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Research Article

Gender Differences in Verbal Behaviour Style in Dyadic and Triadic Interviews in Family Medicine -

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ABSTRACT

Objective: To describe the gender differences in verbal behaviour of physician-patient-companion (triadic consultations), and doctor-patient (dyadic consultations), and to assess the implications that these possible differences may have in clinical management and interpersonal relationship. This article is the third and last part, which completes the analysis of a study on verbal behaviour in the interview in family medicine, having previously published the data of gender differences without taking into account the presence of companions of the patient, and the comparison of female patients with and without companion.

Participants and methods: Secondary analysis of existing dataset coded to explore patient-clinician verbal communication during ambulatory visits in a family medicine office in a health Centre in Toledo (Spain) was carried out. A qualitative and quantitative study was performed by audio recording of the consultations and verbal content analysis of the interviews. A convenience sample was carried out. A suitable sample number was considered when saturation occurred. Once the qualitative study was completed, the results of the number of behaviours in the total of triadic and dyadic consultations were presented in a quantitative way (frequencies: N°, %). The bivariate comparisons were performed using the test of chi-square and exact probability Fischer.

Results: 10 unaccompanied consultations (dyadic consultations: physician-patient), and 10 consultations with companion (triadic consultations: physician-patient and companion) were included in the analysis. There were more verbal behaviours in female patients than in male patients [266 (65%) vs. 144 (35%)]. In the case of unaccompanied (dyad) female patients, there are less "Disagreeing" than in males patients (1% vs. 16%; $p < .05$). In the case of female patients with a companion (triads) there are fewer "Proposing" than in males patients (4% vs. 13%; $p < .05$). In female companions there are more behaviours of "Seeking Information" than in male companions (20% vs. 4%; $p < .05$). In the triadic consultations with female patients vs. dyadic consultations with female patients, there are no statistically significant differences. In the triadic consultations of male patients vs. dyadic consultations with male patients, there are more verbal behaviours of "Proposing" (13% vs. 3%, $p < .05$) and fewer of "Disagreement" (2% vs. 16%, $p < .05$).

Conclusions: In the clinical interview in family medicine, the presence of women in the dyadic or triadic consultation, or as a companion of the patient, offers a better verbal behaviours profile vs. male consultation or male companion, to achieve a good consultation. Triads' consultations with male patients have a better profile of verbal behaviours those dyads with male patients.

Keywords: Medical Chaperones; Family Practice; Family Members; Caregivers; Physician-Patient Relations; Interpersonal Relationships; Methodology; Gender Differences; Verbal Behaviour Style; Communication; Language

INTRODUCTION

Verbal communication is the conscious effort of expression that tries to facilitate the understanding of the message on the part of the other through the use of the words. On the most obvious level, language allows us to satisfy basic functions such as describing ideas, making requests, and solving problems; but beyond these functions, the way we use language also influences others and reflects our attitudes in more subtle ways [1]. The cornerstone of general practice is the consultation. Communication is an important component of patient care, and the most important aspect of practice that health care professionals have to master, particularly in primary medical care [2-4].

The clinical interview is a technique or channel and place of communication, where the doctor-patient relationship is produced and developed. And communication in the doctor-patient relationship points out signalizes (like signalling a path in the forest, so that we can focus our field study on the natural values of the place) the clinical setting [5-8]. The clinical interview and communication seem to focus on an encounter between two people: the patient and the physician. But, in practice, a third person (companion, who is usually a family member) frequently accompanies to the patient during medical encounter (triadic consultation). Nevertheless studies about the presence of a companion of the patient in consultation are rather scarce in our environment. It should be noted that, the subjective experience of disease is built by patient in the family context and is expressed in the medical consultation, often, with the presence of a companion of the patient [9-12]. The group communication dynamics that are developed in the bipartite and tripartite meetings are not identical. But previous research on communication in the interview has focused primarily on "dyadic" consultations between physician and patient [13-20]. If little is known about the presence of

the patient's companion in the family medicine consultation, the less we know about gender differences in the dynamics of communication in triadic interviews, although it has been reported that verbal behaviour in interview in the family medicine consultation with female patients vs. males shows more behaviours of "Supporting", and less of "disagreement" in women [21]. In this context, we carried out a secondary analysis of existing dataset with the objective of describing the gender differences in verbal behaviour of physician-patient-companion in the triadic consultations, and doctor-patient in the dyadic consultations, and to assess the implications that these possible differences may have in clinical management and interpersonal relationship

PATIENTS AND METHODS

Design and Variables

Secondary analysis of existing dataset coded to explore patient-clinician verbal communication during ambulatory visits in a family medicine office was carried out

The methodology of the study was qualitative, observational, and narrative and has already been described previously [21,22]. Therefore, only the fundamental data for the independent understanding of this text are repeated, without having to read the previous publications. During the months of November and December 2016, through the audio recording of the consultation, and verbal content analysis of the interviews, based on the identification of 6 categories of classification of the behaviours in meetings that describe the class or behavioural style of the interaction process, not its content, proposed by its simplicity by Open University, and based on the principles of Bales and Flanders, reviewed from a study by Huthwaite Research Group [23]:

1. Proposing a behaviour that advances a new concept or suggests a course of action
2. Supporting or agreeing: a behaviour that includes a conscious and direct statement of support or agreement with another person or their concepts
3. Disagreement: a behaviour that involves a conscious and direct statement of difference of opinion, or criticism of the concepts of another person
4. Giving information: a behaviour that offers facts, opinions or clarifications to other individuals
5. Seeking information: a behaviour that seeks facts, opinions or clarifications of another individual or individuals
6. Building: a behaviour that extends or develops a proposal that has been made by another person.

Other variables that were collected were age and sex the companion and the patient. The study is descriptive in its approach since it aims at describing an existing phenomenon and it is qualitative in nature although the study uses a quantitative method for data collection and complementary analysis.

In all cases the doctor was the same professional, a family doctor who remains in the same consultation for over 25 years. The location was a family medicine office, in the Health Centre Santa Maria de Benquerencia, Toledo, Spain, which has a list of 2,000 patients. Patients of both sexes over 14 years old were included (In Spain family doctors attend patients over 14 years old). Companion was defined as any person who accompanied the patient in the consulting room or that consult instead the patient. Patients were included only one time, thus, were excluded the repeated consultations of same patient, including only the first visit. Also excluded were interviews in which the patient was not present (his or her companion was alone), when there were more than 1 companion with the patient (since it made the verbal analysis very complicated by the interference of one another), emergency consultations, and the phrases of courtesy of initial and final greetings were not included in the content analysis of the interview.

Sample

A non-random sampling, intentional - of convenience - was carried out by the investigators. A suitable sample number was considered when saturation occurred, i.e., no new data were obtained [24]. The criterion of maximizing the diversity in obtaining the sample was taken into account, and all types of interviews were included, with the widest possible situations.

Analysis

The interview was recorded in audio, and later transcribed to Microsoft® Word. With the written text of the interview, their content was subsequently analyzed, classifying the interaction in the doctor-patient interview or in the physician-patient-companion group, according to the 6 proposed categories [25,26].

Once the qualitative study is completed, the results of the number of behaviours in the total of triadic and dyadic consultations are presented in a quantitative way. This is only as an orientation, because the size of the sample was not calculated as a quantitative, but qualitative. The bivariate comparisons were performed using the test

of chi-square and exact probability Fischer. Control of validity and reliability of the study has already been published [21,22,27].

RESULTS

10 unaccompanied consultations (dyadic consultations: physician-patient), and 10 consultations with companion (triadic consultations: physician-patient and companion) were included in the analysis.

There were 410 verbal behaviours of patients: 198 in dyads (101 in women, 97 in men), and 212 in triads (165 in women, 47 in men). There were more verbal behaviours in female patients than in male patients [266 (65%) vs. 144 (35%)]. In addition, 86 verbal behaviours were recorded in patients' companions (40 in women and 46 in men).

In the case of unaccompanied (dyad) female patients there are more behaviours of "Supporting/Agreeing" and "Give information" and less of "Disagreeing" than in male patients (34% vs. 28%; NS, 53% vs. 45%; NS, and 1% vs. 16%; $p < .05$, respectively) (Table 1, Figure 1).

In the case of female patients with a companion (triads) there are more behaviours of "Supporting/Agreeing" and less of "Proposing", than in male patients (42% vs. 32%; NS, and 4% vs. 13%; $p < .05$, respectively) (Table 2, Figure 2).

In female companions there are more behaviours of "Seeking Information" than in male companions (20% vs. 4%; $p < .05$) (Table 3, Figure 3). In the triadic consultations with female patients vs. dyadic consultations with female patients, there are no statistically significant differences (Table 4).

In the triadic consultations of male patients vs. dyadic consultations of male patients there are more behaviours of "Proposing" (13% vs. 3%, $p < .05$) and fewer of "Disagreement" (2% vs. 16%, $p < .05$) (Table 4).

DISCUSSION

The clinical interview: dyads and triads

The clinical interview is an essential competence of the family doctor and communication a key piece in the doctor-patient

Table 1: Verbal behaviours in female patients vs. Males in consultations without companions (dyads).

	DYADIC RELATIONSHIP: FEMALE PATIENTS (N =)	DYADIC RELATIONSHIP: MALE PATIENTS (N = 5)	STATISTICAL SIGNIFICANCE
VERBAL BEHAVIORS	Nº (%)	Nº (%)	
Proposing	1(1%)	3(3%)	Fisher exact test = 0.361241. NS.
Supporting or agreeing	34(34%)	27(28%)	X2 = 0.7885. $p = .374558$. NS.
Disagreement	1(1%)	15(16%)	X2 = 13.9551. $p = .000187$.
Giving information	54(53%)	44(45%)	X2 = 1.3001. The p -value is .254189. NS.
Seeking information	9(9%)	4(4%)	X2 = 1.8484. $p = .173966$. NS.
Building	2(2%)	4(4%)	Fisher exact test = 0.437855. NS.
Total	101(100%)	97(100%)	
Edad	X = 41 (rango: 32-46)	X = 51 (rango: 38-62)	

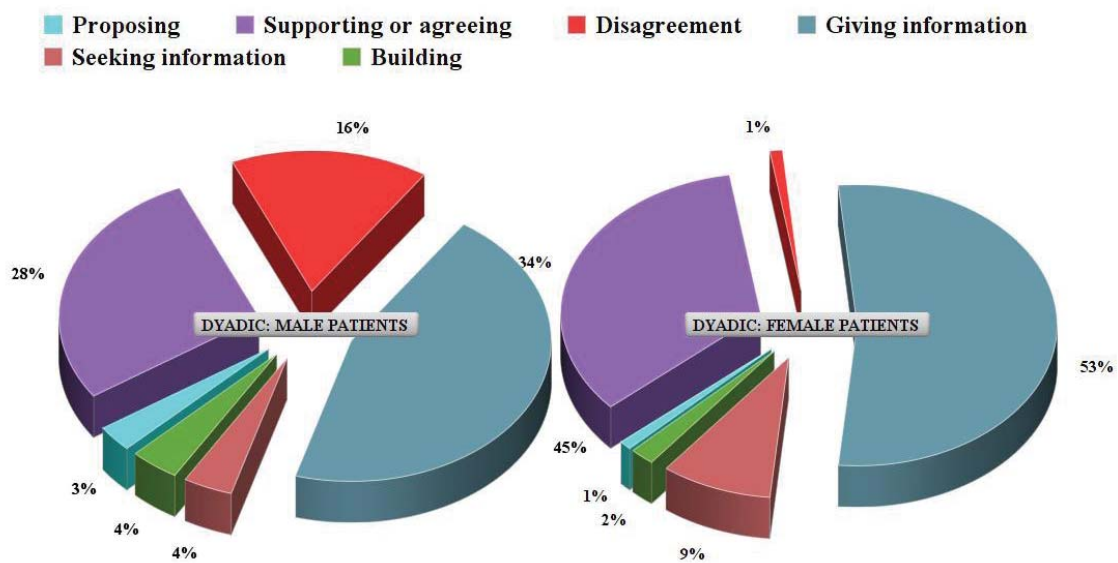


Figure 1: Verbal behaviours (%) in female vs. Males patients in consultations without companions (dyads)

Table 2: Verbal behaviours in female vs. Males patients in consultations with companions (triads).

	TRIADIC RELATIONSHIP: FEMALE PATIENTS (n = 7)	TRIADIC RELATIONSHIP: MALE PATIENTS (n = 3)	STATISTICAL SIGNIFICANCE
VERBAL BEHAVIORS	Nº (%)	Nº (%)	
Proposing	7(4%)	6(13%)	X2 = 4.617. p = .031656.
Supporting or agreeing	70(42%)	15(32%)	X2 = 1.6821. p = .194648. NS.
Disagreement	7(4%)	1(2%)	Fisher exact test = 0.687859. NS.
Giving information	71(43%)	21(45%)	X2 = 0.0406. p = .84037. NS.
Seeking information	9(6%)	2(4%)	Fisher exact test = 1. NS.
Building	1(1%)	2(4%)	Fisher exact test = 0.124283. NS.
Total	165(100%)	47(100%)	
Edad	X = 45 (rango: 14-64)	X = 52 (rango: 20-70)	

relationship. Health care and its outcomes depend on how the professional and the consultant communicate, since profitable communication is a major component in health recovery [14,28]. The conceptualization and physician training focuses on an encounter between two people: the patient and the physician; in practice, a third person (companion) frequently accompanies a patient during medical encounter, and there is a high prevalence of the presence of companion (25% of the interviews are with companions; triadic consultations) [10,29]. It has been reported that the presence of a companion can improve medical proposals or interventions [22,30-33].

Gender differences in verbal behaviour style in interviews in family medicine

The relationship between gender and language is a confusing

subject. There are many differences in the ways men and women speak: the content of their conversations varies, as do their reasons for communicating and their conversational styles [1]. A variety of sociolinguistic studies have showed that boys use talk to assert control over one another, whereas girls use talk to maintain harmony. Women behave differently in conversations than do men; so, women ask more questions in mixed-sex conversations than do men [34,35]. Men are more likely than women to emphasize making conversation fun. By contrast, women's conversations focus more frequently on feelings, relationships, and personal problems. Because women use conversation to pursue social needs, female speech typically contains statements showing support for the other person, demonstrations of equality, and efforts to keep the conversation going [1].

It is found that not only do women consult more often than men but also the correlates of primary care utilisation differ between the sexes. Health status (need) and social role factors (including parenthood and marital status) are found to be more important for men, while psychological predisposition is of greater significance among women [36]. It has also been reported that women more than men see their symptoms as an expression of a psychic disturbance [37]. However, research shows that the notion that men and women communicate in dramatically different ways is exaggerated. It seems that verbal behaviour in interview in the family medicine consultation with female patients vs. males shows only small differences. "Neither the men are of Mars, nor the women of Venus; maybe men are from North Dakota and women from South Dakota". In any case, we have communicated that the interviews with women and males, differ in showing more "Supporting", and fewer "Disagreement" [21]. On the other hand, we also communicated that consultations of female patients with a companion are longer and more verbal behaviours are performed. In patients female the triadic consultations have more agreements, but less information is obtained than in the dyadic [38].

Therefore, is this trend in verbal behaviours of more "Supporting" and less of "Disagreement" in interviews with female patients vs. male patients in family medicine varies according to the consultation

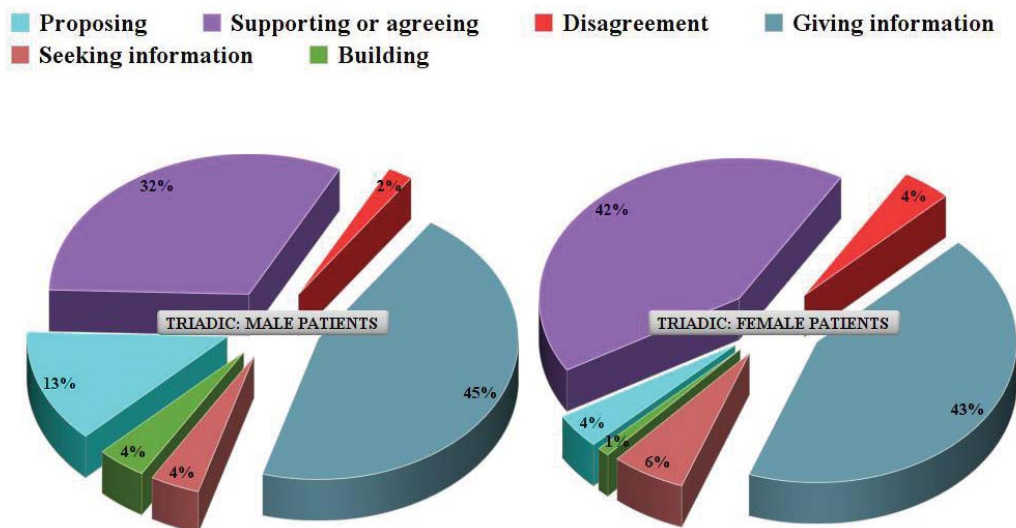


Figure 2: Verbal Behaviours in Female vs. Males Patients in Consultations with Companions (Triads).

Table 3: Verbal behaviours in female vs. Males companions in triads consultations.

	TRIADIC RELATIONSHIP: FEMALE COMPANIONS (n = 4)	TRIADIC RELATIONSHIP: MALE COMPANIONS (n = 6)	STATISTICAL SIGNIFICANCE
VERBAL BEHAVIORS	Nº (%)	Nº (%)	
Proposing	1(2%)	1(2%)	Fisher exact test = 1. NS.
Supporting or agreeing	12(30%)	22(48%)	X2 = 2.8441. p = .091709. NS.
Disagreement	1(3%)	1(2%)	Fisher exact test = 1. NS.
Giving information	17(43%)	20(44%)	X2 = 0.0084. p = .92718. NS.
Seeking information	8(20%)	2(4%)	X2 = 5.101. p = .023913. This result is significant at p < .05.
Building	1(2%)	2(4%)	Fisher exact test = 1. NS.
Total	40(100%)	46(100%)	
Edad	X = 56 (rango: 40-67)	X = 55 (rango: 39-66)	

is dyadic or triadic? In this study, we found that female patients, both when they go to the consultation alone (without companion; dyadic consultation) and when they go with a companion (triadic consultation), show behaviours of “Supporting or agreeing” (a conscious and direct statement of support or agreement with another person) to a greater extent than male patients in dyadic or triadic consultations. On the other hand, when females are companion of patients they show more behaviours of “Seeking Information” than male companions.

Effective and empathic management of triadic communication that avoids unnecessary disruption and frustration requires specific communication skills (e.g. rules and order of conversation). Triadic communication in medical encounters can be useful, but it is difficult.

They have been suggested some preliminary strategies for health professionals to increase the utility of physician-patient-companion communication [39,40]. We can add that, in triadic consultations, the presence of female patient or female companions of the patient would be a positive factor for a better communication.

LIMITATIONS OF THE STUDY

Our study has limitations, which have already been published in part [6,7] in relation to 1) coding difficulties [23]; 2) transcription from audio to text: doctor, patient and companion contribute to the discourse, and thus present overlaps, juxtapositions and narrations together, and these are difficult to transcribe and codify; 3) difficulties in the role of patient and companion: in the triadic interviews: the companion, not infrequently consults for herself or herself, and there is an inversion of roles: the one who was a companion becomes a patient, and vice versa. This situation complicates the coding of behavioral styles; 4) the question of representativeness of the sample: interviews were recorded on normal consultation days, communication was not subject to fluctuations, and we thought that by maximizing the diversity of the participants, they represented the patients and companions usual of the consultation. It may be thought that the size of the sample is small, but in qualitative studies this usually is small, and the sample size was given by the saturation of the data, and was similar to that of other studies of the same subject [27]; and 5) the content of the interviews was not collected: only the class or behavioral style of the interaction process. The conceptualization of the disease is another point of interest that can vary between participants, doctor, patient and companion. A different understanding of the origin of a disease, for example, can cause communication problems and lead to misunderstandings.

CONCLUSION

This article is the third and last part, which completes the analysis of a study on verbal behaviour in the interview in family medicine, having previously published the data of gender differences without taking into account the presence of companions of the patient [21], and the comparison of female patients with and without companion

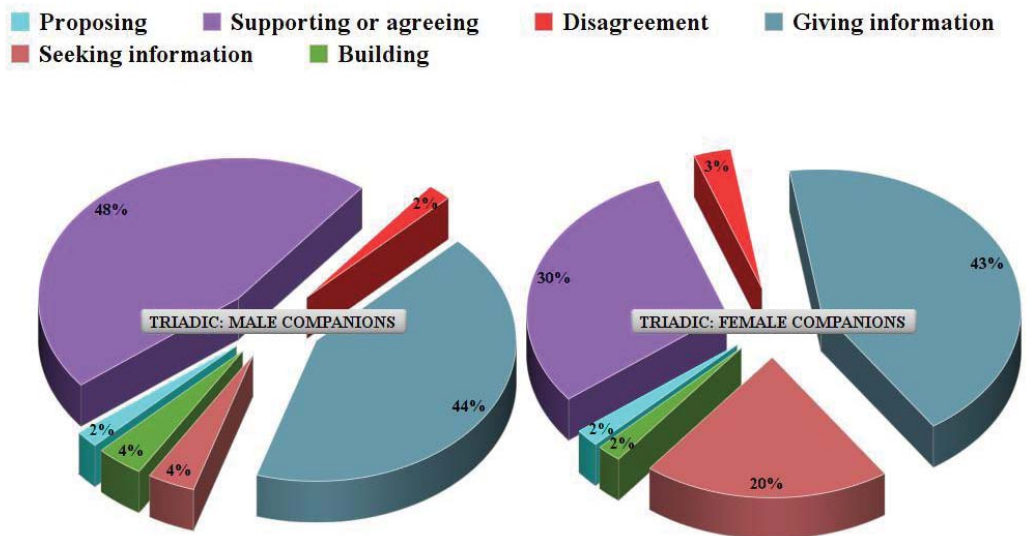


Figure 3: Verbal Behaviours in Female vs. Males Companions in Triads Consultations.

Table 4: Comparison between verbal behaviours in women patients in dyadic and triadic consultations, and in men patients in dyadic and triadic consultations.

VERBAL BEHAVIORS	DYADIC RELATIONSHIP: FEMALE PATIENTS (N = 5)	TRIADIC RELATIONSHIP: FEMALE PATIENTS (n = 7)	STATISTICAL SIGNIFICANCE	DYADIC RELATIONSHIP: MALE PATIENTS (N = 5)	TRIADIC RELATIONSHIP: MALE PATIENTS (n = 3)	STATISTICAL SIGNIFICANCE
Proposing	1(1%)	7(4%)	X2 = 2.2718. p = .131749. NS.	3(3%)	6(13%)	X2 = 5.0558. p = .024543.
Supporting or agreeing	34(34%)	70(42%)	X2 = 2.0195. p = .155295. NS.	27(28%)	15(32%)	X2 = 0.2551. p = .613523. NS.
Disagreement	1(1%)	7(4%)	X2 = 2.2718. p = .131749. NS.	15(16%)	1(2%)	X2 = 5.7013. p = .016953.
Giving information	54(53%)	71(43%)	X2 = 2.7387. p = .097944. NS.	44(45%)	21(45%)	X2 = 0.0059. p = .938716. NS.
Seeking information	9(9%)	9(6%)	X2 = 1.1863. p = .276076. NS.	4(4%)	2(4%)	Fisher exact test = 1. NS.
Building	2(2%)	1(1%)	Fisher exact test = 0.559406. NS.	4(4%)	2(4%)	Fisher exact test = 1. NS.
Total	101(100%)	165(100%)		97(100%)	47(100%)	

[38]. Female patients in both dyads and triads show a greater number of verbal behaviours than males. Female patients, both when they go to the consultation alone (without companion; dyadic consultation) and when they go with a companion (triadic consultation), show behaviours of "Supporting or agreeing" (a conscious and direct statement of support or agreement with another person) to a greater extent than male patients. When females are the companion of patients they show more behaviours of "Seeking Information" than male companions. Triads with female patients agree more, and less information is obtained than dyads with female patients, but without statistically significant differences. In triads vs. dyads with male patients there are proposing more and have fewer disagreements.

In short, in the clinical interview in family medicine, the presence of women in the dyadic or triadic consultation, or as a companion of the patient, offers a better verbal behaviours profile vs. male consultation or male companion, to achieve a good consultation [41]. Triads' consultations with male patients have a better profile of verbal behaviours those dyads with male patients.

REFERENCES

- Adler RB, Rodman G. Understanding human communication. Oxford University Press. New York. 2014. <https://goo.gl/Z5PnBP>
- Turabian JL. Cuadernos de medicina de familia y comunitaria [family and community medicine notebook]. Madrid: Diaz de Santos S.A. 1995. <https://goo.gl/v7ougs>
- Pendleton D. The consultation. An approaching to learning and teaching. Oxford: Oxford University Press. 1984. <https://goo.gl/GGmdBa>
- Neighbour R. The inner consultation. Lancaster: MTP press. <https://goo.gl/c1RnBP>
- Teutsch C. Patient-doctor communication. Med Clin North Am. 2003; 87: 1115-1145. <https://goo.gl/mEQnLo>
- Roberts L, Bucksey SJ. Communicating with patients: what happens in practice?. Phys Ther. 2007; 87: 586-594. <https://goo.gl/PnMnXb>
- Beck RS, Daughtridge R, Sloane PD. Physician-patient communication in the primary care office: a systematic review. J Am Board Fam Pract. 2002; 15: 25-38. <https://goo.gl/7p23rK>
- Turabian JL, Perez Franco B. The effect of seeing the sea for the first time. An

- attempt at defining the family medicine law: the interview is clinical medicine. *Aten Primaria*. 2008; 40: 565-566. <https://goo.gl/36DSuk>
9. Schilling LM, Scatena L, Steiner JF, Albertson GA, Lin CT, Cyran L, et al. The third person in the room: Frequency, role, and influence of companions during primary care medical encounters. *J Fam Pract*. 2002; 51: 685-690. <https://goo.gl/uK7pL5>
 10. Turabian JL, Minier-Rodriguez LE, Rodriguez-Almonte FE, Cucho-Jove R, Moreno-Ruiz S, Villarin-Castro A. The Companion of the Patient in Family Medicine: The Fable of the Painting and the Frame. *Epidemiology (Sunnyvale)*. 2006; 6: 274. <https://goo.gl/eEQ94v>
 11. Turabian JL, Perez-Franco B. Modelos de atención centrada en el "acompañante" del paciente. La familia y el contexto: en el borde de la relación médico-paciente en medicina de familia [Models of care centered on the patient's "companion". Family and context: on the edge of the doctor-patient relationship in family medicine]. Editorial Académica Española. Schaltungsdienst Lange OHG, Berlin. 2015. <https://goo.gl/Q2eRZb>
 12. Turabian JL, Perez Franco B. The presence of a companion in the primary care consultation. *Semergen*. 2015; 41: 206-213. <https://goo.gl/jDnuip>
 13. Clayman ML, Morris MA. Patients in context: recognizing the companion as part of a patient-centered team. *Patient Educ Couns*. 2013; 91: 1-2. <https://goo.gl/xGY4dA>
 14. Ishikawa H, Roter DL, Yamazaki Y, Takayama T. Physician-elderly patient-companion communication and roles of companions in Japanese geriatric encounters. *Soc Sci Med*. 2005; 60: 2307-2320. <https://goo.gl/8ZwPmd>
 15. Schmidt KL, Lingler JH, Schulz R. Verbal communication among Alzheimer's disease patients, their caregivers, and primary care physicians during primary care office visits. *Patient Educ Couns*. 2009; 77: 197-201. <https://goo.gl/1XYbGj>
 16. Shields CG, Epstein RM, Fiscella K, Franks P, McCann R, McCormick K, et al. Influence of accompanied encounters on patient-centeredness with older patients. *Am Board Fam Med*. 2005; 18: 344-354. <https://goo.gl/oYrGDL>
 17. Marvel K, Major G, Jones K, Pfaffly C. Dialogues in the exam-room: Medical interviewing by resident family physicians. *Fam Med*. 2000; 32: 628-632. <https://goo.gl/hkAfDy>
 18. Main DS, Holcomb S, Dickinson P, Crabtree BF. The effect of families on the process of outpatient visits in family practice. *J Fam Pract*. 2001; 50: 888. <https://goo.gl/XkXE86>
 19. Wehlage DF. Use of a family member interview to teach the bio psychosocial model. *Psychosomatics*. 1987; 28: 371-377. <https://goo.gl/9qobtg>
 20. Boon H, Stewart M. Patient-physician communication assessment instruments: 1986 to 1996 in review. *Patient Educ Couns*. 1998; 35: 161-176. <https://goo.gl/TScVHQ>
 21. Turabian JL, Minier-Rodriguez LE, Moreno-Ruiz S, Rodriguez-Almonte FE, Cucho-Jove R, Villarin-Castro A. Gender differences in verbal behavior style in interviews in family medicine: mars and venus, or north dakota and south dakota? *J Women's Health Care*. 2017; 6: 365. <https://goo.gl/VuwmvS>
 22. Turabian JL, Minier-Rodriguez LE, Moreno-Ruiz S, Rodriguez-Almonte FE, Cucho-Jove R, Villarin-Castro A. Qualitative and quantitative study of verbal behavior style in interviews with patient's companion in family medicine: understanding and measuring. *Scientific J Fam Med*. 2017; 1: 22-31. <https://goo.gl/FckkLa>
 23. Bell J. *Doing your research project. A guide for first-time researchers in education and social sciences*, Buckingham: Open University Press. <https://goo.gl/tLA2nk>
 24. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies. Guided by information power. *Qual Health Res*. 2015. <https://goo.gl/yTTPHh>
 25. Bowling A. *Research methods in health. Investigating health and health services*. Buckingham. Philadelphia: Open University Press. <https://goo.gl/MLFNnd>
 26. Burnard P, Gill P, Stewart K, Treasure E, Chadwick B. Analysing and presenting qualitative data. *Br Dent J*. 2008; 204: 429-432. <https://goo.gl/M4TLiA>
 27. Ostlund U, Kidd L, Wengstron Y, Rowa-Dewar N. Combining qualitative and quantitative research within mixed method research designs: A methodological review. *Int J Nurs Stud*. 2011; 48: 369-383. <https://goo.gl/YNDKTB>
 28. Schmidt KL, Lingler JH, Schulz R. Verbal communication among Alzheimer's disease patients, their caregivers, and primary care physicians during primary care office visits. *Patient Educ Couns*. 2009; 77: 197-201. <https://goo.gl/3sFUoo>
 29. Turabian JL, Cucho-Jove R, Minier-Rodriguez LE, Rodriguez-Almonte FE, Moreno-Ruiz S, Villarin-Castro A. Epidemiology of companions of the patients in family medicine: making the invisible visible. *Health Edu Care*. 2016; 1: 37-40. <https://goo.gl/ebuX2q>
 30. Cené CW, Haymore LB, Lin FC, Laux J, Jones CD, Wu JR, et al. Family member accompaniment to routine medical visits is associated with better self-care in heart failure patients. *Chronic Illn*. 2015; 11: 21-32. <https://goo.gl/po4nuU>
 31. Andrades M, Kausar S, Ambreen A. Role and influence of the patient's companion in family medicine consultations: "the patient's perspective". *J Family Med Prim Care*. 2013; 2: 283-287. <https://goo.gl/1nhHcw>
 32. Douglas SL, Daly BJ, Lipson AR. Relationship between physical and psychological status of cancer patients and caregivers. *West J Nurs Res*. 2016; 38: 858-873. <https://goo.gl/qPKBta>
 33. Shepherd HL, Tattersall MH, Butow. Physician-identified factors affecting patient participation in reaching treatment decisions. *J Clin Oncol*. 2008; 26: 1724-1731. <https://goo.gl/drmHxq>
 34. Giles H, Street RL. Communication characteristics and behaviour: In Knapp ML and Miller GR. *Handbook of interpersonal communication*. Beverly Hills, CA. Sagepp. 1985; 205-261.
 35. Kohn A. Girl talk, guy talk. *Psychology Today*. 1988; 22: 65-6.
 36. Briscoe ME. Why do people go to the doctor? Sex differences in the correlates of GP consultation. *Soc Sci Med*. 1987; 25: 507-513. <https://goo.gl/UebzGh>
 37. Hetzel W, Huppmann G, Rechenberger HG. [Sex differences in illness behavior of patients in a psychotherapeutic outpatient clinic]. *Psychother Psychosom Med Psychol*. 1989; 39: 342-347. <https://goo.gl/gYhjKd>
 38. Turabian JL, Minier-Rodriguez LE, Moreno-Ruiz S, Rodriguez-Almonte FE, Cucho-Jove R, Villarin-Castro A. Differences in verbal behaviour style in interviews of patients females with patient's companion (triads) and without patient's companion (dyads) in family medicine. *J Gen Pract (Los Angel)*. 2017; 5: 313. <https://goo.gl/EEXEft>
 39. Lang F, Marvel K, Sanders D, Waxman D, Beine KL, Pfaffly C, et al. Interviewing when family members are present. *Am Fam Physician*. 2002; 65: 1351-1354. <https://goo.gl/PHQ8o1>
 40. Laidsaar-Powell RC, Butow PN, Bu S, Charles C, Gafni A, Lam WW, et al. Physician-patient-companion communication and decision-making: a systematic review of triadic medical consultations. *Patient Educ Couns*. 2013; 91: 3-13. <https://goo.gl/XsDXrw>
 41. Turabian JL. What is a good consultation in general medicine?. *J Gen Pract (Los Angel)*. 2017; 5: 115. <https://goo.gl/SXitXw>