CASE STUDY
Coding sheet

Continued

11 Consultation stages (this derived from Robert Hilliard's attempt to identify a series of stages from a greeting exchange to elicitation of symptoms, through to examination and diagnosis statement (see Silverman, 1985: 265–9)):
   Stage
   Questions asked
   Topics covered
   Notes/Markers
12 Does doctor invite questions?
   No
   Yes (When:)
13 Use of medical terminology:
   Stage
   Doctor/Family
14 Scope of consultation:

	Family	Doctor
Prior treatment		
History		
Extra-cardiac		
Physical states		
Child development		
Child behavior		
Family's practicalities of treatment or attendance		
Doctor's practicalities of treatment or attendance		
Anxieties and emotional problems of family		
Social situation of family		
External treatment agencies		

15 Family's presentation of a referral history.
16 Format of doctor's initial elicitation question (for example how is she? Is she well?)
17 Patency (this referred to whether symptoms or diseases were visible or 'patent' to the family):
   Family's presentation of problems/symptoms
   Doctor's mention of patent symptoms
   Family's assent to problems/symptoms
   'Not patent'?
18 Location of examination:
   Desk
   Couch
   Side-room
19 Diagnosis statement:
   (a) Use of 'well' (Dr/Family/Both)
   (b) Use of 'normal' (Dr/Family/Both)
   (c) Possible diagnoses mentioned (0/1/>1)

20 Decisions:
- (a) Possible disposals mentioned (0/1/>1)
- (b) Medical preference stated (Yes/No)
- (c) Medical intention stated (Yes/No)
- (d) Family assent requested (Yes/No)
- (e) Family allowed to make decision (Yes/No)
- (f) Family wishes volunteered (Yes/No)
- (g) Family dissent from doctor's proposed disposal (Yes/No)

21 Uncertainty expressed by doctor:
- (a) Over diagnosis
- (b) Over treatment

(Source: Silverman, 2006: 90–1, Table. 3.2)

This coding form enabled the researchers to identify some behavioral patterns:

> For instance, by relating Item 14 on the scope of the consultation to the decision-format (Item 20), we were able to see differences between consultations involving Down's children and others. Moreover, it also turned out that there were significant differences between these two groups both in the form of the elicitation question (Item 16) and the diagnosis statement (Item 19).
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> . . . Obviously, in making fieldnotes, one is not simply recording data but also analyzing them. The categories you use will inevitably be theoretically-saturated – whether or not you realize it! So the coding form . . . reflected my interest in Goffman's (1974) concept of 'framing.' This meant that I tried to note down the activities through which the participants managed their identities. For instance, I noted how long the doctor and patient spent on social 'small talk' and how subsequent appointments were arranged.
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> These concerns show how theoretically-defined concepts drive good ethnographic research . . . They also demonstrate how one can develop analysis of field data after a research problem has been carefully defined. (Silverman, 2006: 92).