



**Socio phenomenology and conversation analysis:
interpreting video lifeworld health care interactions**

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Socio phenomenology and conversation analysis: interpreting video lifeworld health care interactions.

Article for submission to Nursing Philosophy

Jane Bickerton
Sue Procter
Barbara Johnson
Angel Medina

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Abstract

This article uses a socio phenomenological methodology to develop knowledge and understanding of the healthcare consultation based on the concept of the lifeworld. It concentrates its attention on social interaction rather than strategic action and a systems approach. This article argues that patient centred care is more effective when it is informed through a lifeworld conception of human mutual shared interaction. Videos offer an opportunity for a wide audience to experience the many kinds of conversations and dynamics that take place in consultations. Visual sociology used in this article provides a method to organise video emotional, knowledge and action conversations as well as dynamic typical consultation situations. These interactions are experienced through the video materials themselves unlike conversation analysis where video materials are first transcribed and then analysed. Both approaches have the potential to support intersubjective learning but this article argues that a video lifeworld schema is more accessible to health professionals and the general public. The typical interaction situations are constructed through the analysis of video materials of consultations in a London Walk in Centre (WiC). Further studies are planned in the future to extend and replicate results in other health care services. This method of analysis focuses on the ways in which the everyday lifeworld informs face to face person centred health care and supports social interaction as a significant factor underpinning strategic action and a systems approach to consultation practice.

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A phenomenological approach

The aim of this article is to describe a method for understanding human interactions in a health consultation through the use of a visual socio phenomenological lifeworld schema of social interaction. (Bickerton et al, 2010a). This video lifeworld schema is compared with conversation analysis (CA) a methodology often used to analyse social interaction in health care.

This article describes the philosophical underpinnings of human interaction based on a phenomenological methodology of understanding (i.e. Husserl and Schutz) (Speigelberg, 1972). It will recommend a socio phenomenological model of practice which begins from an everyday perspective of intersubjective interaction and involves all participants in a dynamic process which organises along a continuum into typical consultation situations (Schutz, 1964). This method of analysis describes the experience of health consultation interaction at the level of lifeworld in the stream of consciousness. It applies essential qualities of phenomenological sociology and argues that intersubjectivity facilitates shared practice more than a positivistic or mechanistic approach (Bickerton et al, 2010b). A phenomenological understanding of consultation interactions, this article argues, describes shared decision making in action in a more dynamic way than a method such as conversation analysis.

A video lifeworld schema constructed through video materials offers patients as well as practitioners the opportunity to develop greater awareness of how human interaction affects consultation outcomes. The work of the philosopher Alfred Schutz emphasized the social and intersubjective nature of our experience of others and identified how the interpretation of human interaction in a culture at a particular time affects expectations. The relationship between practitioner and patient is changing with active consumer involvement encouraged in health care decisions (Stevenson et al., 2004). Today a patient led culture of communication in the NHS means that both practitioner and patient are expected to develop a shared understanding through interaction in a consultation situation, which will influence the health care outcome. The use of a socio phenomenological method to interpret videoed health consultations builds awareness of how our culture influences our expectations and understanding of the consultation process (Atkinson & Heritage, 1984).

Human interaction

Human interaction can be understood through communicative action and strategic action and it is Habermas who differentiates between these two approaches in philosophy (Habermas, 1967). These two approaches include a phenomenological lifeworld where communicative action occurs within a mutually shared everyday inner perspective and strategic action which supports external perspectives driven by systems. These two actions: strategic and communicative can be used in health consultation practice and have the potential to lead to a better understanding of social interaction in the lifeworld of a health consultation. This particular article will focus on a phenomenological understanding of communicative (social) action in the lifeworld of the primary care health consultation (Spiegelberg, 1972).

Phenomenology is concerned with how everyday things appear and are present in our conscious subjective experience. The lifeworld provides the essence or truth of everyday experience through our subjective understanding of reality. Phenomenological methodology describes subjective experience through perception, thought, memory, imagination, emotion, desire, bodily awareness, embodied action and social activity such as language. These experiences are organised within an intentional structure that is transparent and in which the relationships are understood directly without drawing on existing theories and belief. Phenomenology views the structure of experience as intentionally directed toward objects and this structure is an act/object relationship. This relationship emerges in the stream of consciousness and is different from the things they represent so that there is a thing in itself and a representation of the thing. The structure of experience involves a temporal and spatial awareness that includes kinaesthetic, intellectual, emotional, empathic and intersubjective awareness. Patterns of experience are built from experience that is perceived or understood in consciousness and is organised into a personal narrative. Only knowledge that is experienced directly or transparently through our senses is included in this experience. In this sense, knowledge such as whether there may or may not be a god cannot be experienced directly and so is bracketed. Knowledge is bracketed when it is not experiential or existential reality. The video lifeworld schema used in this article represents this act/object structure. The act element of the structure constructs images through movement, knowledge, emotional, empathic and intersubjective elements and the object element of the structure is the video image itself.

Sartre used Husserl's phenomenological approach to develop a psychological theory of the imagination. Sartre's (1969) model of the imagination includes emotion as well as movement and knowledge; whereas Schutz's analysis of consciousness is less concerned with human emotions. Sartre described how knowledge, emotion and movement interactions construct the imagination (Sartre, 1969). Video materials provide a way for everyday conversations to be experienced through the interactions of act/object relationships. These elements which include emotion, knowledge and movement elements are never experienced separately in our perceptions but are identified in this study as discrete elements for the purpose of analysis (Bickerton, 1992).

Scheler and Schutz understood social action as originating in the intersubjective consciousness of the everyday lifeworld (Schutz, 1964, Scheler et al., 1979). In contrast to this view, Husserl, did not believe in social action and social phenomenology. Husserl was never able to prove transparency or interconnectedness in social action and was unable to resolve the problem of human solipsism. By this Husserl meant that there is no intersubjectivity or knowledge of other human beings in consciousness, but only our perceptions of people as separate present beings. Unlike Schutz, Husserl bracketed social action so that it stood outside the boundary and horizon of the lifeworld of human experience.

This article argues that an understanding of social action is facilitated by acknowledging intersubjectivity in the stream of consciousness as being the foundation of shared communication and understanding.

Social construction of reality

The socio phenomenological lifeworld recognises consciousness as an unbroken stream of lived experiences where facial expressions and gestures are the “fields of expression” for the inner life (Schutz, 1967). Schutz analyses in considerable detail the manner in which human knowledge is ordered in society. Social action, although it pertains to a particular socio historical situation, provides individual experience with its order of meaning and is relative to a particular natural way of looking at the world (Berger et al., 1979). Schutz (1964) argued that language is built on a stock of knowledge that is acquired to enable social interaction, and is built up of social interactions through which the world is understood and is typical of how individuals understand others and their world. Shared understandings are arrived at through social interaction, but depend upon the social distance between the participants involved. This distance is dependent on our knowledge of particular people and our lifeworld. Thus for the health practitioner the world of the consultation is likely to be richer and fuller in the understandings of the patient situation from a health perspective, whereas the patient’s understanding of the illness process will be richer but the health perspective more distant. The typification of the disease is more likely to be narrower, more restricted and more inflexible where the lifeworld typical situations are not so well understood.

Our understanding of a health care interaction is dependent on many factors such as personal experience, even though there is a common general understanding about healthcare in general (Berger et al., 1979). Individual health care needs are understood differently from patient to patient, from practitioner-to-practitioner, from NHS service to NHS service and from country to country, although there is a general overall understanding of illness, disease, health and wellbeing. A significant factor is cultural expectations of healthcare. As an example, a UK citizen is expected to be registered with a general practice. All citizens are encouraged to be collaborators with their health providers concerning their own health and wellbeing programme. In other countries and societies there will be different patterns, models and expectations in healthcare.

During the primary care health consultation, personal health experiences are influenced by a core set of cultural expectations. In this generalised approach the practitioner organizes the consultation process using strategies such as listening to the patient’s history, completing a physical assessment and a possible diagnosis and plan of action. The expectation is that the patient will have less understanding of organised strategies for communicating their illness and disease process. They may bring their practitioner a list of questions about their health and health treatment to help them begin an informed decision making process. Despite these generalised expectations, each health consultation will be different. Each patient brings a unique history to the consultation and each practitioner differences in the breadth and depth of their experience. Commonsense reasoning accepts the subjective nature of each individual’s experience of his or her world. A problematic aspect of effective health consultation is taking into account all the multiple realities and expectations that both patient and practitioner bring to a consultation.

A video lifeworld schema of practice allows patients as well as practitioners to begin to question the UK accepted attitude to NHS health care in the UK. If the NHS is to be patient led, it is argued that patients would benefit from the opportunity to observe health consultation interactions on video so they might think about how to optimize their

engagement in these situations. This model of practice also offers the practitioner an opportunity to experience different typical consultation situations and to reflect on best practice for each, for example, times when the practitioner might need to be directive in order to achieve patient satisfaction. The examination of video examples of different consultation situations encourages all participants to identify human signs such as language and knowledge, emotion and expression, as well as patterned bodily movements that indicate ways to increase engagement in a consultation process. The lifeworld consists of mostly shared or intersubjective socially created interactions that are shaped or constrained by pre-existing social and cultural structures. These everyday social interactions organise into typical situations. It is these typical situations that are identified through analysis of videoed health consultations.

The healthcare interaction

“Medicine as a helping interaction between persons is not aimed primarily at truth, but at guiding the ill back to health again.” (Svenaeus, 1999, 285)

Parsons was arguably the first medical sociologist to develop a theory of the structure of social action and the phenomenology of the sick role. Parsons (1975), like Scheler and Schutz, was interested in the theory of action, and the concerns of both theorists were broadly similar. However, Parsons focused more on an objective empirical scientific theory of action; whereas Schutz (1967), following Scheler et al (1970), focused more on the philosophical aspects, the nature of human action itself. Social phenomenology addresses ontologic concerns, emphasizing that human knowledge is always already given in society and provides a ground for all individual experience and meaning. (Scheler et al., 1979).

Parsons' moves away from the socio-historical context and his own theory of structural functionalism towards pragmatism. Parsons identifies patients as passive actors in the health care process, whereas Schutz provides an alternative and less passive role arguing for mutual freedom and creativity in the intersubjective or interpersonal everyday interaction. Schutz's everyday social action is quite different from Parson's more scientific objective theory of action where structural functional processes are systemized (Parsons, 1937). Both approaches influenced ethnomethodology which broadly includes conversation analysis (Psathas, 1995).

Ethnomethodology is influenced by the phenomenological approach to lived experience and social action in everyday life proposed by both Parsons and Schutz (Parsons, 1949, Schutz et al., 1964). As with social phenomenology, ethnomethodology is concerned with the micro – social and face-to-face interactions (Meltzer et al., 1975). Ethnomethodology, unlike socio phenomenology, focuses less on perceptual knowledge in consciousness and more on identifying and objectifying embodied actions as social facts in lived experience.

Ethnomethodology extends phenomenological concern to an analysis of how an experience is accomplished. This change in focus moves ethnomethodological analysis away from analysis of the experience to how people make sense of their experience. Ethnomethodology is interested in learning about the rules or orderliness of human expressions that shape social interaction and how these expressions are organised to make sense of experience. Through this approach, Garfinkel extends Schutz's understanding of human behaviour constructed through unique social actions, to a systematic search for ways in which shared meanings are created and sustained in a social structure (Psathas, 1999; Garfinkel, 1967).

Conversational analysis

Conversational analysis (CA) can be considered within the broad movement of ethnomethodology because they both study social order and focus on the use and effects of

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language. This includes behavioural features that occur within the conversation context and how these features are interpreted through practical actions (Psathas, 1995). CA studies how action, structure and intersubjectivity are achieved and managed. These features are understood as always interpreted through the context in which they are constructed. CA moved away from examining the objective reality of social facts within the context of everyday actions, to consider structural qualities of the language used in social interaction. CA examines the beginnings and endings of conversations to discover how language is related to thinking. Using this approach the research starts with an audio transcription rather than analysing audiovisual materials directly. CA always analyses transcripts of naturally occurring talk from audio or audiovisual tapes to discover where speakers pay attention to the dialogue to provide structure, organisation or orderliness. In the context of the health consultation CA has been used as a method to build a considerable body of work that provides evidence of action, structure, and intersubjectivity in the consultation interaction that can be validated and replicated. However, while CA analyses transcriptions of visual materials, it is unlike the video lifeworld schema discussed in this article because it views visual aspects such as gaze and gesture as supplementary to the transcription of spoken interaction. In the video lifeworld the gaze and gesture are an essential part of the experience required to determine conversations as well as the typical situations. The video materials represent the emotion, movement and knowledge elements of the intention and the video image represents the object part of the intention in a socio phenomenological analysis.

CA is concerned with the structure of social interaction with discrete elements such as turn talking and the order of interaction (Sacks and Jefferson, 1989). In order to analyse these syntactical relations CA has developed a system of symbolic notations that describe the details of an interaction through what and how people are speaking. This system of notation was developed in the main by Gail Jefferson and identifies different kinds of intonation, pauses, sound stretches, emphasis, etc (Sacks and Jefferson, 1992). For example, Jefferson's notation includes emphasis noted by underlining or italics where sounds are stressed such as stretched sounds marked as colons, cut off sounds are marked by a dash, pauses of less than 2/10 seconds by a dot (.), brackets ([]) show overlapped speech, punctuation indicates pitch e.g. (?) rising intonation, (,) comma continuing intonation and (.) falling intonation at end of sentence.

CA is commonly used for a systematic exploration of the syntactical arrangements in the health consultation. Using CA, Campion and Langdon (2004) identified where patients introduced new topics in health consultations. Their research results supported the importance of providing opportunities to discuss multiple topics in a consultation, rather than focusing on one illness topic per consultation as in a problem oriented approach. The video lifeworld schema identifies particular emotion, knowledge and movement interactions that organise into conversations and these multiple topic conversations organise along a continuum of a typical situation. Where practitioners are not engaged and supportive of multiple topics when they are raised the consultation dynamic is likely to lead to a practitioner directive focus. In a problem oriented consultation with an active patient and a directive practitioner the typical situation interaction will be in tension and may not provide patient satisfaction. However, a patient that does not like the tension may choose a more passive dynamic in order to reach an outcome in harmony and not be satisfied. A CA analysis may focus on a particular discrete tense or harmonious event but would not analyse the consultation interaction through narrative. These authors argue that the Jefferson notation is more difficult for patients and practitioners to access and understand to use by themselves than a video lifeworld which can be interpreted through narrative and experienced like movies. In order to make a comparison

I will first show a fragment of CA analysis (Campion and Langdon, 2004 pp 84-85). This will be followed on page 11 by a fragment of a video lifeworld schema analysis.

Fragment 0 [A3:c3]

Patient (Pt) a 61-year-old man, accompanied by friend (Fr).

3 Dr: hello: (.) hi: come on in have a seat Mr Worthing=

4 Pt: =hello=

5 Fr: =hello

6 Dr: got moral support with you to:day have you

7* Pt: yeah I've had had to:err first of all (.) I was drunk about a

fortnight before Christmas and I fell (.) did all my lips and my teeth,

8 Dr:ri:ght=

9 Pt: ='nd had stitches and I rung here they didn't tell me at the hospital to come and have me: stitches out=

10 Dr: =umm=

11 Pt: =or what so I come up here nd they said you've got to go back to the hospital=

12 Dr: =ri::ght=

13 Pt: =so any way I've rung hospital and they said well we don't know now't about it you've got to do as you are (.) some have come out here but I've still got some underneath here=

14 Dr: = okay

15 Pt: nd I don't know whether they should come out because it's a fortnight ago today

16* Dr:ri:ght we need to have a look at that don't we.

17* Pt: nd I've nd I've got a: form for a claim if you can do that for me(.) it's one of these err HSA claims for any accident

18 Dr: o: h ri:ght=

19 Pt: =so: =

20 Dr: =yeah sure

21 Pt: I haven't filled it I haven't err

22* Dr:yeah we'll have a look at that in a minute shall we=

23* Pt: =right so nd apart from that I've got somethin' on my chest and I feel absolutely (.)crap

24 Dr: ri:ght (.) lets take one thing at a time shall we (.) can I just look at this err

25 ((doctor examination))

A video lifeworld schema

The elements in a video lifeworld analysis provide a broader brush-stroke interpretation of conversations and text occurring in a dynamic intersubjective consultation context. This schema does not transcribe the audiovisual materials word for word, gesture for gesture as in CA notation. Nor does it identify particular emotions, rather it is concerned with a more generalised interpretation of the consultation interaction practice evidenced through observing and experiencing the video (Bickerton et al, 2010b). Both CA and video lifeworld approaches are oriented to the shared (intersubjective) interaction but in these authors' opinion the video lifeworld schema requires less specialised knowledge than CA as viewers can approach the video in similar way to watching a movie; the viewer analyses the video as

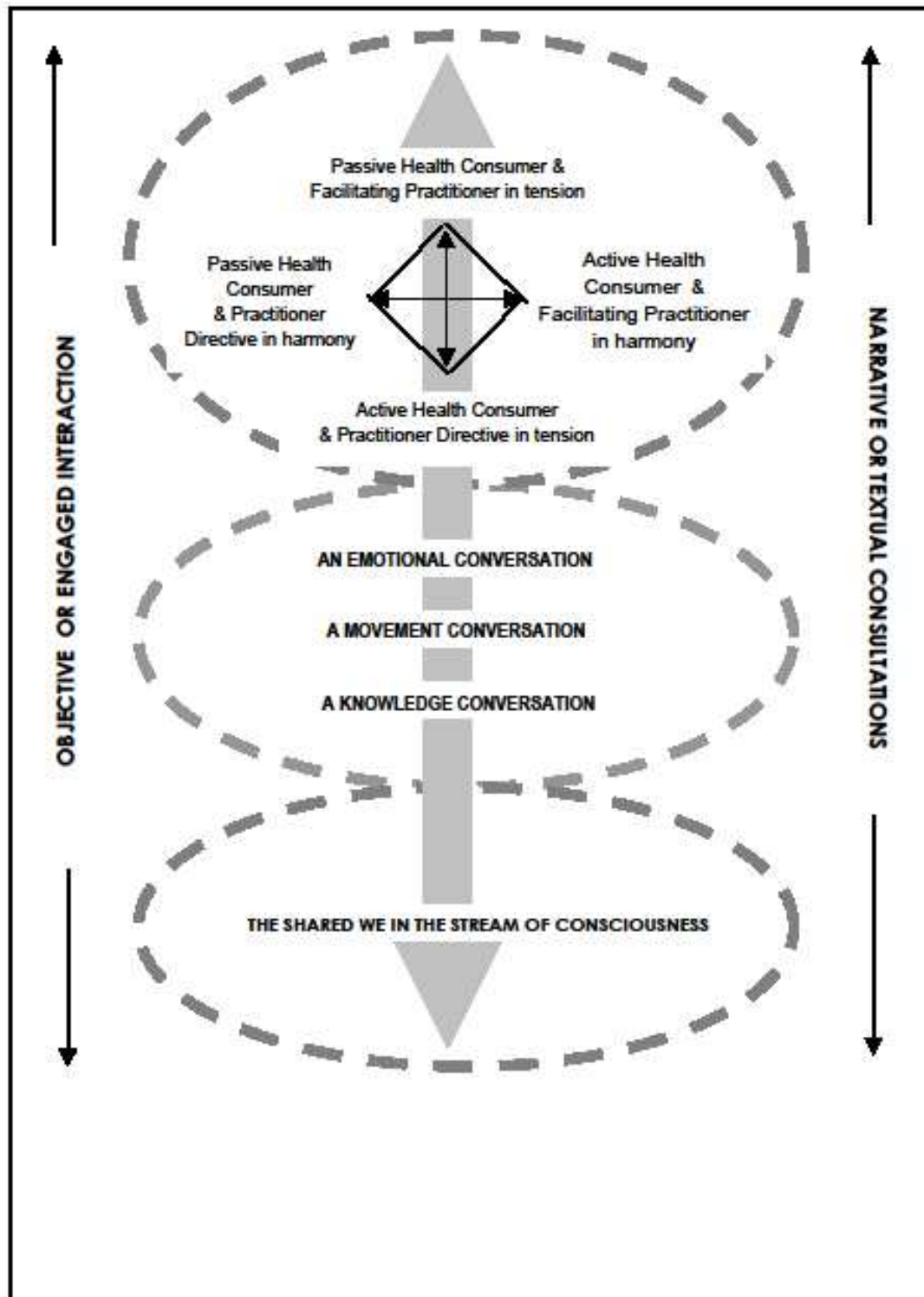
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it is showing although it can be rewound and played over and over again rather than with CA the audio or video is first transcribed and then analysed using symbolic notation. Finally consultation video interactions of particular approaches could be accessed through the internet with the instructions for analysis included. Videos of consultation practice are often used for reflection and these authors argue is more readily accessible for students and the public than CA.

A shared (intersubjective) perspective orients the viewer so that they are more aware of the mutual inner perspective of the lifeworld: how we are similar as opposed to different. Starting from this shared stance avoids focussing on either the practitioner or the patient and allows the video to be experienced as a whole conversation. In this way the viewer discovers different kinds of conversations taking place in the video that include emotions, knowledge and action. A knowledge interaction focuses most on sharing information, a movement interaction is experienced through non-verbal elements such as gestures, and emotional interactions are experienced through feeling elements (Sartre 1969). It is likely that one of these interactions will be more apparent in the video than the others and this will lead to the viewer deciding on a particular overall conversation.

These conversations may occur through an engaged empathetic conversation where the participants are attentive to each other, or they may take place in a less caring and objective manner. As the video consultation (which can last from a few minutes up to an hour) evolves the viewer begins to identify particular conversations and a typical dynamic running through an accumulation of topics or conversations which can be organised along a continuum of one of four typical situations. Consultation actions cluster together as either active/passive, facilitative/directive in tension or harmony typical situations (Schutz, 1964). Interpreting the typical situations exhibited in videoed WiC consultations provided this continuum of typical consultation situations (Bickerton, 2010a).

NHS primary care consultations tend to take problem oriented approaches in which consultations are expected by both practitioner and patient to focus on one problem per visit. A double appointment is made when there is more than one problem to address. A problem orientated approach to a consultation leads to an overall textual approach which may have an objective or engaged orientation. It is textual because the problem oriented approach does not allow for a richer narrative that engages many combinations of viewpoints about the presenting concerns (Bickerton, 1992). The video lifeworld schema is illustrated below in Figure 1 (Bickerton et al, 2010a).



The method of analysis using this video lifeworld schema is demonstrated through a fragment below (Bickerton et al, 2010b, pp.165-166)

“ The practitioner empathises with the consumer as she relates her health history over the past 3 days. She actively shares her health problem as the practitioner facilitates the conversation. The two participants are engaged sharing knowledge and are interacting in harmony and their consultation dynamic presents an active participant and facilitative practitioner..... The video shows the health consumer listening intensely to the practitioner. Her posture is less upright and she appears to be passively accepting what the practitioner shares as he directs a knowledge conversation. There is an anxiety and movement element to the conversation but the knowledge element holds the attention of the participants. The dynamic presents a passive consumer and a directive practitioner in a typical situation that is still in harmony but is diametrically opposed from earlier interactions.”

To summarise using this video lifeworld schema the video is examined for the orienting and synthesizing activity of emotions, movement and knowledge consciousnesses that construct conversations in the video as outlined in Fig 1 above. The video lifeworld analytical process enables participants to begin to understand the interaction from the already present shared connection in the stream of consciousness. That is to say, the consultation is always oriented to a shared connection and is co-constructed as participants distance themselves from the shared connection in order to articulate, reflect and objectify their interactions, influencing the process. This conversation may become engaged, objective and reengaged depending on the distance of each of the participants as well as their engagement for each other. The consultation is always considered within a whole context which in this study includes the lifeworld person centred aspects of the health video: person’s social, cultural, personal experience and expectations. However, using this video lifeworld method of interpretation, it is only the audiovisual world of the consultation that provides the context for this analysis of the participant interactions.

Method

The video lifeworld schema integrates the four modes of visual sociology: a scientific mode, image elicitation, the use of a phenomenological methodology, and a reflexive model of practice (Harper 1988). This method used to analyse videos in a WiC is outlined below.

Scientific mode

The video lifeworld schema provides an interpretative method to analyse audiovisual health consultations. The video schema is based on a study that was carried out in a Walk-in centre (WiC) adjacent to a busy Accident and Emergency Department in London. Patients attending the WiC were invited to participate in the study as well as practitioners working at the WiC. The sampling method was opportunistic. The study was a pilot study and received ethical approval. All study participants signed a consent form. A total of 28 consultations were analysed. The practitioners included general practitioners (GPs), nurse practitioners (NPs), and nurses treating patients with minor ailments. The typical situations were in the main knowledge conversations, with more than half of them presenting as typical situations where the patients were active and the practitioners were facilitative and were in harmony (Bickerton 2010b). The video lifeworld schema is a new approach to consultation analysis and requires further research to support validation and replication unlike CA which has been used for over 50 years and has long been validated.

Image elicitation

Audiovisual materials are used in the video schema for image elicitation. In the study discussed in this article an audiovisual tape recorder was left running in the consultation room. The participants were taped from a fixed point of view where interactions were visible. The participants moved out of the camera view during the physical examination. These video interactions provided visual material for lifeworld schema analysis of the consultation.

Phenomenological methodology

The video schema uses a phenomenological methodology and includes both socio phenomenology and phenomenology. A video lifeworld schema was constructed using these theories and typical situations proposed in Schutz' theory of typification (Schutz, 1964). The consultations fell along a continuum and were typified as directive or facilitative practitioners and active or passive patients who were either in tension or harmony. The video narratives were interpreted using a socio phenomenological method as well as a phenomenological approach used in earlier work that includes descriptive and interpretive phenomenology (Bickerton, 1992). The videos were interpreted as problem oriented or text rather than narrative.

The reflexive model of practice

The reflexive model of practice in the study included a nurse consultant (NC) who worked as a nurse practitioner at the WiC. The NC viewed and analysed all the videos. As the researcher was the lead practitioner at the centre it was important that none of the participants felt obliged to participate in the study. After the videos were collected the NC viewed them and discussed the tapings with another author and together they constructed the typical situation dynamic. Previously these authors had been involved in analysing video art performances using a descriptive and interpretive phenomenology (Bickerton, 1992).

Discussion

The video schema fits within the visual sociology discussed above whereas for CA the visual element used for analysis is often used only to expand understanding of transcribed aural interaction. CA has its roots in ethnomethodology rather than phenomenology. However, both CA and the video schema use reflexivity as a mode of practice for interpretation. CA has accumulated a substantial body of scientifically validated research whereas the novel video lifeworld schema requires further study. Results in this study are based on a pilot study using video lifeworld schema methodology with further research planned in the future.

CA and socio phenomenology can be viewed as complementary. CA provides discrete analyses of participants' everyday conversational interactions in such areas as turn taking. The video lifeworld narrative unfolds and demonstrates how participant dynamics affect the overall narrative process without isolating particular moments. These two approaches to interaction analysis are quite different. In the video schema analysis of the visual aspect of the schema is essential because the intentional act/object relationship exists through the video materials and video image. CA on the other hand does not consider audiovisual materials themselves to be unique to the analysis.

Evidence suggests that the consultation at the core of healthcare still continues to be strategically medically driven or directed (Bensing et al., 2006) and different practitioners have varying approaches to communication in consultation practice (Collins, 2005). CA is commonly used to interpret health care practice and, in particular, general practitioners practice (Campion et al., 2002). Campion et al found GP student videos demonstrated only a limited ability to achieve patient-centred outcomes (Campion et al., 2002): This article argues

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that a video lifeworld schema offers the potential for practitioners to visually explore how their different approaches to communication might support a more patient centred narrative in a more constructive way than is possible using CA alone.

The results of the WiC video lifeworld pilot study suggests that the dynamics of the patient as much as the practitioner directly affect patient centred care. The author argues that a video lifeworld is more accessible to the lay public as well as health professionals than CA because video examples can be studied directly and video consultations are available for examination directly on the internet (BBC4, 2011). Both CA and the video lifeworld support communicative and intersubjective interaction and can be used to identify areas of consultation practice that might benefit from strategic action. This article argues that the video lifeworld schema has the potential for use alongside strategic action approaches and through an iterative process could provide greater awareness of the lifeworld patient centred consultation.

This article recommends the use of both lifeworld and system approaches for learning through reflective practice. Video material is often used in general practice for reflection with the consent of both the patients and practitioners appearing in the videos. Videos could be used not only to develop effective consultation strategies but also to raise awareness of how a video lifeworld influences practice. For example, a practitioner who experiences their video lifeworld practice as knowledge based, unengaged and directive might benefit from learning facilitative skills through a strategic model like Heron's six intervention category system (Heron, 1976). Alternatively, the three function model of interviewing which supports information gathering, emotion handling and behaviour management enriches knowledge of emotion, knowledge and action conversations (Lyn, 1987). In this way practitioners would be encouraged to move between experiencing and recognising the ways in which they might like to practice differently through an iterative process of reflective practice. This reflective video lifeworld approach could also be used by patients wishing to become more familiar with consultation practice.

Summary

The video lifeworld is a novel approach to interpreting consultation interactions through visual elicitation, phenomenology, reflexivity and a scientific mode. The video lifeworld supports patient centred care and offers patients the possibility to experience how taking a more active role in understanding a health care consultation narrative can have a positive effect on the consultation process and outcome. A video lifeworld approach will also help practitioners understand the intersubjective, co-constructed nature of health care interactions and how best to facilitate effective understanding and outcomes in consultation practice and this article argues is more user friendly than CA.

A socio-phenomenological analysis of videos and health consultation videos in particular provide an opportunity to increase understanding of intersubjective, shared understandings and collaboration. The videos provide an opportunity to experience different kinds of conversations and the discovery of typical situations that take place in the health consultation. The benefits of a video lifeworld schema understanding applies equally to both health professionals and the general public by focusing on the everyday lifeworld informing patient centred health care and providing a stronger underpinning for consultation interventions. Future studies will provide greater understanding of the everyday intersubjective lifeworld of both practitioner and patient occurring in other health services.

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For Review Only

OBJECTIVE OR ENGAGED INTERACTION

NARRATIVE OR TEXTUAL CONSULTATIONS

