Routine, Ceremony, or Drama: An Exploratory Field Study of the Primary Care Clinical Encounter

William L. Miller, MD, MA
Hartford, Connecticut

Background. Practicing family physicians often find family systems theory and the biopsychosocial model attractive, but have difficulties applying them in a busy office practice.
Methods. Two family physicians in a four-person group practice were identified as "exemplars" at managing daily office practice. A collaborative, qualitative methodology was used to explore their strategy. A series of semistructured key informant interviews with the two physicians and the head nurse identified themes later clarified using ethnoscience interviewing techniques. The resultant clinical encounter typology and decision-making taxonomy were evaluated using participant observation and key informant review. The final results were compared with the literature on physician-patient relationships.
Results. Three clinical encounter types were identified. "Routines" were simple, single, and brief visits in which a contractual style and the biomedical model were used. "Ceremonies" were linked rituals that invoked a covenantal style. "Dramas" were a series of visits concerning situations of conflict and emotion and included psychosocial problems. The family was often convened for dramas. Determination of the presenting concern, the trigger for coming, the patient request, the illness prototype, and the type of communication allowed recognition of the clinical encounter type.
Conclusions. Identifying a clinical encounter as a routine, ceremony, or drama may help family physicians integrate family systems concepts into their busy office practices. These findings have numerous implications for future research, clinical practice, and teaching.
Key words. Physician-patient relationship; clinical protocols; appointments and schedules; family practice; research, qualitative. *J Fam Pract 1992; 34:289-296.*

After completing family practice residency, a colleague and I joined a small eastern Pennsylvania town's only two family physicians and formed a four-person family practice group that cared for 12,000 patients. We were energized and eager to create a model of family-oriented, biopsychosocial primary health care. Hopes were high. We two younger physicians had a vision of a new type of practice, while the two older physicians had experience, one with 20 and the other with 30 years of solo practice.

One year into practice, my visionary music became discordant because of three dissonant sounds. I struggled to maintain a high-volume rhythm, but I kept slipping into a web of complexity, ambiguity, and family intrigue. A second dissonance was the unnerving frequency with which I found myself being paternalistic; I felt guilty and yet sensed that sometimes being paternalistic just might be appropriate; then, after following my intuition, I would feel guilty again. The third cause of dissonance was the patients who bristled with resistance whenever I tried to implement my understanding of the biopsychosocial model. Meanwhile, the two older family physicians were enjoying the group practice. They were embracing many of the new ideas contributed by my younger colleague and myself, yet maintaining a high-volume pace, being no more paternalistic, and encountering less resistance than I was. I was frustrated and perplexed. At a monthly practice meeting I asked, "How can this be?" Following a brief exchange of questions and clarifications, one of the older physicians suddenly blurted, "You mean you always think family? That will never work. You can only be superdoc some of the time." I refined my original question "How can this be?" into a research question: "How do the two older family physicians organize and manage their daily clinical encounters so that they can anticipate 'surprise' and 'difficult' encounters, know which physician-patient relationship style to use, and know when to be family-oriented?" Arising from the dilemmas and conflicts created by moving from the ide-

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From the Department of Family Medicine, University of Connecticut Health Center, Hartford. Requests for reprints should be addressed to William L. Miller, MD, MA, Department of Family Medicine, University of Connecticut Health Center, 123 Sigourney St, Hartford, CT 06105.

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alized expectations of residency to the realities of private practice, this question led to the design and implementation of an exploratory field study.

This article is a report of what I learned about the different kinds or types of clinical encounters recognized by the two older family physicians. The distinguishing features of each type are characterized, and the process by which each type was identified is delineated. In summary, both a clinical encounter typology and its associated decision-making tree or taxonomy are presented.

Methods

The goal of the research was to reach a collaborative understanding of the two older, more experienced family physicians' perceptual scheme for the clinical encounter.[1] The research objectives were to identify what was perceived as important, to describe what was going on, and to explore what possible patterns existed with the hope of discovering an implementable typology or decision-making taxonomy or both. It was anticipated that the concepts discovered would have relevance and transferability, with contextual modifications, to other primary care sites. There was no intent to generalize to a population beyond the immediate study site. Given these goals and objectives, qualitative or field methods rooted in naturalistic (constructivist) inquiry[2] as a guiding paradigm were selected as the most appropriate research framework.

The overall research design was sequential in structure and iterative in process. Semistructured key informant interviews of the two older family physicians were the predominant initial mode of inquiry.[3] These in-depth discussions were designed to elicit and identify the concepts and factors used by the two physicians in organizing and managing their patient encounters. The following three open-ended questions, which were derived directly from the research question, were asked: (1) how do you think about (plan, organize) your day in the office? (2) how do you know what is going to happen in a given patient encounter? and (3) when do you "think family"?

Analysis of the information obtained during these first interviews indicated that both physicians were scanning their patient schedules each morning and noting where they anticipated "problems" or "bottlenecks" and where they expected "smooth sailing" and "breathing room" for making telephone calls, seeing emergency call-in patients, or catching up on paperwork. This information was then shared by the physicians with the head nurse, who had the responsibility of screening all telephone calls and deciding who saw which call-in patients and when. The analysis also revealed that the two older family physicians distinguished between types of visits, types of patients, and types of problems.

The next cycle of key informant interviews included the head nurse and focused on eliciting the attributes that characterized the various types of visits, patients, and problems. An ethnoscience-type interview strategy[4,5] was used since the aim was to establish the informants' taxonomies. *Category* questions (eg, "What else distinguishes the 'difficult' visit?"), *contrast* questions (eg, "What is the difference between visits that are 'schedule busters' and those that are 'always the same'?"), and *special incident* questions (eg, "Are there any exceptions to your rules about when to convene the family?") predominated in these interviews.

Because I was a member of the practice (an insider), I had continuous access to all of the physicians and staff (actors) and could observe most of the activities and encounters that took place. As a result, during the same time frame as the key informant interviews with my colleagues, a series of brief, informal, unstructured interviews[6] were conducted with the same two physicians and the head nurse. These "conversations" were either planned or spontaneous. The planned interviews occurred in the morning and at noon when the two older family physicians reviewed their schedules. Category, contrast, and special incident questions (described above) were the major focus. The head nurse was asked similar questions throughout the day as she was making schedule decisions for call-in patients. The spontaneous questioning happened whenever one of the two physicians and I were waiting together between patient visits. During these moments, the questions centered on the previous and upcoming clinical encounters. Because they were obtained closer to the time of actual decision-making and collected over time, these data were a useful credibility check on the information obtained from the key informant interviews and on my evolving understanding. Several additional key informant interviews with the same persons were conducted as further understanding of the research question developed.

All the data were recorded in the form of field notes. The interviews were not taped. Most of the field notes were jotted immediately following the interview. Preliminary analysis occurred concurrent with data collection.[7] I reviewed my field notes weekly, and any new analytic constructs or more refined questions were discussed at the next interview session. As a result, the developing understanding was both my own and that of the research participants. We were not seeking the "true" or "real" way to manage clinical encounters; we were searching for a pragmatic, jointly created way to make our family practice better. The style of analysis I employed is often referred to as *heuristic*.[8]

The initial informant interviews occurred during the first 2 weeks of the study period, and analysis of these interview notes took 2 additional weeks. The next series of key informant interviews and the concurrent unstructured interviews were conducted over 3 months, after which an initial typology of encounters and a related decision-making taxonomy were constructed.

During the next phase of the research, I implemented the typology and taxonomy. Over the next 4 months, as a self-reflective participant-observer (emphasis on participant),[9] I began to employ and modify the typology and taxonomy as I managed and organized my daily encounters. All modifications were reviewed with the three other research participants. At the end of 4 months, I was experiencing fewer surprises, and I was anticipating more of the difficult encounters. Consequently, family practice became fun again! The last phases of this exploratory research were the literature review and the writing of the manuscript. The literature review was delayed until after the field research was completed in an attempt to minimize theoretical bias during the discovery phase of the study.

Table 1. Clinical Encounter Typology

Encounter Type	Descriptive Terms	Examples
Routine	"Simple" "Easy" "Bread and butter"	Minor acute infection Minor trauma Reassurance Driver's examination Insurance physical examination
Drama	"Complicated" "Difficult" "Trouble" "Long-playing record"	Crisis time in chronic disease Bad news Family discord Chronic fatigue Low back pain Temper tantrums
Transition ceremony	"Schedule busters" "Hidden time bombs"	"By the way. . ." "Surprise!" New diagnosis of chronic disease
Maintenance ceremony	"Always the same" "Friendly"	Well-child care Prenatal care Shared chronic management plan
	"Hopeless"	Uncomfortable with chronic management plan

Results

Clinical Encounter Typology

Of the three types of encounter, routine, drama, and ceremony, routine encounters were the most common.

Routines

Referred to as "simple," "easy," "just another cold," or "our bread and butter" (Table 1), *routine* encounters were visits for relatively simple, single, straightforward "body problems" for which the physicians believed they had readily available solutions. What distinguished these encounters was the rapid use of a presumed mutually acceptable biomedical protocol applied in prescriptive fashion to an everyday primary care problem; these clinical encounters involved the habitual performance of an ordinary, established procedure. Examples of routines included patients presenting with minor acute infections or minor trauma, uncomplicated requests for a driver's examination or insurance physical, or a need for reassurance that their mild cough was not the lung cancer that killed a close friend's father. Fortunately, for busy family physicians, routines are the most common encounter. As a result of this study, I learned to recognize routines for what they are and to keep them simple.

Dramas

Another type of encounter was called "complicated," "difficult," "trouble," "a long-playing record," or a "bad-news visit." These visits were part of a connected series of visits that revolved around uncertainty, conflict, physician-patient disagreement, family discord, nonadherence, or the delivery of bad news such as the diagnosis of cancer, diabetes, or Down syndrome. The head nurse, a college English literature major, revealed the label for these "complicated" encounters when she noted, "You [referring to the two younger, less experienced family physicians] are always trying to make a drama out of every visit."

Dramas were those clinical encounters occurring over time and involving conflict(s) or intense emotion or both. Dramas were theatrical, as performance, setting, and audience were important characteristics. Dramas always required multiple visits and flexibility and usually involved the family. Genograms were helpful; stories were told; and poetic license was in order. Examples encountered included the new diagnosis of hypertension, the presentation of chronic fatigue or chronic low back pain, and the evaluation of temper tantrums in a family experiencing divorce. These situations required the clarification of central themes and conflicts, all of which built to a dramatic climax and ended, it was hoped, in a therapeutic denouement. Learning to recognize a drama

early helped reduce the "by the way" statements at the end of visits and taught me the value of multiple visits over time. I no longer needed to "solve the problem" during one encounter.

Ceremonies

The first visit in a drama was often unplanned (by the physician) and scheduled as a brief visit. These opening scenes of a drama were called "schedule busters" or "hidden time bombs," and the physician's goal was to "buy time" and allow the drama to "get started." The physicians claimed to accomplish this by following four steps. They suggested that (1) the patient must know that the physician believes him or her, (2) the physician must address what most frightens the patient, (3) the physician should "for heaven's sake always put a stethoscope on him," and (4) the physician should give the patient hope and something to do until the next visit. These encounters were usually quite ceremonial. A *transition ceremony* was thus used when a new drama emerged in a brief visit. The purpose of this ceremony was to provide a transitional explanation, to lessen anxiety, to begin reconnecting the patient to his or her "family," and to protect the patient from further harm until a longer visit, often with family present, could be arranged.

Another, also protocol-driven, category of visits was referred to as "always the same." "Every visit with that patient is just like the one before and the one before that." These *maintenance ceremonies* occurred after a drama had been concluded and the achieved functional state was being maintained. This category had two variations. Some of these encounters were "friendly." These patients had established chronic disease diagnoses and the physician was comfortable with the management plans. The physicians looked forward to these visits; they were opportunities for exchanging "fish stories" and "town gossip." Other maintenance ceremonies, however, were seen as "hopeless." These patients were often depicted as "exasperating" and "lonely." They also had chronic problems, but the physicians were often uncomfortable with aspects of the management, which sometimes included vitamin B_{12} injections or "pain shots." Maintenance ceremonies were often simple and involved set clinical protocols such as prenatal and well-child visits. What distinguished them from routines was their repetitive, ceremonialized character.

Both "schedule busters" (transition ceremonies) and "always the same" (maintenance ceremonies) encounters shared the quality of having a prescribed, repetitive format. It was to highlight this quality that both of these encounters were labeled *ceremonies*. Ceremonies were those clinical encounters involving linked rituals or patterned, repeated processes in time with prescribed formal behavior having reference to shared symbols and to beliefs in mythical powers. Ceremonies were routines performed with elaborate pomp. The physician sometimes invoked the convenantal and parental image of priest. Examples included the placebo use of B_{12} injections, the use of a ritualized examination format, and repetitive 10-minute dialogues with a stable somatizing patient. When physicians used biomedically unproven treatments such as antibiotics for probable viral illness or anticholinergics for irritable bowel syndrome, ceremony was occurring. Ceremony posed the most ethical concerns. Efficacious ceremony seemed to require shared cultural themes. Continuity of care allowed the sharing of illness experience and thus sowed the breeding ground for efficacious ceremony.

Table 2. Physicians' Questions to Determine Taxonomic Categories

	Taxonomic Categories
Questions for physicians to ask patients	
What brings you here today?	Presenting concern
What worries you the most about (that)?	Reason for coming
What do you hope I can do for that?	Patient request
Have you ever had this kind of problem before?	Shared experience
Do you know anyone else. . .?	Shared experience
Have you read or heard about. . .?	Shared experience
Questions for physicians to ask themselves	
What is my past experience with this patient?	Shared experience
How does the patient appear?	The initial examination
What is my "gut feeling"?	Intuition
Is the patient a "straight talker"?	Communication style

The Decision-making Taxonomy

The physician-patient transaction type was usually determined within the first 5 minutes of a visit. The classification was based on answers to seven categories of questions. Eliciting the presenting concern, determining both "why they are here now" and "what they want," matching this story to the initial examination ("eyeballing them"), realizing "your gut feelings" based on "all those past times together," and recognizing "how straight they talk" were how the physicians claimed to make their decisions (Table 2).

Seven *reasons for coming* to a physician were identified by the physicians and are similar to those discussed by McWhinney[10] and Zola.[11] The reasons identified were the following: (1) "illness proof" (sick-role legitimation), (2) "paper work" (administration), (3) "checkup" (prevention), (4) "scared" (intolerable anxiety), (5) "can't

cope" (problem of living), (6) "they made me" (sanctioning), and (7) "can't take it anymore," "the pain, the pain" (intolerable pain). The reason for coming was elicited by asking why the patient came with the particular presenting concern at this time and "What worries [or frightens] you the most about [that]?"

Six *patient requests* were also recognized by the physicians: (1) "friend," "hand-holder" (psychosocial assistance), (2) "magical comfort" (therapeutic listening), (3) "tell me what it is," "a label" (medical information), (4) "what to do" (general health advice), (5) "bread and butter," "fix it" (biomedical treatment), and (6) "completed form" (bureaucratic fulfillment). These expectations were identified by asking, "What do you hope I can do for that?" or "How can I help you?" The first five of these patient requests are consistent with those proposed by Like and Zyzanski.[12]

While eliciting the patient's story, the physicians were "eyeballing them," doing an *initial examination*. They were noting the patient's appearance, expressiveness, and demeanor, and evaluating how closely it fit the story being told.

"Gut feeling" or *intuition* referred to the physician's sixth sense developed from past experiences with the patient ("all those past times together") both as a patient and as a fellow citizen in the community. (All physicians in this study lived near the office.) This sixth sense also derived from past experiences with other patients who shared similar characteristics with the patient of immediate concern. This intuition, often based on *shared experience*, was the primary means by which the two older family physicians claimed to enact the biopsychosocial model.

Finally, the physicians made a determination as to the patient's *communication style*. They simply wanted to know "how straight the patient talks." In other words, is what the patient says what the patient means? This is similar to McWhinney's distinction between direct and indirect communication.[13]

On the basis of the easily obtained information discussed above, the type of clinical encounter was determined. If the presenting concern was simple, single, and recent (within the last 2 weeks), and if the actual reason for coming was anything other than sick-role legitimation or a problem of living, and if the patient's expectation was a "label," "what to do," "completed form," or "fix it," if all of these parts of the story fit with the physician's initial examination and intuition, and if the patient was a "straight talker," then the encounter was probably a routine.

If, on the other hand, there was a new diagnosis of chronic disease, or there was no readily identifiable disease, or the patient's visit was triggered by a problem of living or sick-role legitimation, or the patient's request was for psychosocial assistance, or if in the case of any of the above, the examination or "gut feeling" did not match, or if the patient was not communicating directly, then the encounter was most likely a drama. New dramas in a limited time slot were transition ceremonies. All other encounters, especially those with frequent attenders, were generally maintenance ceremonies. Two cases of irritable bowel syndrome illustrate this decision-making taxonomy.

Two Case Histories

A.G. was a 24-year-old, single, third-year graduate student with known, well-controlled irritable bowel syndrome who presented because of her concern about 1 week of persistent runny diarrhea, nausea, and crampy abdominal pain. The symptoms were not relieved by her usual treatments. She was "scared" that this might be an ulcer, was a "straight talker," and wanted to know "what it is." The physician's "gut feeling," based on past experience with this patient, and a brief examination revealing a healthy-appearing, anxious young woman with normal vital signs and no weight change, were consistent with her presenting issues. Her concerns were simple, single, and recent. This was a routine encounter, and the biomedical model was invoked. Further brief history revealed a viral illness 2 weeks earlier that triggered her irritable bowel symptoms. A brief normal examination supported this diagnosis. Irritable bowel management was reviewed, and A.G. was reassured. Her symptoms diminished over the next week.

B.H. was a 33-year-old steel company executive who presented with a 3-month history of early morning watery diarrhea associated with nausea and crampy abdominal pain. He wanted to know what was going on because "I can't cope" and "I can't take it anymore." A cursory examination revealed a depressed affect, a physically robust appearance, and normal weight and vital signs. He appeared to be a "straight talker," but the physician's "gut feeling" suggested that the presenting concern was only the tip of an iceberg. This encounter was thus a new drama. Unfortunately, the physician had only 15 minutes for this visit, so a transition ceremony was performed. The physician ritualistically did an abdominal and rectal examination and stool hemoccult, and then drew serum for a complete blood count and sedimentation rate. B.H. was asked to keep a stool diary and was rescheduled for an extended visit in 1 week. Over the next few months, irritable bowel syndrome was diagnosed, brief family therapy was conducted because of revealed marital difficulties, and lifestyle modifications were recommended. His symptoms improved, but he

terminated family therapy prematurely. The drama was temporarily over.

Six months after terminating family therapy, B.H. returned complaining of increased abdominal pain and watery diarrhea. He wanted to know if he was doing the right things and if he was correct about this being his irritable bowel again. Everything seemed consistent with his assessment. This was a maintenance ceremony. A ritualistic abdominal and stool examination were performed, and the findings of good health were emphasized. His self-care activities were approved with a minor dietary alteration suggested. He was reminded to stay alert to marital conflict. B.H.'s symptoms lessened.

The Literature: A Synthesis

How do the typology and taxonomy identified and described above relate to the literature on the physician-patient relationship, family medicine clinical method, strategies for implementing the biopsychosocial model, and the ritual process? Several remarkable connections were evident.

Stuart and Lieberman[14] propose a patient care approach, based on the biopsychosocial model, that requires asking four questions early in the encounter. These are: What is going on? How do you feel about it? What troubles you the most? How are you handling it? With the exception of the last one, the questions are similar to those used to determine the type of clinical encounter. There are also close parallels between the taxonomy discovered in this study and the patient-centered clinical method.[15–17] John Coulehan,[18] examining the practice of chiropractic medicine, elucidated four steps required for healing: acceptance, explanation, action, and plan. These four steps correspond to the four steps used in a transition ceremony.

This study suggests that family systems thinking be applied when a drama occurs. This application corresponds closely to what the literature suggests are useful and appropriate occasions for convening the family.[19] Dramas include perplexing diagnostic problems, poor treatment adherence, failure to respond to treatment, emotionally charged encounters, and new chronic diagnoses. These may be times for expanding the context and for involving families in care. Routines may not be the time to involve the family or to do genograms.

One of the original research concerns was to determine when to use a particular relationship style. There remains much debate in the literature about what style is ideal.[20,21] The physicians in this study choose a relationship style according to the type of encounter. They use contractual or mutuality styles for routines.[22] Ceremony often evokes a shamanic image of the physician and thus a style of interaction that can be described as parental; the relationship is bound by covenant.[23] This style should not be confused with paternalism. In recent years, the paternalistic (male-dominant) role has been harshly and justifiably criticized. Much of this criticism, however, fails to recognize the many inherent imbalances and nuances of the physician-patient relationship. If the paternalistic postures of "Pollyanna," "needy child–omnipotent parent," and "persecutor-victim" are avoided,[24] and the encounter is a ceremony, a "shamanic" or parental role bound by covenant may actually promote healing and increase control and independence for the patient.[25,26] Dramas, on the other hand, necessitate the use of ever-changing models of the physician-patient relationship, according to the physicians interviewed in this study.

A search of the literature revealed that other researchers had developed similar analyses of clinical encounters. Marshall Marinker,[27] combining his personal clinical and teaching experience with the theoretical work of Morris,[28] proposed three types of consultations: routines, rituals, and dramas. Routines refer to common problems where the situation and the patient are familiar to the general practitioner. Rituals are cases of "repeat prescriptions"[29] and are based on some past unexplained encounter. Dramas refer to those encounters in which there is a novel situation, the outcome is in doubt, or the outcome is especially important and there is no familiar pattern. Although my research concurs with the routine and drama depicted by Marinker and Morris, my understanding of ceremony presented here expands and builds on their ritual category.

Ritual occurs in all three clinical encounter types. A ritual is any formal, repeated act with both expressive and creative functions, performed in a special place, and achieved through manipulation of symbols. Ceremonies, on the other hand, are a prescribed series of rituals linked for a specific purpose. The literature on ritual process offers both hopes and warnings. We are reminded that the clinical encounter is a ritual space where the ordinary world of the physician meets the extraordinary, intensified experience of the patient.[30] We are warned about the risks of excessive routinization[31] and the role of ritual as a reinforcer of cultural norms and beliefs.[32] La Barre[33] eloquently describes how ceremonies can be a hypnotic substitute for reality such that we see only our reflected expectations and risk being exploitative of our patients.[34] Victor Turner,[35] however, hopes that ritual, as drama, can be transforming if its participants suspend judgment, maintain ambiguity ("liminality"), are playful, and step outside the usual hierarchy (*communitas*). We must be careful with ritual or risk the patient being transformed

into our image and not to one of his or her own creation. While studying the rules and ritual process in my practice, I was reminded of Goffman's observation, "We all act better than we know how."[36]

Discussion

The typology and taxonomy presented in this study were based on careful scrutiny of the perceived management styles of two veteran family physicians within a particular office setting. This is both the study's strength and its weakness. The study tells us nothing about the patient's perspective nor does it offer evidence about the efficacy of the proposed typology and taxonomy relative to patients. This study did promote the efficiency and satisfaction of the physicians and head nurse in the family practice studied, and provided us with a better understanding of some of the day-to-day decision-making processes concerning clinical encounters. The typology and taxonomy were management and physician focused. It is very possible that a disease focus, an illness focus, a patient focus, a family focus, or a community focus would produce a somewhat different pattern of results. These possibilities should be explored in the future.

Four specific strategies were employed to ensure the trustworthiness of the research process. The first strategy used triangulation of methods.[37] Initial formulations were developed from key informant interviews and then checked and revised on the basis of informal and ethnoscientific interviews. These results were then implemented and evaluated using participant observation. A second strategy involved triangulation of research participants.[38] The revealed perceptions of the two family physicians were compared and contrasted with each other and with those of the head nurse. The research participants were continuously engaged in review of my evolving understanding of their management approach to clinical encounters. This iterative review or participants' checking[39] greatly strengthens the likelihood that what is reported is what the research participants actually meant. The fourth trustworthiness strategy was to report sufficient details about the study and its results so that the reader can evaluate the context of the reported findings.[40] Others should be able to repeat this study in another setting and determine the generalizable and the context-dependent qualities of the typology and taxonomy described.

In the future, at least three additional techniques could be used to further enhance trustworthiness. A research analyst from outside the practice would be a valuable antidote to premature closure, cue blindness, and the unconscious biases by which a lone participating field researcher is often trapped. The use of pile-sort techniques[41] could also increase objectivity. Finally, interviews should be taped and transcribed to reduce the possibility of lost information and enhance the ability of others to audit the data.

Future research prospects are varied and exciting. Do other family practice and primary care settings confirm these findings? What is the frequency of the three encounter types in different practice settings? I suspect many residency training sites have significantly more dramas and fewer routines than suburban private practices. How do *patients* understand and manage clinical encounters? Do patients have their own typology? If so, how are the two typologies negotiated and used? Are they ever used as defense mechanisms or as agenda setters as warned by Balint[42] and Stein[43]? How does culture influence the typology and taxonomy presented? Does implementation of the proposed typology and taxonomy improve patient satisfaction and clinical outcome? What is appropriate ceremony? What are the ethics of ceremony? What are the rituals that family physicians currently employ, how do they work, when and how do they fail, and what do they mean to different groups of patients? What are the different ways to stage a drama? How do our dramatic scripts and rituals limit our awareness? How is the discourse in each of these encounters different and the same? How do the encounter types relate and change over time? What is the importance of shared experiences? The possibilities for more practice-based research are exhilarating.

This research evolved out of dilemmas and conflicts created by residency-derived expectations that did not fit the reality of private practice. The findings in this study resolved many of these conflicts for the participants. The typology and taxonomy presented describe expectations concerning the clinical encounter that are realistic and teachable. I am now a teacher of family medicine and have already witnessed the increase of resident satisfaction with patient care as a result of learning the strategy discussed in this article. The pedagogical implications of this study also require refinement and evaluation.

Family systems theory and the biopsychosocial model may sometimes help but can occasionally overwhelm family practice physicians. The typology of clinical encounters and the elicitation taxonomy offered here suggest a framework for facilitating implementation of these exciting visions. What began as a quest for understanding my clinical practice is now shared with my community of peers. The mysteries and surprises of clinical reality will always be there to remind us of how limited our frameworks are. Try the typology and taxonomy, expand the questions, share your self. The next time it's 5:30 PM, your stomach is growling, and you are

seeing a colicky infant and a beleaguered parent, ask, "Is this a routine, a ceremony, a drama . . . or something else?"

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