

A case study of styles of patient self-presentation in the nurse practitioner primary health care consultation

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This case study explores the patient self-presentational aspects of social interactions occurring during nurse practitioner consultations in primary health care. Previous consultation communication research has revealed that styles of patient self-presentation have an effect on the process and outcomes of consultations. However, it is noted that available consultation communication research is focused on doctor–patient interactions. Accordingly, this research aimed to redress the medically focused imbalance in consultation communication research by investigating and identifying the possible effects of patient self-presentation styles on the process and outcomes of nurse practitioner consultations. An observational case study was undertaken in a nurse-led primary care walk-in clinic, utilizing multiple methods of data collection including: direct observations of nurse practitioner consultations, postconsultation semi-structured interviews with nurse practitioners, and a field journal. Two sample groups were used: a purposive sample of 15 patients attending the walk-in clinic with upper respiratory tract infections (URTI), and a convenience sample of six nurse practitioners employed at the same clinic. Five different styles of patient self-presentation were identified, which all had variant effects on the process and outcomes of the nurse practitioner consultation. These styles included: *Seekers* (patients seeking treatment); *Clinical Presenters* (patients presenting clinical histories); *Confirmers* (patients checking the severity of their illnesses); *Seekers to Confirmers* (patients who initially seek treatment, but who change to a confirmatory style); *Anticipators* (patients who anticipate their need for treatment). The nurse practitioner participants were found to be flexibly responding to these styles of patient self-presentation, as an attempt to maximize patient satisfaction with their consultations. It is suggested that the observed nurse practitioners were able to flexibly modify their consultation communication strategies in response to different patient self-presentation styles, which helped resolve the tensions existing between the patients' own reasons for consultation attendance and their actual clinically assessed needs for treatment.

Key words: case study; consultation; nurse practitioner–patient communication; self-presentation

Introduction

In response to the expanding work-load demands of primary care, there is an increasing emphasis upon

nurses, such as nurse practitioners, to deliver first contact health care (Jenkins-Clark and Carr-Hill, 2001; Barnes *et al.*, 2004). Implicit in this provision of first contact care by nurse practitioners is an acceptance that these nurses will be engaged in patient consultations, similar to those performed by general practitioners, whereby a patient presents at a primary care clinic with a health problem, which is then assessed and treated or referred on as appropriate.

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Traditionally general practitioners have undertaken these medical consultations. However, over the past 10 years, nurse practitioners either working as part of a team of nurses and doctors in general practice, or solely as a team of nurses in walk-in primary health care clinics, have also begun to conduct similar consultations (Venning *et al.*, 2000). The outcomes of these nurse-led consultations in the UK have been evaluated as comparable to those of doctor-led consultations in terms of cost effectiveness, clinical benefits and the quality of care provided (Kinnersley *et al.*, 2000; Venning *et al.*, 2000; Grant *et al.*, 2002; Horrocks *et al.*, 2002; Marsden and Street, 2004). Moreover, nurse-led primary health care consultations have been evaluated as acceptable to most patients (Poulton, 1995), with many patients expressing high levels of satisfaction with nurse-led consultations, in some cases over and above those of doctor-led consultations (Shum *et al.*, 2000; Pritchard and Kendrick, 2001; Horrocks *et al.*, 2002).

Whilst the cited studies provide evidence to support the presence of nurse-led consultations in primary health care, their focus on outcome measures neglects analysis of the process of nurse-led consultations, whereby the favourable outcomes are achieved in the first place. Now that nurse-led consultations have evaluated as safe and acceptable, it has been argued that it is time to consider aspects of what actually happens in these consultations and why patients rate them so favourably (Dolan, 2000). Working from this premise, this paper reports a case study of the process of social interactions occurring between nurse practitioners and patients in primary health care consultations, and any identified effects of this process upon the outcomes of these consultations.

The origin of this study also stems from analysis of the available consultation communication research literature, which reveals it is mainly concerned with doctor–patient communication, and in particular, general practitioners working in primary health care clinics (Ong *et al.*, 1995; Dolan, 2000; Marks *et al.*, 2000; Barratt, 2004; Smith, 2004). It must therefore be questioned if there is any justification in generalizing findings from doctor-focused consultation studies to nurse-led consultations, albeit they occur in similar settings. The small amount of available nurse practitioner consultation communication research comprises two pilot studies of the feasibility of conducting

nurse practitioner consultation research (Courtney and Rice, 1997; Dolan, 2000), and a discourse/ethnographic study, which is discussed below (Johnson, 1993).

Aside from the present study, Johnson (1993) presents the only other currently available example of nurse practitioner consultation research, which considers the communicative processes occurring during the nurse practitioner consultation. Johnson (1993) utilized a discourse analysis of 24 audio taped nurse practitioner–patient consultations and ethnographic observations of a primary health care outpatient clinic in the USA. The study was based, in part, on Mishler's (1984: 14) model of medical interviews, which contends that in consultations, patients emphasize the 'voice of the lifeworld', reflecting the subjectivities of everyday life, whilst in response doctors orientate towards the 'voice of medicine' with an objective scientific analysis; with this disparity seen as resulting in dehumanized, ineffective medical care. Johnson (1993) seeks to discover if the voice of the lifeworld is also present in nurse practitioner–patient consultations.

Overall, Johnson (1993) found that in the consultations she studied, the nurse practitioners acknowledged the voice of the lifeworld as presented by patients, and responded appropriately by an attention not only to medical matters, but also to an incorporation of the patients' everyday life experiences in the process and outcomes of the consultation. In conclusion, Johnson (1993: 156) suggests that her study adds a new dimension to Mishler's (1984) model of medical interviews; the 'voice of nursing' in which nurse practitioners are seen to respond to patient dialogues with both the everyday subjectivity of the voice of the lifeworld and the scientific objectivity of the voice of medicine.

Whilst the importance of Johnson's (1993) study as a pioneering contribution to knowledge of the communicative process of the nurse practitioner consultation is acknowledged, her study does have its limitations. Notably, Johnson (1993: 145) states that her study only considered consultations with female patients and female nurse practitioners on the basis that she had an interest in 'woman to woman talk', even though this was not the focus of her study. As a result, it is not possible to ascertain from this study if the voice of nursing also exists in male patient and male nurse practitioner consultations. Further, the applicability of Johnson's (1993)

12-year old American-based work to the context of the contemporary British nurse practitioner consultation must be questioned.

In response to the above points, this paper seeks to redress the imbalance of medically orientated consultation communication research, and the resultant paucity of nurse practitioner consultation communication research, by highlighting the process of interpersonal health communication occurring in consultations undertaken by nurse practitioners in the UK.

More specifically, the feature of the communicative process of the nurse practitioner consultation, with which this study is concerned, is styles of patient self-presentation. The term 'self-presentation' arises from the sociological interactionist concept of 'impression management', which is concerned with the ways that people, in everyday situations, such as a medical consultation, present themselves and their activities to others, in order to guide and control the impressions people form of them (Goffman, 1959: 203). This focus on styles of patient self-presentation in the nurse practitioner consultation arises from the researcher's interest in a sociological case study of styles of patient self-presentation in medical consultations described by Silverman (1989). This case study found that in the consultations studied, variant styles of patient self-presentation had significant effects on the process and outcomes of the consultations, including: clinician anxiety and a resultant increased usage of clinical assessment and investigations; and the stimulation of clinically focused consultation communication strategies.

It was speculated that styles of patient self-presentation may also have similar effects in nurse-led consultations, and therefore the following research question was posed: what effect, if any, do styles of patient self-presentation have in the nurse practitioner-patient consultation? The aims of this study were to identify if there were any different styles of patient self-presentation in the nurse practitioner consultation, and to describe their effects, if any, on the process and outcomes of the nurse practitioner consultation.

Methods

The overall research strategy was a qualitative observational case study. This case study comprised

multiple methods of qualitative data collection in a nurse-led primary health care clinic, including observation, semi-structured interviews and an accompanying field journal. The case study was designed as a descriptive case study, attempting to provide illustrative examples of the effects of different styles of patient self-presentation in nurse practitioner consultations. The local research ethics committee covering the case study clinic granted ethical approval for the research. A pilot study was carried out over a two-month period from October 2002 to November 2002. The main case study fieldwork and data analysis was conducted over a six-month period from October 2003 to March 2004.

The case study setting

The fieldwork for the case study was conducted in a nurse-led primary health care walk-in clinic, which is part of a Primary Care Trust located in a central urban district of London, England. The clinic was selected on the basis of suitability as it was felt that this clinic would provide a typical instance of the type of primary health care nurse practitioner consultation to be investigated. The walk-in clinic is located in a community health centre. The patient group most commonly seen by the clinic is young adults, in the age range of 17–45 years old, who are normally fit and well, and who commute from surrounding areas and work within the locality of the clinic.

During the fieldwork period the walk-in clinic was open seven days a week, from 07:30 to 21:00 h on weekdays, and 10:00 to 20:00 h at the weekend. The clinic is open-access, with no prior patient registration required. Ten nurse practitioners, working on a rotational shift basis, staff the clinic. The range of patient conditions seen and treated by the nurse practitioners typically includes acute episodic presentations, such as upper respiratory tract infections (URTI), ear infections, cystitis, abdominal pain, emergency contraception, minor skin infections, traumatic wounds and musculoskeletal problems. The nurse practitioners are able to supply prescription-only medicines, such as antibiotics, for the treatment of the above conditions.

Sampling

The research sample was divided into two groups: a purposive sample of 15 patients and a convenience

sample of six nurse practitioners. To provide consistency in the patient group and to ensure that their self-presentation styles were as a result of their social interactions, rather than variant medical conditions, adult patients presenting at the clinic with a broad category of one medical condition, URTI, were purposively selected. This medical complaint was chosen on the basis of being a typical instance of the health problems commonly seen by the nurse practitioners at the clinic. Potential patient participants were selected for the study, after their initial triage assessment, once their medical complaint had been identified as an URTI. Demographic details were collected both from the patient and their attendance notes including: age, sex, occupation and ethnic group. Of the 15 recruited patients, nine were female and six were male. Patient participants ranged in age from 16 to 33 years old. A detailed breakdown of the patient sample group is presented in Table 1.

A convenience sample of nurse practitioners was used, because in the selected clinic patients are allocated to the available nurse practitioners on a random basis, when a nurse practitioner calls in the next patient in the queue. This randomness of patient allocation negated the use of any other nonprobability sampling method. Further, due to the randomness of nurse practitioner–patient allocation, five of the

nurse practitioner subjects were recruited more than once, though each time with a different patient. However, it was felt that this iterative feature would add depth to the observational and interview data.

The nurse practitioners were recruited by being informed about the study by the researcher, both as a group in a staff meeting and also individually. A total of six female nurse practitioners were recruited. These nurse practitioners had been Registered Nurses for between six and twenty-seven years. Their periods of practice as nurse practitioners ranged between four months and six years. All of the nurse practitioners had completed or were studying for undergraduate or postgraduate advanced practice/nurse practitioner qualifications.

Observations

A direct observational method called ‘sitting in’ was used (Pendleton *et al.*, 1984: 83; 2003). As the name implies, this method involved the researcher being present in the consulting room during the consultation. The sitting in method offers the advantage of being able to directly observe interactions in the consultation. It also an easy method to use, requiring no equipment. Any potential observer effects and consultation involvement was minimized by the researcher sitting out of the direct sight of

Table 1 Patient sample group

Patient (P) number	Gender	Age	Ethnic group	Occupation	Presenting complaint
P 1	Female	27	White	Teacher	Sore throat
P 2	Male	29	Mixed race	Waiter	Cough
P 3	Female	28	White	Research consultant	Cough/cold
P 4	Male	33	White	Designer	Cough
P 5	Male	20	White	Gardener	Chesty cough
P 6	Female	29	White	Record label manager	Severe sore throat
P 7	Male	20	White	Barkeep	Cough and sore throat
P 8	Female	33	White	Marketing director	Sore throat
P 9	Male	26	Asian Indian	Retail/student	Fever and sore throat
P 10	Male	31	White	Public relations	Sore throat
P 11	Female	16	Asian Bangladeshi	Student	Cough and sore throat
P 12	Female	26	White	Editor	Sinus congestion
P 13	Female	28	White	Accountant	Cough and sore throat
P 14	Female	27	White	Marketing manager	Sore throat
P 15	Female	28	White	Recruitment consultant	Sore throat and cough

both patient and nurse practitioner in the consulting room.

Fifteen nurse practitioner–patient consultations were observed. During the observed consultations, a structured observational approach was adopted, using a four-phase interactional model of the structure of the nurse practitioner consultation described by Johnson (1993). The four interactional phases are: establishing the agenda for the encounter; eliciting information from the patient; conducting the physical exam; and developing a plan of care (Johnson, 1993). This application of Johnson's (1993) model provided a focused framework of pertinent consultation activities to be observed.

Contemporaneous hand-written notes were made during the observed consultations, using a separate sheet for each consultation. These sheets were divided into four sections, as per the four phases of Johnson's (1993) model. As each consultation progressed, observation notes were recorded in the appropriate section correlating to the phase of the consultation reached at that point.

Interviews

A total of 15 postconsultation one-to-one audio taped semi-structured interviews were conducted with the nurse practitioner sample. No patient participants were interviewed as the focus of the research was upon what they actually did in the clinic rather than upon what they thought about what they did.

The semi-structured interviews that were conducted consisted of two parts. The first part included a series of open-ended questions about how the conduct of the four phases of the consultation was perceived by the nurse practitioners, and also their feelings and overall impressions of the consultation. The second part included close-ended questions about the nurse practitioners' length of time of working both as a nurse practitioner and registered nurse, and also their level of nursing educational preparation. This two-part interview schedule had been tested and refined in the pilot study. The interviews ranged between 10 and 15 min. The interviews took place immediately after the completion of an observed consultation, once the patient had left the room. Once all the interviews had been completed the researcher transcribed them verbatim. This data transcription facilitated immersion in the collected data.

Field journal

A contact summary was recorded in the field journal immediately after each field contact, detailing the social encounters observed, the main themes of the contact and any conceptual speculations suggested by the experience of the contact.

Data analysis

The collected data was analysed using Miles and Huberman's (1994) sourcebook of qualitative data analysis, in conjunction with Burnard's (1991) thematic content analysis method. Initial analysis comprised an overview of the case study, noting demographic details of the participants and summarizing the chronology and clinical outcomes of the observed consultations. Following this overview, each observation text, interview transcript, and contact summary were read through twice and memos and text highlighting made throughout the readings on general themes emerging from the data. The data texts were then coded in categories to describe all aspects of the content that related to consultation interactions and outcomes. Placing categories that were similar into a smaller amount of wider categories then generated clustered summaries of these categories, called pattern codes. Contrasts and comparisons were then made across these clustered summaries and the observed consultations to create methodological groups of styles of patient self-presentation.

Verification of the research findings was sought via monitoring of the credibility (trustworthiness) of the collected data. Firstly, a prolonged involvement with the setting facilitated an in-depth understanding of the setting and its participants. Alongside this prolonged involvement, persistent observations were also made of the phenomena in question, the nurse practitioner consultation, to hopefully encompass a wide scope of consultation interactions. The use of multiple methods of data collection facilitated a methodological convergence (triangulation) on the experienced reality of the setting. Informal member checks were also used on the data collected, by discussing initial findings and interpretations with the nurse practitioner participants as the study progressed. As a safeguard from researcher biases such as inaccurate pattern coding or direct involvement with the case study setting, an academic nurse practitioner colleague, independent of the

research setting, was asked to review the pattern coding.

Results

Five methodological groups of identified styles of patient self-presentation were identified after the comparison of similarities and differences in interactions and outcomes across individual consultations. These five groups were given brief explanatory names, which reflected their analytic content. These methodological groupings of styles of patient self-presentation and their related outcomes are presented below in the order they emerged from the data. The patient and nurse practitioner participants in each observed consultation, and their related clinical and chronological outcomes, and corresponding styles of patient self-presentation are presented in Table 2.

Seekers

The Seekers methodological group consisted of one female patient (Patient 1), and one male patient (Patient 9). The common factor amongst this group was their seeking for medical treatment from the nurse practitioners they consulted. This seeking behaviour was evident either in an explicit request for medication, or implicitly, by an apparent

reluctance to accept the medical care recommendations of the nurse practitioners.

This common feature of seeking is exemplified by Patient 9 (P 9), who after being told about appropriate self-care measures, said:

P 9: Is there any other medicine I could take to help this viral infection?

Nurse practitioner 5 (NP 5) commented on this reluctance of Patient 9 to accept her advice:

NP 5: I think he wanted some miracle medicine to make him better, so he could go to work and be better.

In response to this seeking behaviour, the nurse practitioners attempted to reassure the patients that medical treatment, other than self-care measures, was not required. This reassurance and emphasis upon health advice self-care was present throughout the Seekers consultations, and was reinforced on more than one occasion, in response to the apparent reluctant acceptance by the patients of the nurse practitioners' advice. Due to the Seekers reluctance to accept the nurse practitioners' advice, the nurse practitioners expressed a lack of satisfaction with the consultations. This dissatisfaction arose, as they noted a mismatch between what they were able to offer the patients, in terms of what was actually medically required to treat the Seekers illnesses (self-care measures), and the Seekers desire

Table 2 Consultation participants, outcomes and related styles of patient self-presentation

Consultation number	Length of consultation (min)	Patient (P) number and gender	Nurse practitioner (NP) number	Final diagnosis	Final main outcome	Patient self-presentation style
1	9	P 1 female	NP 1	Viral URTI	Health advice	Seeker
2	14	P 2 male	NP 2	Bacterial bronchitis	Antibiotic supply	Clinical Presenter
3	13	P 3 female	NP 3	Viral URTI	Health advice	Confirmer
4	10	P 4 male	NP 1	Viral URTI	Health advice	Confirmer
5	11	P 5 male	NP 4	Viral URTI	Health advice	Confirmer
6	10	P 6 female	NP 3	Viral pharyngitis	Health advice	Confirmer
7	14	P 7 male	NP 5	Viral URTI	Health advice	Confirmer
8	15	P 8 female	NP 5	Bacterial tonsillitis	Antibiotic supply	Confirmer
9	18	P 9 male	NP 5	Viral URTI	Health advice	Seeker
10	15	P 10 male	NP 5	Viral URTI	Health advice	Seeker to Confirmer
11	10	P 11 female	NP 6	Viral URTI	Health advice	Clinical Presenter
12	15	P 12 female	NP 6	Viral sinusitis	Health advice	Seeker to Confirmer
13	14	P 13 female	NP 6	Viral URTI	Health advice	Confirmer
14	7	P 14 female	NP 4	Bacterial tonsillitis	Antibiotic supply	Anticipator
15	12	P 15 female	NP 4	Bacterial tonsillitis	Antibiotic supply	Anticipator

for treatment (e.g., antibiotics). In addition, this dissatisfaction also occurred, as the nurse practitioners felt that the Seekers were doubting their professional advice, as is evident in comments by NP 5 regarding Patient 9:

NP 5: It was alright [the consultation]. It was one of those ones where you don't feel at ease or comfortable with it, because ... they don't ... think that you are telling them the right thing, [they have] an element of doubt.

However, despite this tension existing between the Seekers and the nurse practitioners, regarding need for treatment, their consultations were relatively harmonious with no aggression observed. It is not evident from this study what the Seekers reactions would have been if their desire for prescriptive treatment had been met, as neither of the Seeker patients actually required medical treatment, other than self-care advice. Also noted was the lack of a lifeworld discussion by either patient or nurse practitioner.

Clinical Presenters

The Clinical Presenters methodological group consisted of one male patient (Patient 2), and one female patient (Patient 11). The primary feature of this patient group was the clinical objectivity of their interactions and the subsequent clinical focus of their consultation outcomes.

The Clinical Presenters recounted brief, yet precise histories of objective clinical symptoms. For example Patient 2 (P 2), opened his consultation with:

P 2: I've had a cough for three weeks. I cough up green stuff. I've been taking cough medicines. The cough has stayed the same.

In response to the presentation of these focused symptoms, the nurse practitioners entered straight into a question and answer history format, eliciting relevant further information from the patients.

The patients appeared co-operative throughout their consultations with no apparent hidden agendas or anxieties, being happy to allow the nurse practitioners to interpret their symptoms and take action upon them, and receive whatever treatment the nurse practitioners recommended. For example,

nurse practitioner 2 (NP 2) commenting on Patient 2 said:

NP 2: He was fairly open to anything and I think if I'd told him he didn't need treatment he would still have been happy. I didn't feel any hidden agenda with him at all ... he didn't mention what treatment he wanted, even though I gave him the opportunity to say something.

A further feature of the Clinical Presenters was the lack of feedback the nurse practitioners felt that the patients gave them on their medical advice. Consequently, treatment recommendations were based purely on the clinical features of the patient's history and physical examination findings.

In contrast to the Seekers consultations, both nurse practitioner and patient satisfaction appeared to be a feature of the Clinical Presenters consultations. The nurse practitioners felt that they were providing treatments appropriate to the patient's condition based solely on objective clinical information, and the patients appeared to readily accept these treatments. However, due perhaps, to this apparent patient satisfaction, and a lack of apparent anxiety, reassurance was not a prominent feature of these consultations. Whilst the Clinical Presenters were given self-care health advice, this was too a lesser extent than in the other methodological groups of Seekers, Confirmers and Confirmers to Seekers. In common with the Seekers, discussion of lifeworld issues was not apparent.

Confirmers

The Confirmers methodological group consisted of seven patients. Four of these patients were female (Patient 3, Patient 6, Patient 8 and Patient 13) and three were male (Patient 4, Patient 5 and Patient 7). The key feature of this style of self-presentation was that of the patient confirming or checking that they only had a minor illness and whether or not they required any medical interventions, other than self-care health advice. This confirmatory process is exemplified in comments from Patient 8 (P 8):

P 8: I think I have tonsillitis, I want to *confirm* [researcher's emphasis] that with you and see if I need to take antibiotics.

In contrast to the Seekers, and in common with the Clinical Presenters, the nurse practitioners also perceived the Confirmers as not having an agenda, other than that of checking.

High levels of patient co-operation further characterized the Confirmer consultations, with no patient aggression being observed by the researcher or noted by the nurse practitioners. The Confirmers were forthcoming with their presented histories and were willing to accept the nurse practitioner's advice on the management of their problem. Accordingly, the nurse practitioners reported feeling at ease during these consultations, with no pressure to provide a specific medical treatment, such as antibiotics.

Health advice information formed the main outcome component of the nurse practitioners' responses to the patients' confirmatory self-presentation styles. Again, as with the Seeking style, this health advice was combined by the nurse practitioners with reassurance, albeit with more success, as the patients appeared happy upon completion of the consultations and the nurse practitioners felt satisfied.

The Confirmer presentations and consultations were described as being 'typical' of the kind routinely dealt with at the clinic, which may be reflected in the larger sample size of this methodological group, in comparison to the other groups, as presumably, being typical, the confirmatory self-presentation style may occur more frequently.

Exploration of lifeworld issues was also a feature of some of the Confirmer consultations, though not as prominent as the other interactions discussed above. For example, after eliciting a history from Patient 8 and discovering she had a busy social life, NP 5 asked:

NP 5: Have you been partying and having a good time?

Patient 8 then enquired if partying could have an impact on her current illness and NP 5 then talked about possible immune system effects, but ultimately focused this medical discussion within the patient's lifeworld by saying:

NP 5: [It's] not good that that every time you go out and have a good time you get ill.

Seekers to Confirmers

The Seekers to Confirmers methodological group consisted of one male patient (Patient 10)

and one female patient (Patient 12). The transformational nature of this group is their defining feature. This transformation can be seen in their initial presentation as per the Seekers methodological group at the outset of their consultations, only to change to a Confirmer self-presentation style, as their consultations progressed. For example, nurse practitioner 6 (NP 6) noted this seeking self-presentation style, whilst commenting on Patient 12 attempting to establish her consultation agenda:

NP 6: She did sort of almost come in with an agenda. The agenda was antibiotics.

The key difference between this group, and the Seekers group was the use of the voice of the lifeworld by the patients and a correspondent reflection of this by the nurse practitioners. The following dialogue between Patient 10 (P 10) and NP 5, whilst waiting for the results of a two-minute throat swab test, exemplifies this lifeworld incorporation:

P 10: My job's a nightmare. I've been overdoing it, burning the candle at both ends.

NP 5: Maybe your immune system is run down, have you had any days off work? You need to be careful and look after yourself.

P 10: [not recorded verbatim] says that he has been working a lot.

NP 5: Yes, this is negative [throat swab result], so there's no bacteria, I think you need to get some rest. This could be stress. You need to recharge your batteries. I don't think you need antibiotics. There is nothing to treat with antibiotics.

P 10: I don't want to take antibiotics for the sake of antibiotics.

As is evident, from the above dialogue example, once these lifeworld issues had been broached by the patients and similarly responded to by the nurse practitioners, the consultation agenda appeared to change from one of Seeking to a more confirmatory orientation of checking the severity of their illnesses and accepting self-care health advice.

This acknowledgement of the Seekers to Confirmers' lifeworld appeared to make their consultations easier to manage than the Seekers' consultations, as the patients seemed to find it easier to express their anxieties, rather than continuing to

focus on seeking a particular medical treatment. Once this had been done, the Seekers to Confirmers, mirroring the Confirmers, readily accepted the nurse practitioners' self-care treatment recommendations, despite their initial desire for prescriptive medical treatment.

Yet, despite this time for allowing the patients to speak, the Seekers to Confirmers consultations, at 15 min each, lasted no longer than any other of the consultations. The Seekers to Confirmers consultations were further characterized by patient co-operation and openness, despite the initial seeking for medical treatment on the part of the patients.

Accordingly, patient and nurse practitioner satisfaction appeared evident in these consultations. The patients appeared happy when they left the consultations, and the nurse practitioners expressed their satisfaction with the consultations, as they had been able to negotiate with the patients, and prevent an unnecessary use of prescription medicines whilst maintaining the patients' apparent satisfaction with the outcomes of their consultations. As with the Seekers consultations reassurance was a prominent feature of the nurse practitioners' response to the Seekers to Confirmers self-presentation style, but in contrast to the Seekers consultations, reassuring the patient seemed to have its desired effect.

Anticipators

The Anticipator self-presentation style comprised two female patients (Patient 14 and Patient 15). The key feature of this group was their evident anticipation of their need for medical treatment, such as antibiotics, based on their prior experiences of similar illnesses.

The Anticipators typically presented a succinct history, which elucidated their prior experience of the current illness they thought they had. Patient 14 (P 14) exemplifies this concise history style:

P 14: I think I've got tonsillitis. Basically, I've got a very swollen throat. I've had it before.

Nurse practitioner 4 (NP 4) captures the essence of this anticipatory style regarding Patient 15, when she said:

NP 4: ... She's had it before [tonsillitis], and again obviously going on the previous experience [of tonsillitis], that's the kind of thing she thought was going to happen [use of antibiotics].

The nurse practitioners acknowledged this anticipatory self-presentation style and immediately responded with clinically focused history taking. This clinical focus continued as both the Anticipators' consultations progressed, and culminated in clinically led medication advice regarding the correct use of the antibiotics they were given. Consequently, in common with the Clinical Presenters, this clinical focus predominated, in place of an emphasis, as occurred in the other consultations, on self-care advice. However, self-care health advice was not absent, being briefly referred to at the end of their consultations.

The Anticipators consultations were further marked by nurse practitioner-patient co-operation and apparent satisfaction with the outcomes of the consultations. In contrast to the Seekers, Confirmers and Seekers to Confirmers, but in common with the Clinical Presenters, reassurance was a much less significant feature of the Anticipators consultations. Discussion of the lifeworld by either patient or nurse practitioner was not evident.

Whilst the Anticipators appeared to be expectant of receiving prescriptive medical treatment, such as antibiotics, they made no explicit requests, only implying their expectant need for treatment through their clinically concise opening statements. It is not clear from the main case study data, what the Anticipators reactions would have been if their expectations for prescriptive medical treatment had not been met, as both of the Anticipator patients did require prescription medicines. However, in the single case of an Anticipator-type patient identified in the pilot study, prescriptive treatment was not required, and yet the patient appeared happy when the attending nurse practitioner told him that medical treatment, other than self-care measures, was not required.

Discussion

In response to the stated research question of: 'what effect, if any, do styles of patient self-presentation have in the nurse practitioner consultation?' it is evident that the identified styles of patient self-presentation do have an effect on the interactions and processes of the observed nurse practitioner consultations, with both negative and positive outcomes.

A finding of particular interest is that, as with Johnson's (1993) identification of nurse practitioners' use of the 'voice of nursing', the nurse practitioner participants in this case study, also used the voice of nursing. This use was seen in a combination of the subjectivity of the lifeworld and the objectivity of medicine as a successful consultation communication strategy in response to the Confirmers and the Seekers to Confirmers self-presentation styles. Moreover, unlike Johnson's (1993) female patient only study, this mixed patient gender case study has been able to demonstrate that the voice of nursing also exists in male patient consultations. However, as the nurse practitioner participants were exclusively female, it is not possible to speculate that the voice of nursing also exists in male nurse practitioner consultations.

A caveat to the presented findings arise, as it is not clear from this case study, as each patient was only observed once, if the same individual style of patient self-presentation is consistently used by the patients in every consultation they have, or whether they use different styles, dependent on the social context of a particular consultation. Contrastingly to the case study patients, five of the six nurse practitioners were observed on more than one occasion, and were seen to modify their consultation behaviours in response to the variant self-presentation styles used by the patients.

This use of consultation behaviour modification suggests it is applied as a strategy by the nurse practitioners to maximize the patient-centred outcomes of their consultations, in relation to their perceptions of the patients' help-seeking behaviours (i.e., why they seek health care) as reflected by the patient's self-presentational attempts to express their needs; for example, health advice information, reassurance or prescriptive medical treatment (RCGP Summary Paper, 1998). This recognition of patients' help-seeking behaviours, as represented by their consultation expectations, has been evaluated as an essential component of an effective consultation (Pendleton *et al.*, 2003). It must be noted the nurse practitioners' use of prescription medicines, was restricted to clinical need, and that no prescription medicines were supplied solely in response to a patient's self-presentation style, despite the nurse practitioners' consultation behaviour modification. Within this context, behaviour modification can be seen to be

occurring not only amongst the nurse practitioners, but also amongst some of the case study patients, such as the Seekers to Confirmers; in a process whereby a patient's help-seeking behaviours are modified by their consultation interactions with the nurse practitioner, which leads to the dissuasion of the patient from seeking inappropriate treatments, such as antibiotics, for the treatment of a condition not requiring antibiotics, such as a viral URTI (Nettleton, 1995; Gan and Yin, 1997).

Aside from the Seekers methodological grouping, these behaviour modification strategies appeared successful, with apparent patient satisfaction ensuing as a result. This feature of patient satisfaction is important when it is considered that patient dissatisfaction with consultation communication has been identified as a cogent factor increasing patient noncompliance with medical advice and treatment (Ley and Llewelyn, 1995). Conversely, this case study has shown that the observed nurse practitioners' consultation communication strategy of consultation behaviour modification, may improve patient satisfaction with their consultations, and in turn lead to a concordant consultation relationship. In this concordant relationship, patients and nurse practitioners negotiate a plan of care, attempting to resolve the tensions existing between the patients' presented reasons for consultation attendance, and the nurse practitioners' clinical assessments of the patients' actual treatment requirements. Successful resolution of this tension would appear to lead to increased patient satisfaction, which may in turn result in improved patient compliance and quicker recovery from illness or injury, with all of its associated social, psychological and economic benefits.

From a research methods perspective, the usefulness of a case study approach, comprising multiple methods of data collection, as a research strategy for study of consultation communication, is demonstrated through the enablement that occurred of a methodological convergence on meanings (how people 'see things') and practices (how people 'do things'); as constructed in the observed social interactions. This multiplicity of data collection, which takes account of the discrete realities of patient and provider existing in a consultation, has been evaluated as offering a complete view of the consultation communication process and how it may be improved (Barry, 2002).

Case study limitations

This research has utilized a case study approach; therefore, the generalizability of the research findings must be questioned. As only one nurse-led primary health care walk-in clinic was studied, with small nonprobability samples of nurse practitioners and patients being selected, it is not possible to say that the findings of the case study are representative of either the chosen clinic or other nurse-led primary health care walk-in clinics. However, it is hoped that the description and analysis of the nurse practitioner consultations studied, has provided a typical instance of similar consultations, both in the chosen clinic, and other nurse-led primary health care walk-in clinics; with sufficient details of setting and methodology to enable other consultation researchers to relate their research to that presented. As such, the richness of the data generated in this small-scale case study, through its typicality, may provide a theoretic generality of the patient self-presentational aspects of the nurse practitioner consultation (Holloway, 1997). It is also acknowledged that a formal member check process would have enhanced the data credibility. Accordingly, a follow-up formal member check evaluation of the case study data is envisaged.

Conclusion

A qualitative observational case study of nurse practitioner–patient interactions in a walk-in primary health care centre has been presented. Concurrent methodological approaches of consultation observations and postconsultation interviews were used. Five styles of patient self-presentation were identified. These five styles of patient self-presentation were found to have variant effects on the process and outcomes of the nurse practitioner consultation. It was suggested that the observed nurse practitioners were able to flexibly modify their consultation communication strategies in response to patient self-presentation styles, helping to resolve the tensions existing between the patients' expressed reasons for consultation attendance and their actual clinically assessed needs for treatment.

A summary point for future practice arising from these research findings is that nurse practitioners need to have an adaptable approach to

their consultation interactions with patients; and to be mindful of some patients' apparent preference for discussion of subjective everyday life issues in conjunction with objective medical information, to ensure satisfactory outcomes to their consultations.

Given the current scarcity of nurse practitioner consultation communication research it is now imperative that further study of the communicative process of the nurse practitioner consultation is undertaken, in order to fully understand the unique nursing focus of the nurse practitioner consultation and its resultant benefits for patients in primary health care.

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References

- Barnes, H., Crumbie, A., Carlisle, C. and Pilling, D.** 2004: Patients' perceptions of 'uncertainty' in nurse practitioner consultations. *British Journal of Nursing* 13, 1350–54.
- Barratt, J.** 2004: *An observational case study of nurse practitioner–patient interactions in a walk-in primary health care clinic*. MSc thesis. London: City University.
- Barry, C.** 2002: Multiple realities in a study of medical consultations. *Qualitative Health Research* 12, 1093–111.
- Burnard, P.** 1991: A method of analysing interview transcripts in qualitative research. *Nurse Education Today* 11, 461–66.
- Courtney, R. and Rice, C.** 1997: Investigation of nurse practitioner–patient interactions: using the nurse practitioner rating form. *The Nurse Practitioner* 22, 46–65.
- Dolan, B.** 2000: *The nurse practitioner: real-world research in A&E*. London: Whurr Publishers.
- Gan, G. and Yin, W.** 1997: Primary health care from being just affordable to value for money. *The SMA News*. 29. Online at http://www.sma.org.sg/sma_news/2907/news/2907N32.htm Retrieved January 2005.
- Goffman, E.** 1959: *The presentation of self in everyday life*. London: Penguin Books.
- Grant, C., Nicholas, R., Moore, L. and Salisbury, C.** 2002: An observational study comparing quality of care in walk-in centres with general practice and NHS Direct using standardized patients. *British Medical Journal* 324, 1556–59.

- Holloway, I.** 1997: *Basic concepts for qualitative research*. Oxford: Blackwell Science Ltd.
- Horrocks, S., Anderson, E. and Salisbury, C.** 2002: Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal* 324, 819–23.
- Jenkins-Clarke, S. and Carr-Hill, R.** 2001: Changes, challenges and choices for the primary health care workforce: looking to the future. *Journal of Advanced Nursing* 34, 842–49.
- Johnson, R.** 1993: Nurse practitioner–patient discourse: uncovering the voice of nursing in primary care practice. *Scholarly Inquiry for Nursing Practice: An International Journal* 7, 143–57.
- Kinnersley, P., Anderson, E., Parry, K., Clement, J., Archard, L., Turton, P., Stainthorpe, A., Fraser, A., Butler, C. and Rogers, C.** 2000: Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting ‘same day’ consultations in primary care. *British Medical Journal* 320, 1043–48.
- Ley, P. and Llewelyn, S.** 1995: Improving patients’ understanding, recall, satisfaction and compliance. In: Broome, A. and Llewelyn, S. editors, *Health psychology: processes and applications*. London: Chapman & Hall, 75–98.
- Marks, D., Murray, M., Evans, B. and Willig, C.** 2000: *Health psychology: theory, research and practice*. London: Sage Publications.
- Marsden, J. and Street, C.** 2004: A primary health care team’s views of the nurse practitioner role in primary care. *Primary Health Care Research and Development* 5, 17–27.
- Miles, M. and Huberman, A.** 1994: *An expanded sourcebook: qualitative data analysis*, second edition. London: Sage Publications.
- Mishler, E.** 1984: *The discourse of medicine*. Norwood, New Jersey: Ablex Publishing.
- Ong, L., De Haes, J., Hoos, A. and Lammes, F.** 1995: Doctor–patient communication: a review of the literature. *Social Science & Medicine* 40, 903–18.
- Nettleton, S.** 1995: *The sociology of health and illness*. Cambridge: Polity Press.
- Pendleton, D., Schofield, T., Tate, P. and Havelock, P.** 1984: *The consultation: an approach to learning and teaching*. Oxford: Oxford University Press.
- Pendleton, D., Schofield, T., Tate, P. and Havelock, P.** 2003: *The new consultation: developing doctor–patient communication*. Oxford: Oxford University Press.
- Poulton, B.** 1995: Keeping the customer satisfied. *Primary Health Care* 5, 16–19.
- Pritchard, A. and Kendrick, D.** 2001: Practice nurse and health visitor management of acute minor illness in a general practice. *Journal of Advanced Nursing* 36, 556–62.
- RCGP Summary Paper.** 1998: *Primary health care. Medical Research Council Topic Review*. 98/02. London: Royal College of General Practitioners.
- Shum, C., Humphreys, A., Wheeler, D., Cochrane, M., Skoda, S. and Clement, S.** 2000: Nurse management of patients with minor illnesses in general practice: multicentre, randomised controlled trial. *British Medical Journal* 320, 1038–43.
- Silverman, D.** 1989: *Making sense of a precipice: constituting identity in an HIV clinic*. In: Aggleton, P., Hart, G. and Davies, P. editors, *AIDS: Social representations, social practices*. London: The Falmer Press, 101–26.
- Smith, S.** 2004: Nurse practitioner consultations: communicating with style and expertise. *Primary Health Care* 14, 37–41.
- Venning, P., Durie, A., Roland, M., Roberts, C. and Leese, B.** 2000: Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal* 320, 1048–53.