How potentially serious symptom changes are talked about and managed in COPD clinical review consultations: a micro-analysis.

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Background

The factors influencing delayed diagnosis of cancer have been a key interest for research. Delays of up to a year between onset of worrying symptoms and medical consultation have been reported in the UK. Groups such as long-term smokers, those living alone, and those with conditions such as Chronic Obstructive Pulmonary Disease (COPD) (Young *et al*, 2009), have been found to take longer to consult with lung cancer symptoms (Smith *et al*, 2005). This is significant because people with COPD have frequent interactions with health care professionals. This regular clinical contact provides an opportunity for patients to highlight new symptoms of concern, and for clinicians to be watchful for new symptomatic indicators.

Aims

To describe reoccurring interactional motifs which might impact on whether or not a patient brought up symptoms of concern.

Findings

We observed three main formats that patients used to present new symptomatic concerns. These were: *direct; embedded* and *oblique*. Both settings offered interactional 'slots' for patients to offer new and concerning symptomatic information. However, the structure of nurse led encounters tended to limit opportunities for patients to develop extended symptom narratives which facilitated 'oblique' formats .

Methods

We conducted a micro-interactional analysis of 39 clinical consultations between patients with COPD and primary care professionals. 16 of these involved patients and their GP (n=6 GPs), and 23 with a practice nurse (n=8 nurses). Interactions were examined using conversation analysis to explore how, at the level of the individual turns at talk, participants engaged in symptomatically relevant exchanges. We observed the sequential positioning and interactional outcomes that these types of engagements engendered.

Direct format: The patient volunteers new symptomatic concerns as the result of a straightforward enquiry by the practitioner, often during formalised information gathering.

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1 Doc: I can't find anything on the blood test -
2      things I would be concerned about.
3 Pat: Right
4 Doc: Ok
5      (1.5)
6 Pat: Yes, so- (0.5) would I- (.) could I ask
7       erm: (.) is it possible that I could
8       have some sort of mild sleeping tablet
9       that I could (.) 'cos me sleeping's
10      terrible.
24 Doc: It's terrible
25 Pat: Oh it's terrible, me sleeping.
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Embedded format: New symptoms or concerns introduced by the patient, as a discrete step in a symptom related narrative

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1        . . you've not had a chest x-ray for a
2        while.
3  Pat:  A long time (.) I can't tell you how
long.
4  Nur:  [Typing] would it be years?
5  Pat:  Yes, yes. Er::m I've had a couple of
6        erm: chest do's in the winter, you know
7        (.) chest infections recently.
8   Nur:  Recently?
9   Pat:  Last winter.
10 Nur:  Yes.
11 Pat: The last one would be er:: about January,
12       when I needed to have er:: to have
13       medication
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Oblique format:

- Enables patients to offer new concerns
- Requires interactional space for longer narrative threads
- Patients tend to talk about their concerns in an indirect way
- they may not even broach the specific nature of their worry
- Indirect reference to concerns fragmented into discrete sequences
- Enactment of clinical tasks may compound fragmentation

Conclusions

•Lack of opportunity for 'oblique' format limits opportunities for patients to disclose new symptomatic concerns

•Interactional contexts allowing space for extended narratives are likely to facilitate greater oblique disclosure.

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