with Wissow et al. (1999), who found that although parents consider it part of the physician's job to engage the child, they remain sensitive to their own needs for communication. Finally, since it is critical for physicians to gain a sense of the level of participation the child is capable of, and parents in general might be considered to have the most extensive knowledge of their child, we recommend GPs emphasize and make use of parental expertise. By collaboratively creating a developmental environment, both GP and parent may give children a voice in triadic medical encounters.

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Chapter 7

A multi-perspective analysis of doctor-parent-child communication: Summary and discussion

7.1 Introduction

This thesis aimed at providing further insight into the characteristics and dynamics of doctor-parent-child communication at the general practitioner's surgery in the Netherlands. The study originated with the observation that although the first studies on doctor-patient communication were conducted in a pediatric setting, little attention had been given to the child's role in medical interaction. Over the past few decades, provider-patient interactions have been studied by various disciplines, but hardly any attention has been given to doctor-child communication or to the implications of a child's presence in medical interviews. This observation was the rationale for a review study, the objective of which was to evaluate the state of the art of research into doctor-parent-child communication and to explore the specific role of the child as described in the studies reviewed. Based on the findings of this literature study, four empirical studies were conducted, focussing on various aspects of the communication within the triad. The results of the review and the implications for the present study will be discussed first, followed by information on the key characteristics of the sample used in this thesis.

Review study (presented in chapter 2)

The review study examined whether attention had been paid to the specific role of the child in medical interaction, and determined which aspects of the communication between doctor, parent, and child had been highlighted in the studies reviewed. In addition, the extent to which the methodologies used were suitable for analysing triadic medical conversation was also assessed.

As far as the child's role in medical communication is concerned, the conclusion was that most of the studies ignored the implications of a child's presence in the medical interview, by focussing on the physician-parent dyad. The studies conducted by Korsch probably set the tone for this: Korsch identified the parent as the patient, thereby implicitly disregarding the child's presence in the medical encounter. Insofar as the studies dealt with the specific contribution of the child, they depicted the stereotype of doctor-child interaction as a 'joking relationship', characterized by social behaviour and joking.

Moreover, it was also concluded that a mono-perspective focus was predominant in studies that analysed the communication within this triad. The objective of most of the studies reviewed was to describe the relational aspects of the interaction in terms of affective (or socio-emotional) behaviour as opposed to instrumental (or task-related, problem-solving) behaviour, by applying quantitative coding schemes. A few studies that focussed on the structural aspects of doctor-parent-child communication examined the sequential turn-taking characteristics of the interaction. Finally, by emphasizing the interactional dynamics of medical interactions, studies on the content of the interaction demonstrated the impact of the child's presence on the physician's behaviour in terms of accommodation of conversational style. As a result of this mono-perspective

focus on one aspect of the interaction, knowledge about the different aspects of communication appeared to be highly fragmented and poorly integrated. We concluded that for a full account of the dynamics of this type of triadic medical communication, the various aspects of the interaction should be studied in relation to each other.
Although all the studies reviewed claimed to examine the communication between doctor, parent and child, the majority of research methodologies reviewed were based on the analysis of dyads. Only three studies made use of an observational instrument suited to analysing triads (two of these formed a sub-study of the present study). A consequence of this prevailing dyadic approach is that valuable information on the dynamics of triadic medical communication remained underexposed. The lack of interest in the specific characteristics of medical interviews where a child was involved, was reflected in the finding that most observational systems were dyadic in nature, and hardly any adaptations or changes had been made to analyse triadic interactions.

Implications for the present study

The review study unequivocally demonstrated that the child's participation in the medical encounter is a subject that has not been studied to any significant extent. Even when the patient is a child, the focus of research was usually the doctor-parent interaction, rather than the communication between doctor and child. Children were mainly considered to be passive participants, and their part in medical communication has largely been ignored in research.
There are, however, theoretical, clinical, as well as legal indications that the child's role in medical conversation deserves special attention. Children appear to be able to understand more about concepts of health and illness than has generally been assumed. Another strong argument for child participation is that a more direct communication between doctor and child improves health care in terms of satisfaction with the care itself, adherence to treatment, and a better understanding. Finally, recent legislation, such as the Medical Treatment Agreement (WGBO) in the Netherlands, requires patients to participate actively when decisions about illness and treatment are being taken. In addition, there is increasing acknowledgement that children themselves should be involved in decisions about their own health care.
In order to narrow this gap, this thesis presents a series of consecutive analyses the objective of which was to characterize the communication between doctor, parent and child at the general practitioner's surgery in the Netherlands. Based on the findings of the review study, two basic assumptions were formulated as a necessary condition for a better understanding of doctor-parent-child communication. First, the need to study the various aspects of doctor-parent-child communication in relation to each other. We claimed that only by applying a multi-perspective focus, that captures both the structural and the relational aspects of the communication, as well as the content of the interaction, could a comprehensive view of the communication within this triad be gained. Second, we postulated that a triadic analysis is a prerequisite for a full account of the dynamics of the interaction in the doctor- parent-child triad. For this reason we

took the doctor-parent-child triad as the unit of analysis in our empirical studies. We did not restrict the analyses to the doctor-parent and doctor-child dyads, but explicitly focussed on the interaction between all three participants.
As our data contained triadic consultations recorded over three different periods (the seventies, eighties and nineties), we were interested in whether the communication in the doctor-parent-child triad had changed over the three periods. A number of important changes have taken place in doctor-patient communication in general over the past three decades. The development of a patient-centred approach and increased demands for shared decision-making and informed consent have evoked a shift in the roles of the participants in medical consultations. As a result, the doctor-patient relationship has developed from being very asymmetrical towards being more egalitarian, and patients have become more emancipated and autonomous over the years. We hypothesized that these changes might also apply to the communication between doctor and child over the three periods we investigated. In addition, we expected to see a similar development in the interaction between parent and child, as parenting has become less controlling and authoritarian, and adult-child interactions are increasingly characterized by a greater openness towards the child.
The children in our sample ranged from 4 to 12 years of age (mean age 8). As children's perceptual, cognitive and social skills develop with age, as well as do children's concepts of health and illness, a developmental perspective was opted for; we therefore examined how the age of the child affected the communication within the triad.

Sample

The four empirical studies presented in this thesis were based on 106 video recordings of medical interviews involving a doctor-parent-child triad, within the setting of the general practitioner's surgery in the Netherlands. In the interviews we selected, the child was seeing the GP for temporary illness and minor complaints, such as bronchitis, earache or stomachache. The videos were drawn from a large collection of medical interviews, collected and held by the Netherlands Institute of Health Services Research (NIVEL), and cover three periods: 1975-1978 (n=36), 1988-1989 (n=36), and 1993 (n=34). All participants involved differed over the three periods and were of Dutch origin. The cross-sectional design made it possible to make a comparison over the recording periods: the seventies, eighties and nineties. The children's age ranged from 4 to 12 (mean age 8), and boys and girls were equally represented. In the majority of consultations the child was accompanied by its mother. Fifty- eight GPs participated in the study, and the majority of them were male. Due to this unequal distribution of physician gender in our data, we not able to investigate the influence of physician gender on the communication within the triad. All consultations were for a new complaint, and all the children had previously seen the GP.

This final chapter continues with an overview of the research findings from the four empirical studies. This is followed by a discussion that focusses on the theoretical and

methodological implications of the analyses, and recommendations for future research are made. To conclude, implications for daily medical practice are addressed.

7.2 Summary of the findings

The empirical element of this thesis consisted of four consecutive studies, each focussing on a different aspect of the interaction within the triad, arriving at a multi-perspective analysis of doctor-parent-child communication. The studies can be found in chapters three to six. The study presented in chapter 3 focussed on the structural aspects of the communication. By analysing the interaction in terms of affective (or socio-emotional) and instrumental (or task- related) behaviour, the second study described in chapter 4 captured the relational aspects of the interaction. The finding that both adult participants differed in the extent to which they facilitated child participation was the rationale for an interactional sociolinguistic study on the participation framework in the triad, and thereby focussed on the content of the communication. The results of this analysis are presented in chapter 5. The final study discussed in chapter 6 built on the study on participant roles and aimed at further characterizing doctor-parent-child relationships from a pedagogic perspective in particular.

Turn-taking in doctor-parent-child communication

The first study focussed on the structural aspects of doctor-parent-child communication by analysing the sequential patterns of turn-taking in this triad. As the turn-taking characteristics of a conversation are considered to be indicative of aspects of asymmetry and control, this analysis provided a kind of fingerprint for the participants' opportunities to participate in the interaction. The Turn Allocation System (TAS) was used to analyse the turn-taking patterns within the doctor-parent-child triad. All the verbal turns of the three participants, such as questions, remarks, or directions, were analysed in terms of their initiatory and responsive character, i.e. in terms of initiative, allocation, and response. The coding system was based on the work of Aronsson and Rundström (1988), and adapted for analysing triadic interactions.

The results showed that the child's contribution was rather limited; by allocating most turns to each other, both adult participants appeared to be in strong turn-taking control. In only 13% of the turns did the GP directly address the child, mostly during the physical examination segment. In five out of the 106 consultations the GP did not allocate a single turn to the child. The child directed most turns to the GP, mainly during the medical history-taking segment. Analysis of the responses to the various types of turn allocation revealed that it was the parent who was mainly responsible for the exclusion of the child by interfering in more than half of the turns the GP explicitly directed toward the child.

As expected, the child's age appeared to be a strong predictor of child participation. GPs involved children more directly in the medical encounter as their age increased, and allocated fewer turns to the parent. Concordantly, older children themselves took more

actively part in the interaction. As for the parent, however, the child's age did not seem to play a part at all; the amount of parental control appeared to be independent of the child's age. Over the first two periods we investigated, the child enlarged its part in the medical interview by taking more initiatives, and by interfering more frequently in the adult interaction. At the same time, the GP tended to allocate fewer turns to the parent. However, these changes did not continue in the third period; only the oldest group of children showed increased participation in the last period.

Affective and instrumental behaviour in doctor-parent-child communication (chapter 4)

The second study focussed on the relational aspects of the communication between physician, parent and child, by analysing the interaction in terms of affective and instrumental behaviour. With regard to the medical interview, two types of patient needs are generally distinguished: on the one hand, the cognitive need to be informed, and on the other, the emotional need for support, acceptance and respect. In parallel with this, the physician is assumed to possess two types of skills: instrumental, problem-solving behaviour (such as asking questions and providing information), and affective, socio-emotional behaviour (such as partnership building and showing empathy and concern). Depending on the specific needs of the patient and the goal of the interview, a balance between instrumental and affective behaviour characterizes effective communication between doctor and patient. Most studies that deal with the relational aspects of doctor-parent-child communication depicted the stereotype of doctor-child communication as being largely restricted to affective behaviour, i.e. social conversation and joking. For the purpose of our second study, the verbal communication was analysed using an adjusted version of the Roter Interaction Analysis System (RIAS) (Roter, 1989), a well documented and widely used instrument in the field of doctor-patient communication. As the RIAS was originally designed for analysing dyadic interactions, the coding system was expanded to include the initiative and allocation of utterances for each participant.

Contrary to expectations, in our study physician-child interaction appeared not to be primarily restricted to the affective domain. Both GP and child displayed mainly instrumental behaviour towards each other, and the greater part of the GP's affective behaviour was directed toward the parent. The segment of the consultations also a determining factor for the GP's instrumental behaviour. Whereas during the segment of medical history-taking the doctor directed 40% of the medical questions at the child, 80% of the counselling and advice was directed at the parent. As the child's age increased, the exchange of medical information between GP and child was intensified by both GP and child. An interesting finding was that the age of the child merely affected the instrumental behaviour of both GP and child. This is an important finding from the perspective of child-centred care and increased demands for shared- decision making and informed consent. By taking the child's age into account, physicians were striving for active child participation in medical communication. In return, the older child

itself took the initiative to become a party in the encounter.
An important conclusion of the study was that the stereotype of doctor-child communication as a joking relationship implied an underestimation of the differentiated nature of doctor-parent-child interaction. GP's communication style in interaction with the child had to be typified as both caring (creating a good relationship by affective behaviour) and curing (helping the child to solve the health problem by instrumental behaviour).

Roles and identities in doctor-parent-child communication (chapter 5)
Viewed from the perspective of child participation, a noticeable finding from the first two studies was that GP and parent differed fundamentally in the way they enabled or constrained child participation. By taking the child's age into account, physicians were more inclined to promote child participation, at least during the medical history-taking segment. Parents, on the other hand, appeared to restrict child participation by frequently interfering in doctor-child interactions, irrespective of the child's age. The question of how this difference in the way GP and parent established a relevant context for child participation could be explained was the core of the third study, which focussed on the content of the interaction. The aim of the study was to explore whether these differences stemmed from dissimilarities in the participants' orientations regarding the participation framework they expected to be appropriate in this type of medical encounter. Parents, for example, might feel responsible for their child, and expect the doctor to rely on them to obtain medical information about their child's well-being. A sociolinguistic perspective was chosen by focussing on how the participants displayed their orientation to institutional roles and identities through their verbal and non-verbal behaviour. This dynamic perspective on roles and identities as discursively produced challenges traditional role theory, which ignores the interactional production and regards roles and identities as exogenous and fixed properties of participants (Widdicombe, 1998; Roberts & Sarangi, 1999). A descriptive analysis was conducted in order to characterize how identity construction was accomplished interactionally and sequentially in the doctor-parent-child triad. We followed the standard sequencing of the medical consultation by focussing on structurally important steps in the medical encounter in order to examine how the participants collaboratively co-constructed the course of action, and how these discursive constructions guided the ongoing interaction. The analysis included such elements as the invitation to clarify the reason for seeing the doctor, the formulation of the global and specific problem definition, and direction of diagnosis and treatment. In addition, differences in linguistic formulations were taken into account, such as person reference, lexical and grammatical choice and the politeness form.
The findings of this study emphasized the interactionally constructed character of roles and identities within the doctor-parent-child triad. Participant roles displayed and aligned at the opening of the consultation appeared to be open for renegotiation during the ongoing interaction. With every structurally important step in the consul-

tation, such as the response to the invitation and the transition from global to specific problem definition, parents validated their position as primary speaker and increasingly got the floor. These manifestations of the parental participation framework contrasted with the initial efforts of the GPs to involve the child in the medical interaction by directing a fair amount of the invitations toward the child. This mismatch in the adults' orientations regarding the participation framework explained the difference in the degree to which GP and parent facilitated child participation, especially during the medical history-taking segment. We concluded that when parents speak for their child during medical interactions it should be seen as a cue by which parents signal their view about their child's participant status, and as a display of their own institutional competence. However, during the course of most encounters, GPs, either verbally or nonverbally, accepted this parental role of speaking for their child, and shifted their alignment, and co-constructed a dyadic interaction with the parent, which rendered the child as a non-addressed participant. In addition, children themselves appeared to be co-constructors of this dyadic mode of interaction, by withdrawing from the interaction, or by providing very limited answers. It was therefore concluded, that although GP and parent initially showed incongruent orientations towards child participation, in the further course of the interaction all three participants jointly established a situation in which child participation appeared to be an exception. Therefore, the parental speaking for the child was interactionally co-constructed; parents took their responsibility, which was hardly ever questioned by the children, and GPs ratified this behaviour by refraining from meta-communicative comments and by aligning with the parent in the course of the interaction.

Towards a typology of doctor-parent-child relationships (chapter 6)

The previous studies all emphasized the pivotal role of both adult participants in doctor-parent- child interactions; the child's opportunities to participate in the medical interview appeared to be strongly related to characteristics of adult behaviour. The fourth empirical study built on these findings and aimed at further characterizing the doctor-parent-child relationships from a pedagogic perspective in particular. As a first step towards a typology of doctor-parent-child relationships, we combined a typological approach (by classifying adult behaviour in terms of supporting versus non-supporting child participation) with an interactional approach (by focussing on doctor-parent-child relationships as interactionally constructed). By emphasizing the mutually influential nature of relationships, we opted for a bidirectional approach of adult- child relations, thereby challenging the traditional unidirectional view. The child's behaviour was examined in relation to adult behaviour in terms of the child's display of involvement in the medical interaction and the extent to which the child turned for support during the interaction.

At first glance, the dominant interaction pattern within the doctor-parent-child triad could be typified as paternalistic and non-participatory for the child, with both adult participants dominating the interaction and treating the child as a passive bystander.

This picture is in line with the common stereotype of doctor-parent-child communication being largely restricted to the dyadic interaction between physician and parent. However, due to the additional interactional perspective with its focus on the constructed character of the relationships, we were able to reveal the underlying mechanisms that lead to the stereotypical picture in both the literature and practice of triadic medical encounters being dominated by both adult participants. Children showed least active involvement where both adults assumed a non-participatory role in interaction with the child. This passive, withdrawn child behaviour also co-constructed the dyadic character of this type of doctor-parent-child relationship, and emphasized the child's position as a marginal participant, especially during the last segment of the consultation.

In line with the expectations, the child's age appeared to be a very good predictor of child participation. During the medical history-taking segment, both adult participants more frequently displayed supportive behaviour in interaction with older children. At the same time, older children showed more involvement than younger children, and more frequently turned for support, especially in supportive consultations. The participatory effect of GP behaviour appeared to be an important factor; children displayed most active involvement in those consultations where the GP assumed a supportive role.

The results also showed that doctor-parent-child relations are not static; there was a strong relationship between the segment of the consultation and the participatory effect of adult behaviour. Ninety percent of the consultations ended up in a non-participatory way, largely due to a shift in the Gps' behaviour from supportive during the first segment to non- supportive in the last segment of the consultation. An additional analysis showed that this shift in GP behaviour could be traced back to the behaviour of all three participants. In a number of consultations, the shift could be ascribed to factors relating to the child, such as a lack of background information, or passive, withdrawn behaviour (e.g. older children who were definitely capable of speaking for themselves tended to let their parents do the talking). In addition, parental behaviour appeared to be a highly qualifying factor in GPs shift from supportive to non-supportive behaviour in the course of the consultation. By asking a lot of questions, or by empathically expressing their concern about their child's well-being, parents often forced the GP to focus his attention on them, and as a consequence the GP was no longer able to give the child his undivided attention. Worthy of note here is the fact that these shifts in GP behaviour were irreversible; the GP hardly ever resumed his or her supportive behaviour towards the child after a dyadic discussion with the parent. With regard to GP behaviour, a remarkable finding was the absence of meta-communicative statements; GPs never argued with parents about the desirability and benefits of child participation. As a consequence, non-complementary views on child participation remained implicit.

7.3 Theoretical reflections

The findings of the studies require further theoretical discussion, which will focus on the merits of the distinctive perspectives, the argument in favour of a multi-perspective analysis, and the need for the development of a theoretical framework.

7.3.1 Doctor-parent-child communication reconsidered

The way a researcher looks at her data is largely determined by the observation system that is used and thus by the underlying theoretical notions (Bensing, 1991). In this thesis, the interaction between doctor, parent and child was analysed from a range of different perspectives. The analyses addressed different aspects of the interaction, and thereby differed in their theoretical and methodological origin. The aim of this discussion is not merely to summarize these approaches, but rather to reflect on the distinctive contributions of each perspective and to emphasize the complementarity of the analyses conducted.

Discussions on the theoretical background easily get polarized around the alleged dichotomy between quantitative and qualitative methods applied to the evaluation of (medical) discourse (Roger & Bull, 1988; Norton et al., 1991; Silverman, 1997). In this line of reasoning, quantitative research has been typified as deductive, descriptive, and outcome directed, by its focus on generalizable accounts of 'what' is happening. In contrast, qualitative studies have been described as inductive, interpretative, and elaborating on the meaning of the findings, by its focus on the 'how' and 'why' of the phenomenon under study. In research on medical communication it is the quantitative sociopsychological approach that predominates; doctor-patient communication has mostly been analysed from a top-down perspective, by means of validated coding systems (Wodak, 1997; Verhaak et al., 1998). Whereas in the past the two approaches were rarely combined in a single study as a consequence of this paradigmatic 'battle', nowadays the importance of cross-method research is increasingly being acknowledged (Charon et al., 1994; Roter & Hall, 1992; Potter, 1998; Silverman, 1997, 1998; Roter, 2000).

This thesis advocates a pragmatic rather than a paradigmatic perspective. The question of how to analyse the distinctive aspects of doctor-parent-child communication formed the starting point of the empirical analyses, rather than the tendency to impose a particular theoretical framework. As a result, different research paradigms were applied in order to answer the various research questions within this thesis. While different in both premises and analytical practices, all four empirical studies conducted sought to characterize an important aspect of the interaction in this triad. Analysing the turn-taking characteristics of doctor- parent-child communication (chapter 3) proved to be a useful perspective for identifying the structural organization of the communication within the triad in terms of sequence organization, turn design and interactional asymmetries. Within the tradition of Conversation Analysis, Sacks, Schegloff and Jefferson (1974) focussed on turn-taking as a fundamental and generic aspect of the organization of the interaction. Based on this qualitative concept, Aronsson and Rund-

ström (1988) developed a coding system for classifying the responses to the initiatives the GP directed at the child. For this thesis, the analysis has been expanded to cover the turn-taking patterns between all three participants in terms of initiatives, allocations, and responses. As a consequence of this adaptation, the Turn Allocation System can be qualified as a quantitative triadic classification of turn-taking patterns. The advantage of the triadic sequential character of this analysis was that it exposed the phenomenon of parental control. Had the analysis been restricted to the doctor-parent dyad and the doctor-child dyad, which is usually done in medical communication research, the phenomenon of parental control would not have been exposed.

In the second study of this thesis (chapter 4), the Roter Interaction Analysis System (Roter, 1989) was used to capture the relational aspects of the communication between GP, parent and child, by analysing the interaction in terms of affective (socio-emotional) and instrumental (task-related) behaviour. The RIAS coding system, building on Bales' Interaction Process Analysis (1950), was originally designed to analyse dyadic medical interactions and was adjusted for this triadic application. In social-psychological research it is the most frequently used instrument in the field of doctor-patient communication (Roter, 1989, Bensing & Dronkers, 1992; Verhaak et al., 1998). The GPs' communication style in interaction with the child appeared to be both caring (creating a good relationship by affective behaviour) and curing (helping the child to solve health problems by instrumental behaviour). As affective and instrumental behaviour serve different functions in the medical interview, the application of the RIAS study elucidated the findings of the TAS-study. One significant advantage of the RIAS analysis was the conclusion that the stereotype of doctor-child interaction as a joking relationship implied an underestimation of the differentiated nature of doctor-parent-child communication. Both the TAS and the RIAS-study showed their feasibility in sketching the contours of the interaction within the triad. An important distinguishing factor between the two approaches, i.e. the frequential rather than the sequential nature of the analyses, is addressed in the discussion on the methodology.

The finding of both the TAS and the RIAS study that GP and parent differed fundamentally in the degree to which they established a relevant context for child participation was the rationale for a subsequent study on the content of the interaction (chapter 5) which examined the underlying dimensions of this phenomenon by applying an interactional sociolinguistic perspective based on Goffman's notion of participation framework. Drawing on both the ethnography of communication and on conversation analysis, interactional sociolinguistics is inductive by nature by emphasizing the sequential local management of the interaction. In addition to the qualitative bottom-up approach of defining the research objects categories for research, quantification was used to interpret the range of these findings. Therefore, by focussing on the notions of roles and identities as discursively and interactionally constructed phenomena, the third study enabled us to reveal how these differences stemmed from dissimilarities in the participants' orientations regarding the participation framework in doctor-parent-child interactions. The interactional approach, with its emphasis on the interactionally

constructed character of doctor-parent-child relationships, allowed for a better understanding of the underlying mechanisms leading to the stereotypical picture in both literature and in actual practice of triadic medical interactions being dominated by both adult participants.

The final study (chapter 6) built on the findings of the preceding studies, and aimed at further characterizing the doctor-parent-child relationships, especially from a pedagogic perspective. In this study we did not restrict our analysis to one aspect of the interaction, but instead incorporated several aspects of the preceding analyses. By combining a typological approach with an interactional approach, we opted for a bidirectional view on adult-child relations, challenging the traditional unidirectional approach. The relevance of the proposed typology is that it exposed the dynamics and the diversity of relationships that emerged within the triad. Relationships appeared not to be static during the encounter; ninety percent of the consultations ended up in a non-participatory way, mainly due to a shift in GP behaviour. At a cursory glance, the finding that GPs were less child-oriented towards the end of the consultation is in line with previous studies (Pantell et al., 1982; Worobey et al., 1987; Van Dulmen, 1998), which state that physicians seldom discuss treatment decisions with children. The merit of the typology study, is its disclosure of how this phenomenon is collaboratively co- constructed in the medical interaction by all three participants. Both factors in adult behaviour as child behaviour were distinguished contributing tho the non-participation of children during the last segment of the consultation. This insight could not been gained without an interactional and sequential view on the data.

Including a developmental perspective

As children's perceptual, cognitive and social skills develop with age, a developmental perspective was chosen in the analyses of the communication between doctor, parent and child. In line with our expectations, the child's age appeared to be a determining factor for the opportunities for child participation. The age-related results in this thesis regarding GP and child behaviour, stress the importance of taking the child's development into account, and not to generalize the findings from studies with different samples regarding the child's age.

A critical comment concerns the restricted operationalisation of the concept of development used in this thesis. We used the age of the child as a descriptive index of development, and we acknowledge the restricted scope of this operationalisation. As a result, this study clearly argues for the need for further research on medical communication from a developmental perspective that includes more discernable aspects of the child's development.

Finally, the lack of literature on communicative competence beyond early childhood should be mentioned; there are very few developmental studies on adults in interaction with children aged 4-12 (Garton, 1992; Flavell et al., 1993; Siegal, 1997).

Doctor-parent-child communication over the years

This thesis started with the premise that, in accordance with changes in doctor-patient communication and adult-child interaction, the communication in the doctor-parent-child triad would have changed over the years. The overall results, however, did not unconditionally support this hypothesis; the changes over time were restricted to the first two periods investigated and mainly concerned the communication between GPs and children aged 10-12. First, we have to reconsider why the changes found in doctor-child interaction did not continue in the third period. The relatively short time period between the data collection in the eighties and nineties may possibly have had some consequences for the results. This non-equal distribution of time between the three periods was a consequence of the availability of data at the start of the project. As the NIVEL data collection has increased, a replication of the study will have to show whether the data registered at the end of the nineties reveal further changes in doctor-parent-child communication. Another explanation might be found in the changed training of general practitioners in the Netherlands. With the start of family medicine in the seventies, the curriculum showed considerable social scientific influences with attention for communication skills, and concern for family relationships. In the eighties, the curriculum was less family-centred, and with biomedical expertise coming higher on the agenda, less attention was given to the contributions of social sciences (Van Es, personal communication). As one might expect changes in the curriculum and the subsequent medical debate to affect medical practise about a decade later, this might explain that changes in doctor-parent-child communications remained forthcoming in the nineties. Since an investigation of the curricula over the past few decades falls beyond the scope of this thesis, future research could provide more insight into the plausibility of this explanation. Secondly, in view of the social processes of democratization it was expected that parent-child relationships would have changed over time. Contrary to our expectations, parental behaviour in interaction with the child appeared to be practically stable over the three periods. Irrespective of the period when the videos were recorded, parents tended to speak for their child and reframe the communication into a dyadic interaction with the physician. Strong developments in terms of parents being more participatory in encouraging their children to speak for themselves, could not be found. Despite the changes in parenting described in the literature, we must conclude that these developments did not hold true for the field of medical communication. The group of children aged 10-12, on the other hand, displayed increased maturity and ability to speak for themselves over the periods investigated by taking more initiatives and by interfering in adult interaction. It seems plausible that the developments in communication patterns first and foremost become apparent with the oldest children.

7.3.2 Applying a multi-perspective analysis

The sequence of empirical studies conducted in this thesis has illustrated that a multi-perspective analysis of the communication between doctor, parent and child leads to a more complete understanding of the dynamics of the interaction. The perspectives

used in the TAS and RIAS studies allowed a description of the structural and relational contours of the interaction within the triad, and focussed the attention on differences in adult accommodation, but could not elucidate the underlying dimensions of this phenomenon. The subsequent study on the participation framework and the typology study complemented the descriptive TAS and RIAS studies in several ways. First, by applying the notion of participation framework, the sociolinguistic perspective explained the underlying rationale for the difference in the extent to which GP and parent established a relevant context for child participation. Second, whereas children have traditionally been seen as passive participants in medical encounters, the interactional perspective used in both studies showed how all three participants jointly established a context in which the potential triadic communication was often reduced to a dyadic interaction between GP and parent. This means that the interactional studies have put the control concept used in the TAS study into perspective. The results of the TAS study were analysed in terms of control (Linell & Luckmann, 1991), emphasizing parental control. We have to conclude that the traditional concept of control oversimplifies the nature of asymmetry in the doctor-parent-child triad and overlooks the way asymmetry is constructed. Our interactional analyses emphasized the underlying conversational mechanisms by exposing how the phenomenon of low child participation was achieved interactionally by all three participants. In addition, the typology study allowed for a more comprehensive view on adult control, by emphasizing the enabling aspects of control in terms of providing the child room to participate in the interaction From a theoretical point of view, this is an important advantage of the multi-perspective approach applied in this thesis.

The individual studies provided a certain amount of information, but when put together, the accumulated findings yielded a much richer understanding of doctor-parent-child communication than could ever have been achieved through a mono-perspective approach. It should be emphasized that the study of the participation framework and the typology study could not have been conducted without the findings from the preceding analyses. We claim that by using a multi-perspective approach in this thesis, the whole has exceeded the sum of its parts. In this line of reasoning, the quantitative-qualitative argument is essentially unproductive for typifying the various studies we conducted; there were more important differences between the theoretical backgrounds applied in this thesis than whether quantification was used (which in fact was the case in all studies). Therefore, we advocate a *bridging approach* when analysing a new area such as doctor-parent-child communication by making different perspectives mutually informative, while also reflecting on the distinctive contributions. The bridging approach differs from triangulation in its focus on using several methodological strategies to link different aspects of the phenomenon under study, whereas triangulation refers to examining the same phenomenon from multiple viewpoints (Brody, 1991; Miller, 1997). The suggestion of a combined approach is in line with recent recommendations to develop integrative research methods. Hopefully, this thesis may give the initial impetus for developing an interdisciplinary analysis of doctor-parent-child communication.

7.3.3 The development of a theoretical framework

The review study (chapter 2) stressed the lack of theory-based observation instruments for analysing doctor-parent-child communication. The aim of our study on doctor-parent-child relationships (chapter 6) was to contribute to the development of a typology for analysing relationships within this triad. As a first step towards a typology of doctor-parent-child relationships, the classification of adult behaviour along an interaction dimension in terms of supporting versus non-supporting behaviour towards the child to participate in the medical interaction, yielded insightful results. In order to further characterizing the relationships within this triad, our findings suggest that future research should focus on the meaning of autonomy in medical encounters with a child patient involved.

In research on parenting styles and socialization, the concept of autonomy versus control has centre stage in the discussion on whether or not children have the right to autonomy and separateness (Maccoby & Martin, 1983; Stafford & Bayer, 1993; Socha & Stamp, 1995; Smart et al., 1999). As participation and autonomy are related, yet discernable, concepts, there is a need for a more extensive reconceptualization of the meaning of child autonomy in medical encounters. The focus on child autonomy is in line with the requirements of recent legislation in the Netherlands, the Medical Treatment Agreement (WGBO), which emphasizes patients' rights to self-determination. Since April 1995, children up to twelve year of age have the right to be fully informed, but their parents are responsible for treatment decisions. For children aged 12-16, consent from both child and parent is required (Kalkman-Bogerd, 1998). These new requirements may force the participants in the doctor-parent-child triad to reflect upon their roles and to negotiate and redefine their responsibilities. As the data used in this thesis date from before the introduction of the WGBO, it is important to investigate whether the formalization of autonomy for children has led to changes in the contemporary consultations.

Viewing children as individuals on their way to autonomy, the finding of this thesis that adults are credited a leading role in enabling or constraining child participation, is a very important one. From a developmental perspective, the best way for children to learn to become competent members in medical encounters, is to enable them to take an active part in the interaction (Eiser, 1998; De Winter et al., 1999). Learning by participation instead of being excluded from the interaction is to be considered a powerful tool for guiding children on their way to autonomy (De Winter, 1996). Children can only become socialized in the tacit rules of (triadic) medical interactions through this process of guided participation (Rogoff, 1990). This in-between phase of children on their way to autonomy is typified by 'dependent independency' (Elbers, 1993); children increasingly learn to become competent members in medical interaction, but they require support from the adult participants. It is this moving zone between care and autonomy (Elbers, 1993) that characterizes the dynamics of doctor-parent- child communication. Therefore, the acknowledgment of children developing to autonomous participants in medical encounters will have important consequences for the development

of a theoretical framework for analysing doctor-parent-child communication.
Finally, in developing a theoretical framework, special attention has to be given to the distinguishing characteristics of doctor-parent-child interactions compared with other triadic medical interactions. Many health care encounters may involve more than two participants; for example, elderly patients accompanied by a spouse or adult child, couples visiting a doctor, or, in case of non-native speakers, interpreters accompanying a patient. As it is expected that the nature of the relationships within a triad might be a compelling factor (e.g. the responsible parent versus the neutral interpreter), this issue requires further study and concern.

7.4 Methodological reflections

The findings of the consecutive studies also require further methodological discussion, which will focus on the merits of the distinctive observation methods, the surplus value of triadic analyses, reliability and validity, and the use of video observations.

7.4.1 Observation methods

The order in which the analyses were conducted, and the perspective chosen for studying the diverse aspects of doctor-parent-child communication, was not random. By exploring the data in distributional terms, the TAS and RIAS analyses were well suited to discovering the surface contours of the communication within the triad and to search for specialized features of interest and establish their frequency. Both quantitative by nature, by applying deductive, pre- set coding systems, they supplied background information and showed the generality of the observations. Both the TAS and the RIAS studies focussed attention on the phenomenon of differences in adult accommodation. However, as these frequency-based data cannot take into account the responsive character of communication, nor the context, the analyses were unable to explain this phenomenon. Due to its inductive nature, the interactional study on roles and identities was able to explain the difference in the extent to which GP and parent enabled child participation. Both the study on roles and the typology study were conducted at the interface between qualitative and quantitative research; qualitative in their use of inductive concepts and quantitative in their use of quantification of the results. By taking an interactional perspective, these two studies allowed for contextual knowledge and thereby provided an alternative view to an area that is largely focussed on quantitative assessments of medical interaction.
The order the studies were conducted in also reflects the merits and shortcomings of the methodologies used. Previous studies have already focussed on some important shortcomings of frequency-based RIAS analyses in that they excluded the level of meaning from the utterances, which is essential for understanding the context of talk (Hulsman, 1998; Caris- Verhallen, 1999; Kruijver, 2001). As a consequence, the pragmatic impact of a specific utterance expressed at a specific moment cannot be captured within the RIAS, a shortcoming that also applies for the TAS analyses, though. Whereas

the TAS and RIAS studies only focussed on the frequency of occurrence of specific aspects of behaviour (such as speech interruption or direction of medical questioning), the typology study involved the pragmatic context in the analysis by judging the participatory effect of talk. In our TAS study we interpreted the parents' interrupting behaviour in terms of restricting the child's opportunities to participate in the encounter. The typology study, however, allowed for a more comprehensive view on adult control, by emphasizing the enabling aspects of control in terms of providing the child room to participate in the interaction. An important disadvantage of the RIAS is that it fails to provide insight into the sequential embeddedness of talk. This problem was overcome in this thesis by conducting the sequential TAS analysis. Our interactional studies showed that incorporating a sequential component in the analysis of conversation is a prerequisite for understanding the dynamics of the interaction process. The merits of applying an interactional approach is that it allowed for an understanding of a number of underlying conversational mechanisms in doctor-parent-child communication. However, without the basic quantification produced by the TAS and RIAS studies, the significance of the phenomena under study could not have been comprehended. Due to the linking of methods applied in this study, we were able to refute the frequently uttered criticism on inductive studies that they fail to provide information about the significance of the phenomena under study.

One final remark remains to be made on the importance of involving the segment of the consultation into the analysis. In all the studies conducted there was a strong relationship between the segment of the consultation and the amount of child participation. Whereas during the segment of medical history-taking there was a fair amount of doctor-child interaction, during the diagnosis and treatment segment the communication was largely dominated by both adult participants, and as a consequence, the child was not heard very often. Therefore, we advocate not mixing findings gathered during different segments of the medical encounter.

As sequentiality appeared to be a constitutive factor in our data, we recommend that future research should focus on the incorporation of a sequential component in RIAS analyses. To overcome the shortcomings of the TAS, future research should focus on analysing the communicative function of turn-taking sequences, e.g. by distinguishing the pragmatic function of interruptions.

7.4.2 Dyadic versus triadic observation methods

The review study (chapter 2) showed that children tended to become invisible in research on medical communication because of the focus on dyadic adult interaction. Due to this myopic focus, and, as a consequence, due to a lack of appropriate instruments, children have largely been considered and conceptualized as passive actors in their own medical encounter. We claim that a triadic analysis implies more than the sum of the analyses of the composing dyads. Our study has shown that in this triad of dyadic relationships, the interaction within one dyad affected the dynamics of the interaction in the other dyads. This thesis has attempted to highlight some of the com-

plexities overlooked by a dyadic perspective on doctor-parent-child communication. Both the observation and the explanation of the differences in adult accommodation have only become manifest owing to the application of triadic analyses. We therefore claim that traditional dyadic analyses are bound to fail in fully exposing the interactional dynamics of triadic interactions such as in the doctor-parent-child triad. This thesis has shown both the necessity and the merits of developing or adapting observation methods to take into account a third participants' presence, e.g. by including a category such as allocation of talk. Future research should apply, and focus more extensively on the further development of triadic observation methods in order to make the child's voice heard in research on medical communication

7.4.3 Reliability and validity

The reliability and validity of the separate studies conducted within the scope of this thesis was good. We claim, however, that the multi-perspective focus used in this thesis added considerably to the validity of the study. Some remarks should be made on the number of selected interviews per period used in this study. On the one hand, the relatively small number of interviews enabled us to investigate the patterns of doctor-parent-child communication in a very detailed manner. On the other hand, we acknowledge that the findings of this study cannot be generalized unconditionally.

7.4.4 Video observations

The analyses described in this thesis are based on observation studies of videotaped doctor- parent-child interviews at the general practitioner's surgery. The video tapes used in this study were originally recorded for analysing physician behaviour, and, as a consequence, the video perspective was largely doctor-centred. Due to these mono-perspective recordings, the nonverbal behaviour of the parent and the child could not be analysed optimally in some consultations. Therefore, the findings of this thesis may have underestimated the impact of nonverbal behaviour within this triad. Future research on triadic communication should overcome this drawback by using a multi-angled camera position. In addition, we recommend a more extensive investigation into the various aspects of nonverbal behaviour in doctor- parent-child communication that are expected to play a crucial role, such as eye contact, head nodding, body positioning, and touch.

7.5 Recommendations for future research

The empirical studies conducted within the scope of this thesis were based on 106 video recordings of medical interviews at the general practitioner's surgery. The videos were taken from a large collection of medical interviews, collected since 1975, and held by the NIVEL (Netherlands Institute of Health Services Research). These recordings were used for the analysis of doctor-parent-child communication over three periods: the seventies, eighties, and nineties. As none of the participants took part in more than one pe-

riod, the studies were cross- sectional by nature. Since cross-sectional sub-samples focus on groups of individuals rather than on the individual as the unit of analysis, the study did not provide information about the changes over the years on the level of the individual participant. As doctor-parent-child relationships are also expected to change over time on the intra-individual level, there is a need to obtain longitudinal data. The most efficient design would be a combination of cross- sectional and longitudinal data treated in a systematic way.

The fact that secondary analyses were conducted on the data set, resulted in a number of limitations. Several areas, such as outcome variables, nonverbal behaviour, gender, and cross- cultural differences were inevitably not studied in sufficient detail. A major disadvantage of the use of secondary analyses was that it was not possible to explore the relation between characteristics of the communication in the doctor-parent-child triad and outcome variables, such as satisfaction, adherence to treatment, and information recall. Previous studies stressed that parents who had not been given the opportunity to express their concern about their child's health status were less satisfied and showed less compliance (Korsch et al., 1968; Korsch & Negrete, 1972; Wissow et al., 1998). It has also been demonstrated that more direct communication between doctor and child improves health care in terms of satisfaction, compliance, and a better understanding (Pantell et al., 1982; Colland, 1990; Holtzheimer et al., 1998; Hosli, 1998; De Winter et al., 1999). A deeper understanding of the relationship between the interactional style within the triad and outcome variables could contribute to more effective communication.

From a developmental perspective, future research should aim at generating advice about how to involve children of a specific age in medical interviews. As children's communication skills in medical settings and their understanding of diseases may not only change in relation to their development, but also during the process of a disease, future research should focus on how the experience of illness may, in turn, alter the dynamics of the communication.

Furthermore, the findings of this thesis underlined the need for future research to explore the prevailing assumptions regarding child participation in medical encounters, e.g. by means of interviews, questionnaires, or vignette studies. Knowledge about the participants' perceptions of medical interaction and the characteristics attributed to it is imperative for a thorough understanding of the communication patterns observed within this triad. It is important to address these issues because non-complementary role expectations within the triad may interfere with the process of guiding the child towards becoming a competent and autonomous participant in medical interaction. So far, research on children has mainly made use of adults' reports rather than targeting children directly as the primary respondents (De Winter, 1999; Hogan et al., 1999). The perspective as the child as an active agent, however, makes it possible to consider children to be active contributors in their own socialization, both within the context of parent-child interactions (Hogan et al., 1999; Knapp, 1999), as well within a medical context (de Winter et al., 1999). In line with this emergent trend to include the child's

perspective in research, a challenging task would be to develop methods that are both appropriate to children's expectations and competences, and sufficiently compelling to engage children.

Since most GPs in the data sample were male and the majority of accompanying parents were female, gender distribution was somewhat distorted, and the analysis of adult behaviour was carried out as if there was no gender specific information. As the impact of the gender of the physician and of the adult patient on communication has been widely documented (Meeuwesen et al., 1991; Roter et al., 1991; Hall et al., 1994; Van den Brink-Muinen et al., 1998), the gender issue should be addressed more extensively in future research.

Furthermore, we were unable to address the issue of ethnicity in this thesis since the sample only involved indigenous children. As a result, the findings of this study cannot be generalized to other cultural contexts. It is expected that both medical communication and adult-child communication may vary across ethnic groups, and therefore future research should focus on the diversity of doctor-parent-child communication across ethnic groups.

Another challenging question that has to be addressed in the near future is the issue of how to define patient-centred care in triadic medical encounters. Patient-centred care has been used to connote the optimal form of provider-patient relationships and can be characterized as: medically functional, informative, facilitative, responsive, and participatory (Stewart et al., 1995; Roter, 2000). Since the communication needs of both parents and children may be quite different (Grover, 1996; Wissow et al., 1998), the provision of patient-centred care in triadic encounters may place an additional burden on physicians. Future research will have to focus on the possible tension between the physician's obligation to respect the child's right to self- determination and the parental responsibilities and concerns. Wissow et al. (1998) explored patient-centred care within the setting of emergency care, and found that patient-centeredness toward both parent and child lead to a greater understanding of parent and child concerns and improve parent satisfaction. An important finding was that parents remained sensitive to their own needs for communication, and it was concluded that patient-centred care should be coupled with asking more direct questions about parents' opinions about treatment and concerns for their child. Further research is indispensable to explore the needs and interests of both children and parents in order to provide optimal patient-centred care in the doctor-parent- child triad. The finding of Theunissen (1999) that children, parents and physicians can value the child's health problems differently, is indicative in this regard.

7.6 Practice implications

The findings of this thesis lead to a number of implications for medical practice and for health promoting activities. Given the ongoing relationship between GP, parent and child, and the fact that young children who go to see the doctor are always accompanied

by one of their parents, it is important to realize how adult language behaviour channels and directs child participation in triadic medical interaction. Children are socialized indirectly in the ongoing verbal interaction with physician and parent. Consequently, as far as health education is concerned, it is important that both GP and parent guide the child towards managing illness and health care. Treating children as non-participants would appear to undermine the developmental potential of learning by participation. By excluding children from important parts of the medical interaction, they miss the opportunity to develop a gradual sense of responsibility for their own health care. Learning by participation rather than by being excluded from the interaction should be promoted as an important tool for guiding children toward becoming competent participants in medical encounters. Since developing new participant roles occurs through socialization processes, children should be acknowledged as an active party in triadic medical encounters. In this way they will develop a sense of responsibility for their own well-being.

Considering the fact that GPs in the Netherlands have the key role when it comes to curative care for children, we should not underestimate the importance of approaching children in a participatory manner. Physicians and parents should therefore attempt to create a developmental environment which enables children to participate actively in medical contexts. Our study exposed the differences in the participants' orientations regarding child participation. Orientations that were taken for granted by GPs appeared to be unknown to the parent and could therefore be a source of mis-communication. The adults' non-complementary views on child participation may prevent the child from taking an active part in the medical encounter, and may lead to sub-optimal treatment in triadic interactions.

When we look at the perspective of effective communication in the doctor-parent-child triad and in terms of education and counselling of both the child and the parent, then GPs should provide information about the benefits of active child participation in medical communication. With information sharing being a prerequisite for decision-making, GPs should strive to elicit children's perceptions of their illness and expectations associated with the disease in order to arrive at an effective exchange of information. This requires the GP to be clear, to the child as well as the parent, about the desirable participant roles in triadic consultations. In view of the lack of the GP's use of meta-communicative statements regarding the participant roles desired in this triad, we strongly recommend that physicians should explain explicitly why it is important that the child itself should have an active role in medical the interview. It may be possible that parent and child advocate a passive child role, not fully aware of the alternatives. Developmental studies have shown that implicit and explicit assumptions regarding the character of the interaction are quite a constitutive factor for child participation (Elbers & Kelderman, 1994; Elbers & Streefland, 2000). The low degree of child participation may result from children not being aware of how the interaction will proceed. When children are not explicitly told to speak for themselves in a medical context, they obviously take it for granted that their parents will do the talking. Therefore,

the physician should try to break this passive attitude by being clear about the desirability of active contribution to the child itself.
Clarity about the desirability of child participation should also be coupled with attention for parental concerns and communication needs. We focussed on parental concern as a possible cause for the break in GPs' supportive behaviour. The need for parents to express their concerns about their child's health has been documented long ago (Korsch et al., 1968; Freemon et al., 1971), as well as recently (Wissow et al., 1998). In addition, it has been shown that parents expect the physician to use their expert knowledge in making the diagnosis. As these parental communication needs may interfere with the opportunities for child participation, physicians should discuss the benefits of child participation with parents, and in addition address the parents' own needs. This recommendation is in line with Wissow et al. (1999), who found that, although parents consider it part of the physician's job to engage the child in conversation, they remain sensitive to their own communication needs. Finally, since it is critical for physicians to gain a sense of the level of participation the child is capable of, and parents in general might be considered to know most about their child, we recommend that GPs stress and make use of parental expertise. By collaborating and creating a developmental environment, both GP and parent are likely to allow children to be heard in triadic medical encounters.

The findings of this thesis show that, in the case of the doctor-parent-child triad, there are still some gaps to bridge in order to reach the goal of talking *with* children rather than talking *to* children. We therefore recommend that doctor-parent-child communication deserves a place at the very core of research into medical communication.

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Samenvatting

1 Inleiding

In dit proefschrift staat de communicatie tussen huisarts, ouder en kind centraal. Aanleiding voor deze studie was de constatering dat het onderzoek op het terrein van medische communicatie vooral gericht is op de interacties tussen arts en volwassen patiënt. Hoewel de eerste onderzoeken naar arts-patiënt communicatie plaatsvonden binnen de kindergeneeskunde, is er nauwelijks iets bekend over de plaats van het kind in medische gesprekken.
Deze constatering vormde de aanleiding voor een literatuurstudie naar de stand van zaken op het terrein van triadische medische communicatie tussen arts, ouder en kind. Op grond van de resultaten van dit literatuuronderzoek zijn vier empirische onderzoeken verricht met als doel het karakteriseren van de communicatie binnen de triade huisarts, ouder en kind.
In deze inleidende paragraaf worden de resultaten van de literatuurstudie gepresenteerd en de consequenties hiervan geformuleerd voor het huidige onderzoek. Daarna volgt informatie over de gebruikte dataset.

De stand van zaken in het onderzoek naar arts-ouder-kind communicatie (hoofdstuk 2)

De centrale vraag in de literatuurstudie was op welke wijze er de afgelopen drie decennia onderzoek is verricht naar het aandeel van het kind in medische gesprekken. Daarbij is onderzocht welke aspecten van de communicatie binnen de triade arts-ouder-kind centraal stonden en hoe de specifieke rol van het kind in medische gesprekken werd getypeerd. Tot slot is nagegaan in welke mate de in de onderzoeken gehanteerde methodologieën geschikt zijn voor het analyseren van triadische medische interacties.
Het literatuuronderzoek wees allereerst uit dat de communicatie tussen arts, ouder en kind een weinig onderzocht terrein is. De meeste onderzoeken hebben nauwelijks oog voor de rol van het kind in medische interacties. Het bestaande onderzoek naar arts-patiënt communicatie richt zich voornamelijk op de dyade arts-volwassen patiënt. Zelfs als er sprake is van een triade arts-ouder-kind wordt de conversationele bijdrage van het kind veelal buiten beschouwing gelaten. De toon hiervoor lijkt te zijn gezet door het onderzoek van Korsch et al. (1968), waarin de ouder werd vereenzelvigd met de patiënt. Voor zover er aandacht wordt besteed aan de specifieke inbreng van het kind tijdens het medisch interview blijkt dat deze inbreng zeer beperkt is.
Een tweede belangrijke conclusie van de literatuurstudie was dat het schaarse onderzoek naar arts-ouder-kind communicatie gekenmerkt wordt doordat het zich veelal concentreert op één bepaald aspect van de interactie (in termen van relationele, structurele en inhoudelijke kenmerken van de communicatie). Het bestaande onderzoek is vooral gericht op de relationele aspecten van de communicatie en er gaat weinig aandacht uit naar de structurele en inhoudelijke kenmerken van de interactie tussen arts, ouder en kind. Het merendeel van de studies was gericht op het beschrijven van de relationele kenmerken van arts-ouder-kind communicatie in termen van affectief (of so-

cio-emotioneel) en instrumenteel (of taakgericht) gedrag. Dit type onderzoek vindt vooral plaats aan de hand van kwantificerende coderingsschema's. Daarnaast richtten een aantal onderzoeken zich op de structurele kenmerken van arts-ouder-kind communicatie door middel van een karakterisering van de beurtverdeling binnen de triade. Tenslotte was een aantal studies gericht op de inhoud van de interactie in hun nadruk op accommodaties van de interactionele stijl van de arts als reactie op de aanwezigheid van een kind bij een consult. Als gevolg van deze slechts op één aspect van de interactie gerichte analyses, is de kennis over de verschillende aspecten van arts-ouder-kind communicatie gefragmenteerd en nauwelijks geïntegreerd. Voor zover er aandacht werd besteed aan de specifieke inbreng van het kind in het medisch consult, bleek dat deze inbreng zeer beperkt was.
Hoewel de in de literatuurstudie onderzochte studies claimden de communicatie tussen arts, ouder en kind te onderzoeken, bleken de gehanteerde observatiesystemen voornamelijk gebaseerd te zijn op het analyseren van dyades. Slecht in drie onderzoeken is gebruik gemaakt van een observatie-instrument dat was aangepast voor het analyseren van triadische interacties. Een gevolg van deze overheersende dyadische benadering is dat de dynamiek van triadische medische interacties onderbelicht blijft.

Waarom is nader onderzoek naar arts-ouder-kind communicatie nodig?

De literatuurstudie maakt duidelijk dat het aandeel van het kind in medische gesprekken nog nauwelijks is onderzocht. Het schaarse onderzoek op het terrein van arts-ouder-kind communicatie schetst vooral het beeld van kinderen als passieve toeschouwers in medische consulten.
Er zijn echter zowel theoretische, klinische als ook juridische argumenten om meer aandacht te besteden aan de rol van het kind in medische gesprekken. Zo blijkt uit onderzoek dat kinderen meer begrijpen van medische zaken dan tot nu toe werd aangenomen. Daarnaast blijkt uit ontwikkelingspsychologisch onderzoek naar volwassene-kind interacties dat kinderen in instructiesituaties zelf een actievere bijdrage aan de communicatie leveren dan tot nu toe werd aangenomen. Een tweede argument om aandacht te besteden aan de participatie van kinderen in medische gesprekken is het onderzoeksgegeven dat een meer directe communicatie tussen arts en kind een positief effect heeft op het genezingsproces, therapietrouw en tevredenheid. Tenslotte onderstreept de wet Geneeskundige Behandelings Overeenkomst (WGBO) het belang van onderzoek naar communicatie met kinderen in een medische context. Met de invoering van de WGBO is formeel vastgelegd dat in toenemende mate ook van kinderen wordt verwacht dat zij actief deelnemen aan beslissingen op het terrein van ziekte en gezondheid.

Doel en opzet van het huidige onderzoek

Dit proefschrift beoogt een karakterisering te geven van de communicatie tussen huisarts, ouder en kind om zo meer inzicht te verkrijgen over de rol van het kind in medische gesprekken. Op basis van de resultaten van het literatuuronderzoek zijn twee

belangrijke uitgangspunten geformuleerd. Allereerst de claim dat voor een volledig beeld van de communicatie binnen deze triade het noodzakelijk is om de verschillende aspecten van de communicatie in onderling verband te analyseren. Een combinatie van onderzoeksstrategieën, met aandacht voor zowel de structurele, relationele en inhoudelijke kenmerken van de gesprekken, is noodzakelijk voor het verkrijgen van een compleet beeld van de interactie binnen de triade. Het tweede uitgangspunt is dat alleen triadische analyses, waarin het gedrag van alle drie de participanten in onderling verband wordt geanalyseerd, in staat zijn inzicht te geven in de specifieke kenmerken van de interactie tussen huisarts, ouder en kind. Analyses die zich beperken tot de dyadische communicatie tussen arts-ouder en arts-kind verwaarlozen de interactie tussen ouder en kind en negeren de invloed van de aanwezigheid van een derde participant op de dyadische interacties. Voor een goed inzicht in de dynamiek van arts-ouder- kind communicatie kan derhalve niet worden volstaan met het analyseren van de dyades arts-ouder en arts-kind.
Bij deze uitgangspunten is gekozen voor een ontwikkelingspsychologisch perspectief, aangezien de verwachting is dat de participatie van het kind in het medisch consult gerelateerd zal zijn aan de leeftijd van het kind.
Tenslotte hebben zich de laatste decennia zowel op het gebied van arts-patiënt communicatie als in de interactie tussen volwassenen en kinderen een aantal verschuivingen voorgedaan, waarvan verwacht kan worden dat zij van invloed zijn op de interactie tussen huisarts, ouder en kind. Door de ontwikkeling van de meer patiëntgerichte benadering heeft de arts-patiënt relatie zich ontwikkeld van een sterk asymmetrische tot een meer gelijkwaardige relatie. Zo is er in toenemende mate aandacht voor een actieve patiëntparticipatie in processen van informatie-overdracht en besluitvorming. Ook de relatie tussen volwassenen en kinderen is de laatste jaren aan verandering onderhevig. De verhouding tussen ouders en kinderen is minder hiërarchisch geworden en er wordt meer gecommuniceerd tussen ouders en kinderen in een opener klimaat.

Samengevat stelt het onderhavige onderzoek zich het volgende tot doel:
1. Het karakteriseren van de communicatie tussen huisarts, ouder en kind in termen van de structurele, relationele en inhoudelijke kenmerken van de interactie.
2. Het onderzoeken van de invloed van de leeftijd van het kind op de communicatie binnen deze triade.
3. Het onderzoeken of zich de afgelopen dertig jaar veranderingen hebben voorgedaan in de communicatie tussen huisarts, ouder en kind.

Data

Het databestand waarop de in dit proefschrift gepresenteerde studies zijn gebaseerd, bestaat uit 106 videoregistraties van medische consulten waarbij een huisarts, een ouder en een kind zijn betrokken. De video-opnames zijn geselecteerd uit het databestand van het NIVEL (Nederlands instituut voor onderzoek van de gezondheidszorg) en omvatten drie opnameperiodes: 1975-1978 (n=36), 1988-1989 (n=36) en 1993 (n=34).

De leeftijd van de kinderen lag tussen de vier en twaalf jaar (de gemiddelde leeftijd was acht jaar) en er waren evenveel jongens als meisjes bij het onderzoek betrokken. In de meeste consulten werd het zieke kind begeleid door de moeder (n=88) en alle kinderen hadden de huisarts eerder ontmoet. In het onderzoek namen in totaal 58 huisartsen deel; 22 in periode 1 (gemiddeld 1.6 consulten), 15 in periode 2 (gemiddeld 2.4 consulten) en 21 in periode 3 (gemiddeld 1.6 consulten). Het merendeel van de artsen was man (n=53). Alle participanten namen aan slechts één opnameperiode deel en hadden de Nederlandse nationaliteit. De gemiddelde duur van het consult was rond de zeven minuten.

De opbouw van dit hoofdstuk is als volgt: eerst worden de resultaten van de vier empirische studies weergegeven. Daarna volgt een discussie waarin wordt ingegaan op de theoretische en methodologische consequenties van de verrichte analyses. Vervolgens worden aanbevelingen voor vervolgonderzoek geformuleerd en wordt ingegaan op de consequenties voor de dagelijkse medische praktijk.

2 Samenvatting van de resultaten van de empirische deelstudies

Het empirische deel van dit proefschrift bestaat uit vier onderzoeken die elk ingaan op een onderscheiden aspect van de communicatie tussen huisarts, ouder en kind. In hoofdstuk 3 wordt door middel van een analyse van de beurtverdeling nader ingegaan op de structurele kenmerken van de communicatie binnen de triade. De studie beschreven in hoofdstuk 4 gaat in op de relationele kenmerken van de interactie tussen huisarts, ouder en kind, in termen van instrumenteel (of taakgericht) en affectief (of socio-emotioneel) gedrag. De bevinding dat de beide volwassen participanten aanzienlijk verschilden in de mate waarin zij het kind bij het medisch gesprek probeerden te betrekken, was de aanleiding voor de derde deelstudie. Vanuit een interactioneel sociolinguïstisch perspectief wordt in deze studie ingegaan op de inhoudelijke kenmerken van de communicatie in termen van participantenrollen. De resultaten van deze analyse staan beschreven in hoofdstuk 5. De in hoofdstuk 6 beschreven studie bouwt voort op deze resultaten en heeft als doel de arts-ouder-kind relaties nader te karakteriseren vanuit een pedagogisch perspectief.

Beurtverdeling in arts-ouder-kind communicatie (hoofdstuk 3)

De eerste empirische studie richtte zich op de structurele kenmerken van arts-ouder-kind communicatie door analyse van de sequentiële patronen van beurtverdeling binnen de triade. De manier waarop een interactie is gestructureerd in termen van beurtverdeling en conversationele bijdrage kan gezien worden als een typering van de communicatie in termen van asymmetrie en controle. De sequentiële patronen van beurtverdeling binnen de triade werden geanalyseerd met behulp van het Turn Allocation System (TAS), gebaseerd op het werk van Aronsson en Rundström (1988) en aangepast voor het analyseren van triadische interacties. Alle verbale beurten van de

drie gespreksdeelnemers zijn geanalyseerd in termen van initiatief, beurttoewijzing en reactie. Dit resulteerde in een dataset van 8373 beurten.
De resultaten maakten duidelijk dat de conversationele bijdrage van het kind beperkt was: de arts richtte de meeste beurten tot de ouder; slechts 13% van de beurten van de arts waren tot het kind gericht. In vijf van de 106 consulten sprak de arts het kind geen enkele keer aan. Analyse van de reactiepatronen liet vervolgens zien dat vooral de ouder verantwoordelijk was voor het buitensluiten van het kind aan het gesprek, door in meer dan de helft van het aantal beurten dat de arts tot het kind richtte, de beurt over te nemen. Conform de verwachting was de bijdrage van het kind sterk afhankelijk van de leeftijd; het aandeel kindgerichte beurten van de arts nam significant toe naarmate het kind ouder was. Tegelijkertijd namen oudere kinderen zelf meer initiatieven om deel te nemen aan het medisch gesprek. De patronen van beurtverdeling binnen de triade bleken ook veranderlijk in de tijd; vergeleken met de consulten uit de jaren zeventig vertoonden de kinderen in de jaren tachtig zelf meer initiatieven en interrumpeerden zij frequenter in arts-ouder gesprekken. Daarnaast richtte de arts minder beurten tot de ouder in deze tweede periode. In tegenstelling tot de verwachting zette deze trend zich niet voort in de consulten uit de derde periode; slechts de groep tien- tot twaalfjarigen gaf ook in de jaren negentig een toegenomen participatie te zien. De ouderlijke patronen van beurtverdeling bleken echter zeer constant; onafhankelijk van de leeftijd van het kind en van de periode was de ouderlijke controle constant.

Arts-ouder-kind communicatie in termen van instrumenteel en affectief gedrag (hoofdstuk 4)

Als aanvulling op het onderzoek naar de beurtverdeling richtte de tweede empirische studie zich vooral op de relationele kenmerken van de communicatie binnen de triade. In sociaal-psychologisch onderzoek naar medische communicatie staan in het algemeen twee dimensies van gedrag centraal die gerelateerd zijn aan de behoeften van de patiënt: instrumenteel of taakgericht gedrag en affectief of socio-emotioneel gedrag. Instrumenteel gedrag is gericht op het oplossen van medische problemen en betreft vaardigheden als het stellen van vragen en het verschaffen van informatie, terwijl affectief gedrag vooral gericht is op het scheppen van een goede relatie tussen arts en patiënt.
Voor het in kaart brengen van deze relationele aspecten is gebruik gemaakt van het Roter Interaction Analysis System (RIAS). Het RIAS is momenteel het meest gehanteerde codeerinstrument voor medische interacties. Voor het doel van het huidige onderzoek werd het RIAS aangepast voor het analyseren van triadische medische interacties. Van elke deelnemer werden alle uitingen rechtstreeks van de videoband geclassificeerd in een van de 16 gedragscategorieën, waarbij tevens werd genoteerd tot wie de uiting was gericht. In tegenstelling tot het in de literatuur geschetste beeld bleek de interactie tussen arts en kind niet beperkt te zijn tot het affectieve domein. De arts-kind relatie bleek beslist meer te omhelzen dan een 'joking' relationship. Zo stelde de arts bijna de helft van de medische vragen rechtstreeks tot het

kind. Vervolgens richtte de arts zich bij het verstrekken van medische informatie en medische adviezen echter weer voornamelijk tot de ouder. Slechts negen procent van de medische informatie werd rechtstreeks aan het kind gegeven, terwijl het verstrekken van medisch advies aan het kind beperkt bleef tot vijf procent. De leeftijd van het kind bleek alleen van invloed op het instrumentele gedrag van arts en kind; naarmate het kind ouder was nam de uitwisseling van medische informatie tussen arts en kind toe. Het blijft echter opmerkelijk dat de arts het (oudere) kind kennelijk wel in staat acht tot het verstrekken van medische informatie, maar niet capabel genoeg voor het ontvangen van medische informatie en advies. De aard van het gedrag van de ouder werd niet beïnvloed door de leeftijd van het kind. Een vergelijking van de drie perioden liet zien dat veranderingen in de tijd beperkt waren. Alleen in de groep tien- tot twaalfjarigen was er in de tweede periode sprake van een toegenomen uitwisseling van medische informatie tussen arts en kind.

Participantenrollen in arts-ouder-kind communicatie (hoofdstuk 5)

Vanuit het oogpunt van de participatie van het kind in medische gesprekken is de bevinding dat arts en ouder fundamenteel verschillen in de mate waarin zij het kind betrekken in de medische interactie een belangrijke uitkomst. De voorafgaande studies maakten duidelijk dat artsen probeerden deelname van het kind te stimuleren door, afhankelijk van de leeftijd van het kind, hen actief te betrekken, met name tijdens de eerste fase van het consult. Ouders daarentegen, leken participatie van het kind juist tegen te werken door onafhankelijk van de leeftijd van het kind frequent in te breken in de communicatie tussen arts en kind. De vraag hoe deze verschillen te verklaren, was de aanleiding voor een derde empirische studie, gericht op de inhoudelijke kenmerken van de interactie binnen de triade. Het doel van deze analyse was na te gaan of deze verschillen in het conversationele gedrag van arts en ouder te herleiden waren tot verschillende oriëntaties op deelnemersrollen binnen de triade.

Vanuit een interactioneel sociolinguïstisch perspectief is geanalyseerd hoe de gespreksdeelnemers in hun verbale en nonverbale gedrag blijk geven van hun oriëntaties op deelnemersrollen in arts-ouder-kind gesprekken. De analyse concentreerde zich op een aantal sequentieel belangrijke beurten in het medisch gesprek, zoals de uitnodiging tot het presenteren van de klacht, de realisering van zowel de globale als de specifieke klachtpresentatie en het adresseren van de informatie over diagnose en therapie. De linguïstische realisering van deze beurten fungeerde als signaal; aanspreekvormen, verwijzingen naar personen, blikrichting en lichaamshouding waren indicatief voor onderliggende aannames ten aanzien van deelnemersrollen en de status van het kind in het triadische medisch consult.

De resultaten illustreren het interactieve karakter van deelnemersrollen binnen de triade arts-ouder-kind. Het conversationele gedrag van arts en ouder maakte duidelijk dat zij zich bij aanvang van het consult oriënteren op verschillende deelnemersrollen. De arts gaf tijdens de eerste fase van het consult herhaaldelijk blijk te streven naar een actieve participatie van het kind. De ouder daarentegen manifesteerde zich vanaf de

aanvang van het consult als woordvoerder voor het kind ("Ik kom voor zijn keel'). In de loop van het consult leken artsen de rol van de ouder als woordvoerder voor het kind meer en meer te accepteren; zij oriënteerden zich minder op het kind en brachten een dyadische interactie met de ouder tot stand. De conclusie is dan ook dat de status van kinderen als toeschouwers in hun eigen medisch consult door alle drie de deelnemers gezamenlijk tot stand wordt gebracht. Ouders lieten door hun gedrag zien dat zij zich beschouwen als woordvoerder van het kind op het terrein van ziekte en gezondheid. Met elke stap in het consult bevestigden zij hun status als primaire spreker. Kinderen ratificeerden dit gedrag door zich afwachtend op te stellen in het medisch consult. De arts tenslotte werkte mee aan de uitsluiting van het kind tijdens de laatste fase van het consult door zich in de loop van het gesprek te conformeren aan de door de ouders gehanteerde deelnemersrollen

Een typologie van arts-ouder-kind relaties (hoofdstuk 6)

De voorgaande studies benadrukten de cruciale rol van de volwassen participanten in arts-ouder-kind interacties; het conversationele gedrag van arts en ouder bleek bepalend te zijn voor de mogelijkheden voor het kind om deel te nemen aan het medisch gesprek. De vierde empirische studie bouwde voort op deze bevindingen en stelde zich ten doel de relatie tussen arts, ouder en kind nader te karakteriseren vanuit een pedagogisch perspectief.

Uitgangspunt van de analyse was het gedrag van de volwassenen en van het kind in onderlinge samenhang te analyseren. In deze aanzet tot een typologie van arts-ouder-kind relaties werd daartoe een typologische benadering gekoppeld aan een interactionele benadering. De eerste stap in de analyse bestond uit het typeren van het verbale en nonverbale gedrag van arts en ouder naar de mate waarin zij het kind aanmoedigden deel te nemen aan het medische gesprek. Het gedrag van de arts werd als steunend getypeerd wanneer de arts het kind direct probeerde te betrekken in de medische informatie-uitwisseling en de besluitvorming, het kind aanmoedigde actief deel te nemen aan het gesprek en het kind aansprak bij de voornaam. Ouderlijk gedrag werd als steunend getypeerd wanneer de ouder het kind de ruimte gaf om in gesprek te raken met de arts, bijvoorbeeld door niet onnodig in te breken in arts-kind interacties en het kind aanmoedigde actief deel te nemen aan het gesprek. Daarnaast werd het gedrag van het kind getypeerd aan de hand van twee dimensies. Allereerst werd onderzocht in welke mate het kind zich betrokken toonde bij het medisch gesprek. Vervolgens is gekeken in welke mate het kind steun zocht bij de ouder tijdens de medische interactie.

Op het eerste gezicht kon de relatie tussen huisarts, ouder en kind getypeerd worden als paternalistisch; beide volwassen participanten domineerden de interactie. In de meeste interacties werd het kind nauwelijks gestimuleerd tot deelname aan het gesprek. Deze constatering is conform het stereotype beeld van arts-ouder-kind interacties, waar de feitelijke communicatie zich afspeelt binnen de dyade arts-ouder. Het additionele interactionele perspectief bood echter inzicht in de onderliggende mechanismen die leidden tot dit stereotype beeld. Er bleek sprake van een sterke wisselwer-

king tussen de mate waarin het gedrag van arts en ouder gericht was op het stimuleren van deelname van het kind aan het gesprek en het gedrag van het kind zelf. Kinderen toonden zich meer actief betrokken in consulten waarin de arts steunend gedrag vertoonde. In consulten waarin beide volwassenen een niet- steunende rol aannamen in interactie met het kind, toonde het kind zelf nauwelijks enige betrokkenheid Dit passieve, teruggetrokken gedrag van het kind was mede verantwoordelijk voor de totstandkoming van het dyadische karakter van de interactie en droeg bij aan de status van het kind als passieve toehoorder in het medisch consult.
De resultaten onderstreepten ook dat arts-ouder-kind relaties niet statisch zijn; de mate waarin de arts het kind stimuleerde tot deelname aan het gesprek bleek sterk afhankelijk van de fase van het consult. Terwijl 28% van de artsen zich tijdens de eerste fase van het consult nog steunend opstelde, beëindigde 90 % van de artsen de consulten op een niet steunende manier. Een additionele analyse maakte duidelijk dat deze verandering in artsgedrag te herleiden was tot het gedrag van alle drie de participanten. In een aantal gevallen kon de verschuiving in artsgedrag toegeschreven worden aan het kind, zoals een gebrek aan achtergrondkennis of passief en teruggetrokken gedrag van het kind. Het gedrag van de ouder bleek echter een meer bepalende factor te zijn voor de toename van niet-steunend arts gedrag tijdens de laatste fase van het consult. In veel gevallen forceerden ouders deze verandering door het aanhoudend stellen van vragen en het uiten van bezorgdheid over de toestand van het kind. De arts werd hierdoor gedwongen aandacht te besteden aan de ouder. Tenslotte waren ook arts-gerelateerde factoren debet aan de verschuiving; in geen van de 106 consulten stelde de arts de wenselijkheid van een actieve deelname van het kind expliciet aan de orde.
Conform de verwachting bleek de leeftijd van het kind bepalend voor de mogelijkheden tot deelname aan het medisch gesprek. Tijdens de eerste fase van het consult vertoonden zowel arts als ouder frequenter steunend gedrag in interactie met oudere kinderen. Tegelijkertijd toonden oudere kinderen zich zelf meer betrokken bij het gesprek dan jongere kinderen.

3 Theoretische en methodologische reflecties

Zoals gesteld in de inleiding, staan in dit proefschrift twee lijnen centraal. Allereerst het uitgangspunt dat aandacht voor de verschillende aspecten van de communicatie door middel van een combinatie van onderzoeksstrategieën een vollediger beeld geeft van de interactie tussen huisarts, ouder en kind. Daarnaast de stelling dat in het geval van een triadische medische interactie de communicatie tussen alle drie de participanten in de analyse moet worden betrokken. Wat zijn nu de theoretische en methodologische conclusies die op grond van de resultaten van dit onderzoek kunnen worden getrokken?

Arts-ouder-kind communicatie: een terugblik

In dit proefschrift is de communicatie tussen huisarts, ouder en kind vanuit een aantal verschillende perspectieven geanalyseerd. In de literatuur over het analyseren van (medische) mondelinge interacties concentreerde het debat zich lange tijd op de dichotomie tussen kwantitatief en kwalitatief onderzoek. In deze tweedeling wordt kwantitatief onderzoek getypeerd als deductief, objectief en uitkomstgericht. Dit type onderzoek is vooral gericht op het classificeren en kwantificeren van 'wat' er gebeurt. Daartegenover wordt kwalitatief onderzoek geplaatst, dat meer inductief, subjectief en procesgericht van aard is. De aandacht is hierbij vooral gericht op de betekenis van de bevindingen; op het 'hoe' en 'waarom'. In onderzoek naar medische communicatie staat de sociaal-psychologische benadering centraal, waarbij de interactie vanuit een 'top-down' perspectief wordt geanalyseerd met behulp van gevalideerde codeersystemen. In dit type analyse ligt de nadruk vooral op de relationele aspecten van de interactie. Zowel vanuit sociaal-psychologisch onderzoek naar medische interacties als vanuit de praktijk van de gespreksanalyse wordt echter steeds meer benadrukt dat het onderscheid kwantitatief versus kwalitatief gepolariseerd is en dat het onjuist is om de beide onderzoeksparadigma's als wederzijds uitsluitend te beschouwen.

Bij de in dit proefschrift gepresenteerde studies is dan ook expliciet gekozen voor een pragmatisch in plaats van een paradigmatisch perspectief. Uitgangspunt bij de analyses was niet de principiële keuze voor kwantitatief dan wel kwalitatief onderzoek, maar de mate waarin een specifieke onderzoeksmethode een antwoord kon geven op de onderscheiden onderzoeksvragen. Deze keuze leidde ertoe dat een viertal empirische analyses uitgevoerd zijn die verschilden in termen van achterliggende discipline en methode. In de eerste empirische studie werd een kwalitatief concept als beurtwisseling gekwantificeerd teneinde een uitspraak te kunnen doen over de structurele kenmerken van de communicatie binnen de triade. Het daarbij gehanteerde TAS-systeem werd speciaal ontworpen voor het in kaart brengen van de sequenties van initiatieven en reacties van de participanten. Het onderzoek liet zien dat de conversationele bijdrage van het kind aan het medisch gesprek beperkt is. De grote verdienste van deze triadische sequentiële analyse is dat het de aandacht vestigde op het fenomeen van ouderlijke controle. Een dyadische analyse die zich had beperkt tot de communicatie tussen arts-ouder en arts-kind, zoals gebruikelijk is in onderzoek naar medische communicatie, had dit fenomeen niet kunnen blootleggen.

In de tweede empirische studie werd voor het in kaart brengen van de relationele kenmerken van de interactie het RIAS gebruikt. Dit kwantitatieve, uit de sociaal-psychologische traditie voortgekomen codeersysteem, is ontworpen voor het beoordelen van dyadische medische interacties en is op het ogenblik het meest toegepaste analyse-instrument in onderzoek naar medische communicatie. Voor het doel van het huidige onderzoek werd het RIAS aangepast voor het analyseren van triadische medische interacties. In tegenstelling tot het in de literatuur geschetste beeld, blijkt de arts zich in interactie met het kind niet te beperken tot het affectieve domein. Conform eerder onderzoek naar medische interacties waarbij een kind is betrokken, was er een opvallend

verschil in het vragen en adresseren van medische informatie. Hoewel de arts tijdens de klachtverheldering bijna de helft van de medische vragen tot het kind richtte, werd het kind nauwelijks betrokken bij de bespreking van diagnose en behandeling. De kracht van het huidige onderzoek is dat het laat zien dat de onderliggende patronen van beurtverdeling hierin een belangrijke rol spelen. De koppeling van het sequentiële framework van het TAS met de frequentiële resultaten van de RIAS-analyse leidde zo tot een beter inzicht in de dynamiek van de interactie binnen de triade.
De bevinding dat arts en ouder fundamenteel verschilden in de mate waarin zij de participatie van het kind stimuleerden, was aanleiding voor de derde empirische studie, gericht op de inhoudelijke kenmerken van de interactie binnen de triade. Vanuit een interactioneel sociolinguïstisch perspectief werden de participantenrollen binnen de triade geanalyseerd. De interactionele sociolinguïstiek bouwt voort op inzichten uit de etnografie van de communicatie en conversatie analyse en analyseert de interactie als een zich beurt voor beurt ontwikkelend proces. Als aanvulling op deze kwalitatieve, inductieve procedure, werden de onderzoeksresultaten gekwantificeerd. Dankzij dit onderzoeksperspectief was het mogelijk aan te tonen dat het verschil in het conversationele gedrag van beide volwassen participanten te herleiden was tot een verschil in oriëntatie op participantenrollen.
Het doel van het vierde empirische onderzoek was het nader karakteriseren van de relaties tussen arts, ouder en kind, vanuit een gecombineerd typologisch en interactioneel perspectief. Deze deelstudie was niet gericht op één enkel aspect van de interactie binnen de triade, maar incorporeerde verschillende aspecten van voorafgaande analyses. Het gekozen onderzoeksperspectief bood inzicht in de dynamiek en diversiteit van arts-ouder-kind relaties. De verdienste van het onderzoek is dat het laat zien hoe het verschijnsel dat artsen wel informatie vragen aan kinderen, maar kinderen zelden betrekken in de besluitvorming door alle drie de participanten gezamenlijk tot stand wordt gebracht. Deze conclusie zou niet mogelijk geweest zijn zonder het in de laatste studie gehanteerde sequentiële en interactionele perspectief.
De laatste twee studies zetten de interpretaties van de TAS-analyse in een ander daglicht. In de beurtenanalyse werd gebruik gemaakt van het begrip controle om het ouderlijk ingrijpen in de interactie tussen arts en kind te duiden. Op grond van de resultaten van beide interactionele analyses moeten we echter concluderen dat het traditionele concept van controle een versimpeling van de werkelijkheid inhoudt en voorbijgaat aan het interactioneel geconstrueerde karakter van arts-ouder-kind interacties.

Meerwaarde van een analyse vanuit verschillende perspectieven

De vier empirische deelstudies leverden elk voor zich informatie op over belangrijke aspecten van de communicatie tussen huisarts, ouder en kind. De volgorde waarin de onderzoeken zijn verricht weerspiegelt de verdiensten en tekortkomingen van de gehanteerde onderzoeksmethodieken. Door hun complementaire aard bleken TAS en RIAS geschikt om de contouren van de communicatie binnen de triade in grote lijnen te schetsen. Dankzij het frequentiële karakter van beide analyses is een goed inzicht

verkregen in de omvang van de gedragingen van de participanten. De sequentiële inbedding van het TAS-onderzoek geeft daarbij de resultaten van de RIAS-analyse meer diepgang. Hoewel beide analyses de aandacht vestigden op het verschil in de mate waarin arts en ouder kinderen bij het gesprek proberen te betrekken, waren TAS en RIAS niet in staat deze fenomenen te verklaren.
Dankzij het interactionele en sequentiële karakter van de laatste twee empirische onderzoeken was het mogelijk een beter inzicht te krijgen in een aantal onderliggende conversationele mechanismen binnen de triade. Zo maakten de interactionele studies duidelijk hoe de klassieke situatie van het kind als passieve toeschouwer in het medisch consult in feite door alle drie de participanten tot stand wordt gebracht. In dit licht zijn de interactionele studies een belangrijke aanvulling op de descriptieve TAS- en RIAS-analyses. Anderzijds zou het zonder de kwantificering van de eerste twee onderzoeken onmogelijk zijn een uitspraak te doen over de omvang van deze onderzochte gedragingen.
Concluderend kunnen we stellen dat het uitgangspunt dat vooral een combinatie van onderzoeksperspectieven bijdraagt aan een betekenisvolle karakterisering van de communicatie tussen huisarts, ouder en kind, wordt ondersteund door de resultaten van de in dit proefschrift gepresenteerde onderzoeken. De onderzoeksresultaten geven aan dat een analyse vanuit verschillende perspectieven leidt tot een beter inzicht in de communicatie binnen de triade dan door een analyse vanuit een enkel perspectief bereikt had kunnen worden. In dit licht bezien is het onderscheid tussen kwalitatief en kwantitatief onderzoek een onproductieve tweedeling voor het typeren van de uitgevoerde onderzoeken; er waren belangrijkere verschillen tussen de vier deelstudies dan het feit of er gebruik gemaakt werd van kwantificering (wat feitelijk in alle studies plaatsvond).

Meerwaarde van een triadische analyse

De binnen het kader van dit proefschrift uitgevoerde literatuurstudie maakt duidelijk dat de dyadische benadering overheerst in het onderzoek naar arts-ouder-kind communicatie. Deze myopische benadering draagt ertoe bij dat kinderen vrijwel onzichtbaar zijn in het onderzoek naar medische interacties. Dit proefschrift laat zien dat een triadische analyse noodzakelijk is om de dynamiek binnen de triade zichtbaar te maken: interacties binnen de ene dyade beïnvloeden de dynamiek binnen de andere dyades en derhalve dient het communicatieve gedrag van alle participanten in de analyse betrokken te worden. Zowel de constatering als de verklaring van het fenomeen van ouderlijke controle zou niet mogelijk zijn geweest als de analyse beperkt zou zijn gebleven tot de dyades arts-ouder en arts-kind.

4 Aanbevelingen voor verder onderzoek

De empirische studies die binnen het kader van dit proefschrift zijn uitgevoerd, waren gebaseerd op 106 op video opgenomen consulten tussen huisarts, ouder en kind uit de jaren zeventig, tachtig en negentig. Aangezien alle participanten slechts aan één op-

nameperiode deelnamen, is het onderhavige onderzoek cross-sectioneel van aard. Een gevolg van deze opzet is dat het huidige onderzoek geen informatie kan geven over veranderingen op het niveau van de individuele deelnemer. Aangezien de verwachting is dat arts-ouder-kind relaties ook op een individueel niveau aan verandering onderhevig zijn, is het wenselijk dat toekomstig onderzoek gebruik zal maken van longitudinale data om deze eventuele veranderingen in kaart te brengen. Het is daarbij ook van belang om na te gaan hoe de individuele ervaringen van kinderen op het terrein van medische gesprekken van invloed zijn op interactie tussen arts, ouder en kind.
Als gevolg van het feit dat de gepresenteerde onderzoeken berusten op secundaire analyses blijven een aantal belangrijke zaken onderbelicht. Zo was het niet mogelijk om de relatie tussen de gesprekskenmerken binnen de triade te relateren aan uitkomstvariabelen zoals bijvoorbeeld therapietrouw en tevredenheid. Voor het optimaliseren van een effectieve communicatie tussen arts, ouder en kind is nader onderzoek op dit gebied onontbeerlijk.
De resultaten van de serie onderzoeken maken duidelijk dat de participatie van het kind in het medisch consult sterk afhankelijk is van de leeftijd van het kind en onderstrepen de noodzaak om de cognitieve ontwikkeling van het kind expliciet in de analyse op te nemen. Binnen het kader van dit proefschrift werd de leeftijd van het kind gebruikt als een index voor de cognitieve ontwikkeling. Aangezien we ons terdege bewust zijn van de beperktheid van deze operationalisering, is nader onderzoek nodig naar de relatie tussen verschillende aspecten van cognitieve ontwikkeling en de participatiemogelijkheden van het kind in het medisch gesprek. Zowel vanuit een ontwikkelingspsychologisch als een pedagogisch perspectief is het wenselijk dat toekomstig onderzoek zich daarbij richt op de vraag hoe kinderen van een bepaalde leeftijd optimaal bij het medisch gesprek betrokken kunnen worden.
Een belangrijke vraag voor toekomstig onderzoek, tenslotte, is de vraag hoe patiëntgerichte zorg gedefinieerd moet worden in het geval van triadische medische interacties zoals de communicatie tussen huisarts, ouder en kind. Recent onderzoek wijst uit dat zowel de inschatting van de medische toestand van het kind als ook de communicatieve behoeften van ouder en kind sterk kunnen uiteenlopen. Nader onderzoek, bijvoorbeeld in de vorm van interviews, vragenlijsten en vignetstudies, is wenselijk om een gedifferentieerd beeld te krijgen over de wensen en verwachtingen ten aanzien van triadische medische interacties van zowel ouder, kind als arts. Een extra uitdaging daarbij is de ontwikkeling van kindgerichte onderzoeksmethoden die geschikt zijn voor het bevragen van kinderen van verschillende leeftijden.

5 Implicaties voor de praktijk

De resultaten van het onderzoek hebben een aantal belangrijke implicaties voor de praktijk van de medische gespreksvoering en de gezondheidsvoorlichting. Gezien het feit dat jonge kinderen bij hun bezoek aan de huisarts altijd vergezeld worden door (een van) hun ouders, is het van groot belang dat zowel arts als ouder zich bewust zijn

van de invloed van hun conversationele gedrag op de participatiemogelijkheden van het kind. In het kader van de gezondheidsopvoeding van kinderen dienen beide volwassenen zich te realiseren dat kinderen de kans moeten krijgen om te leren deelnemen aan medische gesprekken. Door kinderen uit te sluiten van deelname aan de medische interactie, ontneemt men hen de mogelijkheid om van jongs af aan een (gedeelde) verantwoordelijkheid te ontwikkelen voor hun eigen ziekte en gezondheid. De huisarts heeft een centrale rol in de gezondheidszorg in Nederland en heeft in het algemeen de mogelijkheid om een langdurige relatie op te bouwen met ouder en kind. Deze positie biedt de mogelijkheid om kinderen al van jongs af aan, op een manier die past bij de leeftijd van het kind, te betrekken in het medisch consult. Het verdient aanbeveling dat de arts het kind met name in de conclusiefase meer betrekt bij het consult, aangezien onderzoek uitwijst dat goed geïnformeerde kinderen zo meer onthouden van de medische informatie en sneller genezen.

Het huidige onderzoek maakt duidelijk dat de participanten verschillende verwachtingen kunnen hebben over de deelnemersrollen binnen de triade. Niet-complementaire rolopvattingen van arts en ouder over de deelname van het kind aan het medisch gesprek kunnen de participatie van het kind ernstig bemoeilijken. Het is daarom van groot belang dat de arts duidelijkheid verschaft over de wenselijkheid van een actieve deelname van het kind. Gezien de afwezigheid van meta-communicatie over dit onderwerp, lijkt het raadzaam artsen te adviseren om al bij aanvang van het consult expliciet de deelname van het kind aan de orde te stellen.

Daarnaast dient de arts oog te hebben voor de verwachtingen en behoeften van de ouder. Ouders moeten in staat gesteld worden hun eigen visie op en eventuele zorgen over de gezondheidstoestand van hun kind kenbaar te maken. Zo lijkt een belangrijke taak weggelegd voor de huisarts in het vinden van een balans tussen de behoeften van zowel ouder als kind. Juist door een optimale samenwerking tussen arts en ouder moet het mogelijk zijn het kind een eigen stem te geven in het medisch consult.

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Appendix A: Turn Allocation System (TAS)

DCAT.C:	child-allocated initiative doctor, response child
DCAT.P:	child-allocated initiative doctor, response parent
DCAT.B:	child-allocated initiative doctor, response child+parent
DPAT.P:	parent-allocated initiative doctor, response parent
DPAT.C:	parent-allocated initiative doctor, response child
DPAT.B:	parent-allocated initiative doctor, response child+parent
DBAT.C:	child+parent allocated initiative doctor, response child
DBAT.P:	child+parent allocated initiative doctor, response parent
DBAT.B:	child+parent allocated initiative doctor, response child+parent
PDAT.D:	doctor-allocated initiative parent, response doctor
PDAT.C:	doctor-allocated initiative parent, response child
PDAT.B:	doctor-allocated initiative parent, response doctor+child
PCAT.C:	child-allocated initiative parent, response child
PCAT.D:	child-allocated initiative parent, response doctor
PCAT.B:	child-allocated initiative parent, response child+doctor
PBAT.C:	doctor+child allocated initiative parent, response child
PBAT.D:	doctor+child allocated initiative parent, response doctor
PBAT.B:	doctor+child allocated initiative parent, response child+doctor
CDAT.D:	doctor-allocated initiative child, response doctor
CDAT.P:	doctor-allocated initiative child, response parent
CDAT.B:	doctor-allocated initiative child, response doctor+parent
CPAT.P:	parent-allocated initiative child, response parent
CPAT.D:	parent-allocated initiative child, response doctor
CPAT.B:	parent-allocated initiative child, response parent+doctor
CBAT.D:	doctor+parent-allocated initiative child, response doctor
CBAT.P:	doctor+parent-allocated initiative child, response parent
CBAT.B:	doctor+parent-allocated initiative child, response doctor+parent

Appendix B: Observation form Roter's Interaction Analysis System (RIAS)

Instrumental categories:

Giving directions
(Gives orientation; gives instruction; transition)
Asking for clarification
(Bids for repetition; asks for understanding or opinion)
Medical questioning: open-ended and closed-ended
(Medical condition; therapeutic regimen; request for services)
Psycho-social questioning: open-ended and closed-ended
(Lifestyle / social context; psycho-social / feelings)
Providing medical information
(Medical condition; therapeutic regimen)
Providing psycho-social information
(Lifestyle / social context; psycho-social / feelings)
Medical counselling
(Medical condition; therapeutic regimen)
Psycho-social counselling
(Lifestyle / social context; psycho-social / feelings)
Other instrumental utterances

Socio-emotional categories:

Social behaviour
(Personal remarks; jokes and laughter; approval; complimenting)
Agreement
(Agreement; understanding; back-channel responses)
Paraphrase
(Paraphrase; checks for understanding)
Verbal attention
(Empathy; legitimizes; partnership and support)
Concern
(Showing concern or worry)
Reassurance
(Reassures, encourages; asks for reassurance)
Disagreement
(Disapproval; criticism)

Curriculum Vitae

Kiek Tates was born in Capelle aan den IJssel, the Netherlands, on 3 September 1955. After completing pre-university education (Atheneum) at the Comenius College in Capelle aan den IJssel, she started to study Physiotherapy in Utrecht. From 1978 to the end of 1985 she worked as a physiotherapist with physically retarded children in primary health care and special primary education.

She subsequently obtained a secondary school teaching certificate for the Dutch language, and in 1990 enrolled in a Discourse Studies course at the University of Tilburg, from which she graduated with distinction in 1994. In 1993 and 1996 she was a temporary lecturer in Conversation Analysis in the Faculty of Arts at Tilburg University. Since 1996 she has worked as a research associate in the Department of General Social Sciences at Utrecht University on the present thesis.

In October 2001 she will embark on a social-oncological fellowship funded by the Dutch Cancer Society / KWF. During this fellowship she will focus on processes of information exchange and shared decision-making within the triad child diagnosed with cancer, oncologist and accompanying parent.