INTRODUCTIONS AND CONCLUSIONS:
How we Finish and What we Started

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INTRODUCTION EXERCISE

How can this introduction be improved? What do you expect the paper will discuss? What kinds of evidence will the paper use?

Doctor-patient interactions have been a site of sociological inquiry for some time. Much of this research has examined the "gap" in physician-patient communication where doctors and patients fail to understand each other and how doctors and patients can better negotiate the "gap" [1, 2, 3, 4, 5, 6, 7, 8]. More specifically, through continual inquiry and consideration, conversation analysis (CA) has identified the general process employed in the doctor-patient interaction:

> (1) come together and establish a relationship (opening), (2) the patient expresses the reason for the visit (presenting complaint), (3) the doctor examines the patient (examination), (4) the doctor produces an evaluation of the patient's condition (diagnosis), (5) the doctor proposes treatment for the condition (treatment), and (6) the doctor and patient terminate the visit (closing) [9: 789].

While there is some variation among different analysts, the basic order and conversation themes are fairly consistent among most CA researchers [6, 10, 11, 12]. The documentation of the general access points of a doctor-patient interaction and what transpires creates an important foundation for understanding the relationship between doctors and their patients. However, this approach fails to acknowledge any contextual differences that may relate to *how* doctors and patients interact with each other within the different stages of the general pattern. Little, if any, attention has been given to the ways in which the nature of the doctor-patient relationship may vary across different practices and different locales. While the basic script may remain the same, the nature and type of medical attention provided to patients as well as the nature and type of the relationship between doctor and patient may differ across practice locations, such as urban and rural settings.

A large body of literature suggests that both mental and physical health are significantly enhanced by supportive socioemotional ties and cohesive relationships [13, 14, 15, 16]. Health care providers are one possible source of support that may benefit patients' health above and beyond the specific medical treatment they receive. While different types of health care providers, such as nurses and physicians, may form different types of relationships with their patients [17, 18] this paper focuses on how physician-patient communications may differ across family clinics located in different healthcare sites. Specifically, our research question is: how do physician-patient communications differ across urban and rural family clinics? Based on observation and interview data, each site reveals subtle but important differences in doctor-patient interactions.

CONCLUSIONS

Does this conclusion answer the question "so what"? Does it return to the theme of the introduction? Does it propose something more or something provocative or point to broader implications?

An interesting finding of this study is that despite the different ways in which doctors and patients communicate with each other in the two settings, rural and urban doctors spend approximately the same amount of time with their patients. The interactions observed in the urban settings tend to follow the basic script documented by converstation analysts [9], which are "cure-oriented interactions" that focus on the patient's medical concerns and how they are to be treated. The doctor and patient communication is primarily instrumental and oriented towards the health concerns or reason for the appointment and information that is shared is directly related to the patient's physical health[3]. In contrast, the results of this study suggest that doctor-patient interactions in rural settings involve significantly more socio-emotional communication that is characterized by more "care-oriented interactions" [37]. These socioemotional communications may ease patient anxiety and increase patient-doctor trust, but they do not appear to add extra time to the patient visit. In these rural interactions, medicine happens in between conversation that alleviates anxiety and builds a trusting relationship.

Research suggests that socioemotional communication ultimately leads to better patient outcomes [3, 4]. This implies that health differences between rural and urban settings could be linked to differences in doctor-patient communication styles. And while some might argue that socioemotional communication takes up too much time, the results of this study suggest otherwise. While uncertainties remain about the role of physician communication style and patient outcomes [48], future research might explore the extent to which socioemotional communication may affect the health disadvantage documented in rural areas. By better understanding the different types of doctor-patient communications, it may provide an important piece to the complex puzzle of explaining urban-rural variations in health care and health outcomes.