

Miscommunication between patients and general practitioners: implications for clinical practice

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ABSTRACT

INTRODUCTION: Effective communication is integral to the general practice consultation, yet it is acknowledged that problems commonly occur. Previous research has shown that misunderstandings with potentially significant consequences occur frequently, but does not provide a clear picture of how and why miscommunication occurs, or how such problems can be prevented or resolved. This study explored the occurrence and management of specific examples of miscommunication in two routine general practice consultations.

METHODS: A multi-method case study approach was used. The primary data collected for each case included a video-recorded consultation and post-consultation interviews with each general practitioner (GP) and patient. Instances of communication mismatch were examined using in-depth interaction analysis techniques.

FINDINGS: GPs and patients may not be aware when misunderstandings have occurred. In-depth analysis of the case studies revealed the complexity of miscommunication: it was not a straightforward matter to locate when or why instances of communication mismatch had occurred, and each of the mismatches was quite distinctive: (1) they were identified in different ways; (2) they occurred at different points in the communication process; (3) they arose because of problems occurring at different levels of the communication, and (4) they had different consequences.

CONCLUSION: Given the frequency and complexity of miscommunication in general practice consultations, GPs need to consider adopting various strategies, at both the practice/systems level and the level of the consultation interaction to minimise the risk of communication problems.

KEYWORDS: Communication; general practice; physician-patient relations

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Introduction

Effective communication is an integral part of the general practice consultation. It is the primary way information is exchanged, treatment decisions are made and the therapeutic doctor-patient relationship is established and maintained.¹ Yet research shows that communication problems are a common feature of medical interactions,²⁻⁴ and can have significant adverse consequences for patients' quality of care, health outcomes, adherence to treatment and satisfaction.^{1,5,6} Further, miscommunication is the most common reason for patient medical complaints.⁶⁻⁸

Previous research has identified numerous and complex barriers to effective communication in general practitioner (GP)-patient consultations relating to characteristics of GPs and patients, the nature of the GP-patient relationship, the structure of the consultation and the nature of the different problems treated in primary health care.^{6,9,10} However, much of the research reported in the clinical literature relies on reported data, such as interviews or coding of consultations, and does not take account of the sociocultural and interactional contexts of GP-patient interaction. Research using social science methodologies, such as conversation analysis¹¹ does involve

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a close analysis of doctor–patient interaction. However, little research from either tradition directly examines miscommunication in naturally occurring consultations, and those that do tend to focus solely on either communication problems identified from post-hoc interviews with participants,¹² or on misunderstandings that occur in interaction during the consultation.^{13,14} Existing research thus does not provide a complete picture of the phenomenon.

This paper describes the key findings of a study¹⁵ which used a triangulated case study approach to provide a detailed and multi-layered analysis of miscommunication in two GP–patient consultations, and discusses the implications of the findings for clinical practice. Discourse analysis of video-recorded naturally occurring consultations, along with in-depth interviews with both the GPs and patients, were used to identify instances where communication mismatches had occurred, to explore how and why the mismatches occurred, and whether and how participants managed to resolve them.

Methods

Data collection

Seven consultations were selected from a dataset, video recorded between 2003 and 2005 as part of a larger project: Clinical Decision Making when Rationing is Explicit (the Interaction Study).^{16–19} A total of 58 GPs in the wider Wellington region of New Zealand were approached for the larger project, using local networks and aiming for diversity of practice populations. Participating GPs' consultations were recorded for either a full day or two half-day sessions. Written consent from patients was sought by a research nurse while patients were seated in the waiting room.

For the miscommunication sub-study reported here, data collection followed a sequential model (Figure 1). Consultation recordings were not viewed until after the interviews had taken place (i.e. at the time of the interview the researcher had no knowledge of consultation content). Of the 14 patients approached for the current study, eight agreed to take part, with one patient subsequently excluded due to equipment malfunction.

Ethical Approval for the research was granted by the Wellington Ethics Committee, New Zealand (Ref. 03/09/090).

Analysis

The theoretical framework for this research was interactional sociolinguistics.²⁰ The term 'miscommunication' is an umbrella term used here to refer to the overall process, while a specific instance of miscommunication is termed a 'communication mismatch'. The analysis focuses on mismatches with potentially significant clinical implications. All seven GP–patient consultations recorded and the related interviews were subjected to an initial content analysis; three of the seven linked cases contained apparent communication mismatches determined by the researcher or by the participants themselves. Two were then purposively selected for in-depth case study analysis, as they were particularly rich exemplars which offered detailed insight into the sources and outcomes of different kinds of miscommunication. These consultations were transcribed using adapted conversation analytic conventions (see the Appendix in the web version of this paper), which capture both verbal and non-verbal features, including overlaps in speech, pauses and interruptions. The consultation transcripts were analysed using line-by-line discourse analysis,²¹ supported by contextual information and post-consultation interviews. The interview audio-recordings were transcribed verbatim and were analysed for thematic content.

Findings

Summary

Four separate communication mismatches were identified, two in each of the two case studies examined. The findings suggest that apparently minor misunderstandings may have potentially significant consequences, and that GPs and patients may not even be aware that they have occurred. In-depth analysis of the case studies revealed the complexity of miscommunication. It was not a straightforward matter to locate when or why instances of communication mismatch had occurred in the dataset. Instead, each of the mismatches was unique:

1. they were identified in different ways
2. they occurred at different points in the communication process
3. they arose because of problems occurring at different levels of the communication, and
4. they had different consequences.

The complexity of the mismatches is demonstrated in the following sections by drawing on illustrative data from two of the four mismatches analysed for this study, which provide useful contrasts in terms of the occurrence and management of miscommunication.

Identified in different ways

Communication mismatches in the study data were identified in different ways and were not always readily and/or immediately identifiable by either one or both participants. For instance, in the first case (Case 1, see Appendix in the web version of this paper), the patient's misunderstanding about the urgency of specialist assessment of her bleeding mole was not apparent to the researcher from viewing the interaction data alone, and identification of a mismatch required access to post-consultation interview data. The GP explicitly expressed her concern about the mole and her view that it needed to be removed and a misunderstanding would, therefore, not have been expected. More importantly, the misunderstanding was not recognised by either the GP or patient at any stage during the recorded interaction. The patient was only alerted to the misunderstanding when she contacted the clinic about a week later to enquire about delaying her procedure, and was informed that the referral was urgent.

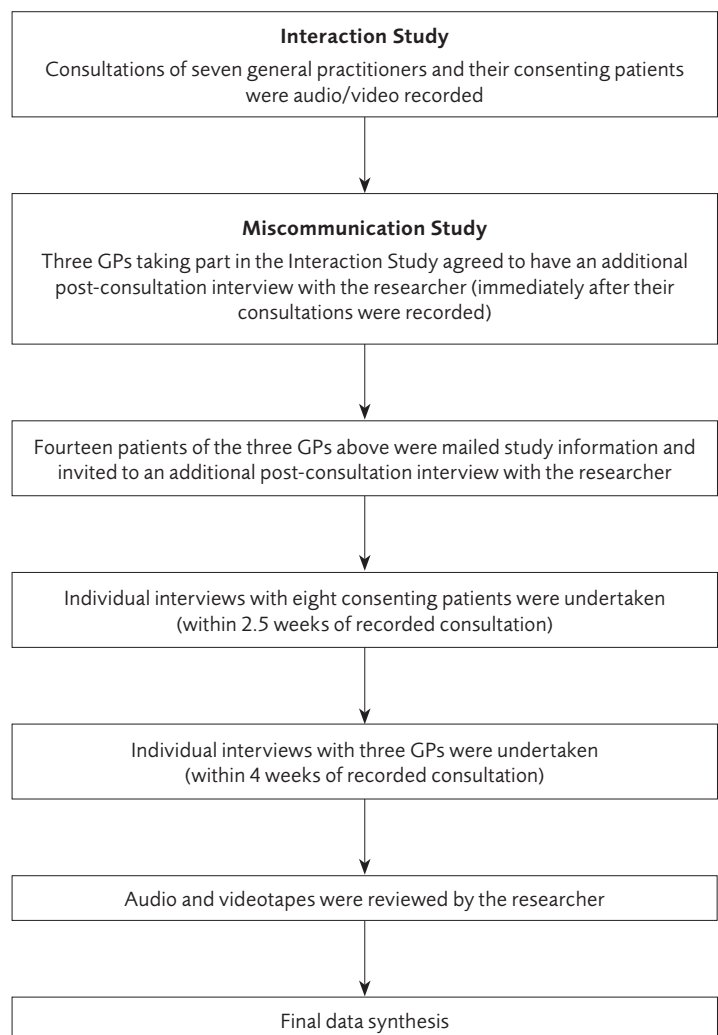
By contrast, in the second case, the patient's misunderstanding about the reasons for taking Cartia was immediately apparent both to the participants themselves during the recorded interaction and to the researcher reviewing the recording subsequently (Case 2, see Appendix in the web version of this paper). The misunderstanding became evident when the GP was reviewing the patient's medications and the patient reported that he had not been taking Cartia. As the GP in this case was alerted to the patient's misunderstanding during the interaction, she had the

WHAT GAP THIS FILLS

What we already know: Effective communication between doctor and patient is an essential component of quality care, good health outcomes, adherence to treatment and patient satisfaction. However, communication problems are a common feature of medical interactions and can have significant adverse consequences.

What this study adds: This study completed detailed analysis of two routine general practice consultations combined with participant interviews to provide a clearer picture of how and why miscommunication occurs. GPs should assume communication mismatches occur frequently, and work to develop a mix of strategies to minimise the risk of more serious communication problems.

Figure 1. Data collection sequence



opportunity to respond at that time, and the patient's misunderstanding was immediately and successfully addressed and resolved (as confirmed at the post-consultation interview).

Occurred at different consultation points

The complexity of miscommunication was further demonstrated in this dataset by the finding that the mismatches occurred at different points in the communication process, building up over time and across interactions. For example, although the patient's misunderstanding about taking Cartia was apparent to both GP and patient during the consultation recorded for this study, the origin of this misunderstanding was in a prior consultation. As mentioned above, it was only the GP's review of medication adherence in this subsequent consultation that alerted her to the mismatch.

Different reasons for occurrence

A detailed discourse analysis revealed the mismatches came about because of multifaceted problems occurring at different 'levels' of the communication. In the absence of a recording of the prior interactions, it is not possible to make any claims about how the Cartia mismatch first occurred. However, in the case of the bleeding mole (Case 1), access to and analysis of the actual interaction where the mole was first discussed revealed some potential sources of the problem. These related to the high-level frames (assumptions based on background knowledge and experiences) through which the GP and patient filtered and interpreted information during the consultation, as well as to localised aspects of the information delivery (such as the GP's use of authoritative and persuasive language which potentially reduced the patient's decision-making).

Different consequences

Finally, the mismatches identified in this study demonstrate that communication problems can have different consequences. In both of the two cases illustrated in this paper, the observed misunderstandings created the potential for serious adverse outcomes. For example, in Case 1, if the patient concerned had not followed up with the

specialist clinic about having her mole removed (and no follow-up had occurred from the GP) serious negative consequences for the patient may have ensued. In Case 2, the patient's misunderstanding (in the past) had already resulted in the negative outcome of the patient misguidedly stopping his Cartia medication, which had potentially placed him at an increased risk of stroke.

Discussion

Some important lessons for clinical practice can be taken from this detailed investigation of miscommunication in two actual general practice consultations. First of all, it is important to realise that communication mismatches occur frequently and cannot be avoided altogether; what is more remarkable is that major communication problems are not documented more often. The GPs in this study were typical, experienced clinicians. They did not make poor decisions in their care of these patients, and yet, despite this, misunderstandings with potentially significant adverse consequences occurred. Furthermore, the finding that a misunderstanding can go unrecognised when both GP and patient felt the consultation went well (mole case), highlights the fact that GPs should not assume their communication has been successful or understood as intended.

General practice consultations are extremely complex interactional events, with numerous potential barriers to effective communication, including strict time constraints. It is therefore essential that GPs work actively on strategies which minimise the risk of more serious communication problems occurring. Yet minimising the risk of miscommunication in general practice is not a straightforward matter. Communication mismatches are complex and multifaceted. They may be identified in different ways (by GP, patient or both), or may not be apparent at all during the consultation. Mismatches may occur at any stage during a single consultation, or they may develop over time, surfacing in subsequent interactions. Mismatches may come about due to problems occurring at different levels of the communication, and they may have different consequences.

Given the demonstrated complexity of miscommunication, different communication strategies

are needed to address different kinds of communication problems. In this study, for example, misunderstandings occurred in consultations involving both chronic and acute conditions. In chronic conditions, shared care plans are increasingly being used and can enable a common understanding about self-management of medications and lifestyle activity. These may have potential to reduce misunderstandings, and encourage patients to take a central role in managing their health and adhere to treatment plans.^{22,23} In acute presentations, where the patient may not be seen again for some time, if ever, it is arguably more crucial that patients leave the consultation with a clear, agreed action plan. Relying on patients themselves to take action subsequent to the consultation (e.g. to make a specialist appointment) may not lead to expected outcomes and GPs should ensure system prompts are in place to monitor agreed actions that have critical outcomes if not followed.

In addition to these management/practice systems approaches, it is important that GPs identify and practise strategies that will increase the chance of patients both understanding and recalling key information and decisions. Summarising and repeating information with patients towards the end of the consultation is one important and commonly used method, as is the 'ask tell ask' strategy.²⁴

Providing patients with a written summary or checklist of the key consultation points may be a useful communication aid. Although few primary care studies have addressed this issue,²⁵ a recent Cochrane review found evidence that people use written- or audio-recordings of consultations to remind themselves of the information communicated, to review information they missed, or to share information with others²⁶ and that such aids to recall are positively viewed by patients.^{26,27} Despite these positive findings, clinicians have been reluctant to adopt such communication/recall aids,²⁸ perhaps challenged by the implementation compliance.

This study also suggests the importance of 'interactional checking' as a safeguard when communicating with patients. For instance, in the example of successful mismatch resolution

identified here (Cartia case), the GP's strategy of reviewing the patient's medications allowed the patient to disclose his non-adherence and his misinterpretation of the Cartia prescription, thus allowing the misunderstanding to be identified. A well-established relationship between GP and patient is likely to facilitate such 'confessions of non-compliance'.²⁹ By contrast, no such 'interactional checks' occurred in the first case study and the misunderstanding regarding the urgency of the patient's mole referral did not become evident until some time after the consultation.

Line-by-line discourse analysis reveals the intricate details of the communication process. It provides an extension of analysis beyond participants' motivated recounting of events.³⁰ In addition, this study triangulated discourse analysis of consultations, with participants' perceptions of consultations gained from participant interviews. Future research using this multi-method case study methodology could be considered to investigate the effectiveness of different interventions to avoid miscommunication (such as using consultation summaries or checklists).

This study is based on just two selected case studies. Although an obvious limitation, this has also made it possible to undertake an in-depth analysis of linked data. It could also be argued that the GPs who were willing to participate had a particular interest in communication, and therefore may have behaved differently from other GPs who did not volunteer. However, misunderstandings still occurred in these consultations, so it is reasonable to expect that other GPs would experience similar communication problems. Whether the recording equipment also affected the behaviour of the participants is unknown. However, modern audio- and video-recording is a well-established, credible and unobtrusive data collection method,^{31,32} with participants reporting they quickly become accustomed to the equipment.

Conclusion

Effective communication is fundamental to the general practice consultation, yet communication problems are frequent. Previous research does not provide a clear picture of how and why miscom-

munication occurs, or how such problems can be prevented or resolved. This study has shown that miscommunication between GPs and their patients is an extremely complex phenomenon. Problems can occur at any point in the communication process, often going unnoticed by the participants, and it is not always possible to determine precisely when a communication breakdown has occurred. In this study, the multi-method case study methodology enabled a detailed analysis from both GP and patient perspectives. In the future, this methodology could be used to examine the effectiveness and acceptability of communication aids to avoid miscommunication at both the systems level and within the consultation itself.

References

- Ong LM, de Haes JC, Hoos AM, Lammes FB. Doctor-patient communication: a review of the literature. *Soc Sci Med*. 1995;40:903–18.
- Lewin S, Skea Z, Entwistle V, Zwarenstein M, Dick J. Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database Syst Rev*. 2001;(4):CD003267.
- Simpson M, Buckman R, Stewart M, Maguire P, Lipkin M, Novack D, et al. Doctor-patient communication: the Toronto consensus statement. *BMJ*. 1991;303:1385–7.
- Thistlethwaite J, Morris P. The patient-doctor consultation in primary care: theory and practice. London: The Royal College of General Practitioners; 2006.
- Kaplan SH, Greenfield S, Ware JE. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care*. 1989;27:110–27.
- Stewart M, Brown J, Boon H, Galajda J, Meredith L, Sangster M. Evidence on patient-doctor communication. *Cancer Prev Control*. 1999;3:25–30.
- NZ Health and Disability Commissioner. General Practitioner, Dr B: an accident and medical clinic report by the Health and Disability Commissioner. New Zealand: Health and Disability Commission; 2004. Report No.: Case 03HDC06973.
- Wofford MM, Wofford JL, Bothra J, Kendrick SB, Smith A, Lichstein PR. Patient complaints about physician behaviors: a qualitative study. *Acad Med*. 2004;79:134–8.
- Heritage J, Maynard D. Introduction: analyzing interaction between doctors and patients in primary care encounters. In: Heritage J, Drew P, Maynard D, editors. *Communication in medical care: interactions between primary care physicians and patients*. Cambridge: Cambridge University Press; 2006.
- Williams S, Weinman J, Dale J. Doctor-patient communication and patient satisfaction: a review. *Fam Pract*. 1998;15:480–92.
- Hutchby I, Wooffitt R. *Conversation analysis: principles, practices and applications*. Cambridge: Polity Press; 1998.
- Britten N, Stevenson F, Barry C, Barber N, Bradley C. Misunderstandings in prescribing decisions in general practice: qualitative study. *BMJ*. 2000;320:484–8.
- Moss B, Roberts C. Explanations, explanations, explanations: how do patients with limited English construct narrative accounts in multi-lingual, multi-ethnic settings, and how can GPs interpret them? *Fam Pract*. 2005;22:412–8.

- Roberts C, Moss B, Wass V, Sarangi S, Jones R. Misunderstandings: a qualitative study of primary care consultations in multilingual settings, and educational implications. *Med Educ*. 2005;39:465–75.
- Morgan S. *Miscommunication in GP consultations: a microanalysis of communication mismatches in two case studies* [master's thesis]. [Wellington (NZ)]: University of Otago; 2008.
- Dew K, Dowell A, Stubbe M, Plumridge E, Macdonald L. 'Treating' patients differently: a qualitative study of how clinical and social factors shape interactions between doctors and patients. *N Z Fam Physician*. 2008;35.
- Dew K, Plumridge E, Stubbe M, Dowell A, Macdonald L, Major G. 'You just got to eat healthy': the topic of CAM in the general practice consultation. *Health Soc Rev. Special Issue: Integrative, Complementary and Alternative Medicine: Challenges for Biomedicine?* 2008;17.
- Dew K, Stubbe M, Macdonald L, Dowell A, Plumridge E. The (non) use of prioritisation protocols by surgeons. *Social Health Illn*. 2010;32:545–62.
- Dowell T, Macdonald L, Stubbe M, Plumridge E, Dew K. Clinicians at work: what can we learn from interactions in the consultation? *N Z Fam Physician*. 2007;34:345–50.
- Gumperz J. On interactional sociolinguistic method. In: Sarangi S, Roberts C, editors. *Talk, work, and institutional order: discourse in medical, mediation, and management settings*. Berlin/New York: Mouton de Gruyter; 1999.
- Paltridge B. *Making sense of discourse analysis*. Queensland, Australia: Gerd Stabler; 2000.
- Russell G, Thille P, Hogg W, Lemelin J. Beyond fighting fires and chasing tails? Chronic illness care plans in Ontario, Canada. *Ann Fam Med*. 2008;6:146–53.
- Martin C, Peterson C. Improving chronic illness care: revisiting the role of care planning. *Aust Fam Physician*. 2008;37:146–53.
- Kemp EC, Floyd MR, McCord-Duncan E, Lang F. Patients prefer the method of 'tell back-collaborative inquiry' to assess understanding of medical information. *J Am Board Fam Pract*. 2008;21:24–30.
- Liddell C, Rae G, Brown T, Johnston D, Coates V, Mallett J. Giving patients an audiotape of their GP consultation: a randomised controlled trial. *Br J Gen Pract*. 2004;54:667–72.
- Pitkethly M, MacGillivray S, Ryan R. Recordings or summaries of consultations for people with cancer. *Cochrane Database Syst Rev*. 2008;(3): CD001539.
- Watson PWB, McKinstry B. A systematic review of interventions to improve recall of medical advice in healthcare consultations. *J R Soc Med*. 2009;102:235–43.
- McConnell D, Butow PN, Tattersall MH. Audiotapes and letters to patients: the practice and views of oncologists, surgeons and general practitioners. *Br J Cancer*. 1999;79:1782–8.
- Stubbe M, Dew K, Macdonald L, Plumridge E, Dowell A. Persuasion and resistance in general practice referral talk. *Conference Proceedings: Presentation Communication, Medicine and Ethics Conference (COMET)*; 2007 28–30 June. Lugano, Switzerland: University of Lugano; 2007. p. 157.
- Bugge C, Jones A. Methods for studying patient participation. In: Collins S, Britten N, Ruusuvoori J, Thompson A, editors. *Patient participation in health care consultations*. England: Open University Press; 2007.
- Coleman T. Using video-recorded consultations for research in primary care: advantages and limitations. *Fam Pract*. 2000;17:422–7.
- Stewart M. Approaches to audiotape and videotape analysis: interpreting the interactions between patients and physicians. In: Crabtree B, Miller W, editors. *Doing qualitative research*. London: Sage Publications Inc.; 1992.

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COMPETING INTERESTS

None declared.

APPENDIX A: Transcripts of two cases of misunderstandings

Key to consultation extracts:

GP: general practitioner

PT: patient

Transcription conventions used in extracts:

(.)	a micro-pause
(2)	a pause of the specified number of seconds
(text)	explanations of content (not actual words spoken by participants)
{text}	transcriber's best guess at unclear talk
()	parentheses without words denote indecipherable talk
((laughs))	descriptions of actions
[text]	overlapping talk
<u>text</u>	increased emphasis on word or syllable
-	an incomplete or cut-off utterance

Case Study 1—Patient with bleeding mole

Background

- Patient presents with an acute condition—a mole on her chest that had been bleeding for about a month. Two other health concerns are also discussed during the consultation.
- The consultation outcome is that the patient is referred privately to have the mole removed and assessed.

The recorded interaction—communication appears unproblematic

- From an examination of the interaction transcript it appears the GP was concerned by the appearance of the patient's mole, saying she would like the mole removed.
- There is no evidence in the interaction data to suggest a misunderstanding may have occurred.

Excerpt from early in the consultation during patient examination:

PT: i sort of explained it [as (.)] being sort of (.) something like that

GP: [mm]

PT: but [(.) but it's] different cos it's protruding

GP: [yeah but mm hm]

no well look i have a very low threshold (.) (PT name) for getting it (.) referred and i- i- i don't know what that is but i don't like it when it keeps bleeding it actually doesn't have any raw areas on it at the moment but there's a [wee] dark area there no i don't like- i just don't like it

PT: [mm]

GP: like that so i'm happy (.) to get you to get that off you [really need] to get that off

PT: [okay]

An excerpt from later in the consultation where the GP and patient are discussing treatment:

GP: If you would ring his rooms today please and get an appointment tell them you've got a little bleeding (.) spot that- on your chest that i would like you to have off [(.)] and he'll see it

PT: [okay]

GP: sorted out for you I'll write him a letter introducing him to y-

Post-consultation interview with patient—a misunderstanding is identified

- Patient reports misunderstanding the urgency and speed of needing to have her mole assessed, and as a result did not act immediately on the referral advice from her GP, and further considered delaying the procedure.
- When the patient eventually rings the specialist clinic and discovers her referral was urgent she is confused:

I find it interesting that I hadn't got that from (GP name) at all that she found it urgent um but in other ways quite good because I didn't worry ((laughs))...I wonder if I, wish she told me she considered it, important that I make it, appointment (soon)

...she did say to make it ((the clinic appointment)) today but I didn't didn't quite realize that she really meant so soon yeah

Post-consultation interview with GP—how did this happen?

- GP confirms she felt the patient's mole was serious and required urgent attention:

I definitely wanted the lesion looked at and probably removed, because I wanted a diagnosis... I would be very keen that she actually gets it removed and diagnosed

...when I looked at (PT's name), that lesion reminded me of the (malignant skin lesion seen in another patient), so I actually referred her to the same plastic surgeon who had removed the skin tumour in my other patient

- GP felt she communicated the importance of the referral clearly to the patient and is perplexed as to how the misunderstanding came about:

...well in actual fact I thought she did (understand the importance of the referral) but her subsequent telephone call to me asking did it really need to be seen then made me wonder

- During interview, GP reports she will now follow up with the patient as to whether the procedure has occurred.

Case Study 2—Patient prescribed Cartia

Background

- A regular consultation with an elderly patient with chronic conditions. The patient presents with ongoing indigestion and skin problems.
- Towards the end of the consultation the GP reviews the patient's medications.

The recorded interaction—a (previous) misunderstanding surfaces

- On reviewing the patient's regular medications the GP discovers her patient has not been taking Cartia prescribed to prevent stroke as he misunderstood the reasons for taking it (i.e. there has been a misunderstanding at some point in the past leading to the patient's non-adherence to treatment).

Consultation excerpt where GP discovers the patient has not been taking Cartia:

- GP:** um (.) you get your cartia over the counter don't you
- PT:** pardon
- GP:** your cartia (.) the a- aspirin
- PT:** no I haven't been taking them for (.) long time
- GP:** ((quietly and with falling intonation)): mm
- PT:** I um- I stopped er using them when I had to pay for them ((laughs)) well it's cheaper the- no-[no-]
- GP:** [so are you- are you-] are you sorry are you using regular aspirin normal kind of aspirin
- PT:** just the um panaday- panadaol things that you can [buy]
- GP:** [right] okay the aspirin's for a different reason it's not for (.) pain killing purposes [it's for that]
- PT:** [yeah i know it's]
- GP:** mini stroke you had [to try]
- PT:** [yeah]
- GP:** and stop you from having a stroke (.) absolutely essential (.) [must take it]
- PT:** [right i'll buy some more]
- GP:** um [the cheapest way of doing it yeah]
- PT:** [(.) is it yeah]
- GP:** the cheapest way of doing it is- is um is plain aspirin (.) break it in half have one of those in the [morning]
- PT:** [er]
- GP:** i'll put them on the prescription cost you three dollars for three months worth
- PT:** okay

- GP:** tell me if it stirs up your indigestion um that- that's the reason for the cartia they've got that little coat on them that [stops you]
- PT:** [right]
- GP:** from getting indigestion [um]
- PT:** [oh yeah]
- GP:** but- but try the- try the plain ones (.) um if they stir up your indigestion then um (.) i'll will have (.) [a think a think about the cheapest]
- PT:** [a think ((laugh)) get your- get your ()]
- GP:** possible way it's- it's- it's absolutely essential [i don't-]
- PT:** [get your thick book] ((laugh))
- GP:** i don't um (.) i don't want to see you in here with a stroke (4) that would really interfere with your tai chi (1) ((laughing)) [having a stroke]
- PT:** [tai chi eh]
- GP:** i think we have to um we have to keep you in- in tai chi condition

- In the excerpt above, the patient's misunderstanding is addressed immediately—the GP explains the reasons for and importance of taking Cartia and the patient agrees to take the medication in future:

Post-consultation interview with patient—the misunderstanding has been successfully resolved

- Patient reports to be taking Cartia for the correct reasons

...um I take one for um thinning the blood, the um dispirins, disprin thing