**Enriching clinical communication teaching
a qualitative study of a curriculum field in UK medical schools**

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Enriching clinical communication teaching: A qualitative study of a curriculum field in UK medical schools.

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This thesis is dedicated to Abbie and Patrick O'Neill

ABSTRACT

This study investigates how does, and how could, current pedagogical practice embody the complexity of clinical communication in undergraduate medial education. Employing a qualitative methodology, ten lead clinical communication teachers from different UK medical schools were interviewed. This enabled exploration of how they construct the nature of the subject and their views on how it contributes to the formation of future doctors. Further insights were gained into which elements of clinical communication predominate teaching in undergraduate curricula, how these relate to assessment practices and how supporting models or theoretic approaches are used to inform teaching of the subject. Additional data was provided from a scoping survey conducted across all UK medical schools, yielding 22 responses.

Thematic analysis of the transcribed interviews, along with simple numeric data from the survey yielded a range of insights grouped under the following categories: The nature and scope of clinical communication as a subject; the aims of clinical communication teaching and attributes of the graduating doctor; pedagogic practice – teaching and assessment. A range of analytical perspectives were applied to the findings which illuminate a number of tensions in the field. These centre on the differing emphases placed on clinical communication as a) primarily instrumental, with a focus on skills and tasks or b) as central to the development of personal and professional attributes. Issues concerning the degree of integration with other strands of learning and the ways in which assessment and teaching practices promote or hinder a more rounded conceptualisation of the subject are also considered, along with the implications for future practice. A schematic framework which may be used as a model for the enrichment of clinical communication pedagogy has been formulated. This sets out a theoretic and values-based vision of the subject which illustrates its scope beyond an instrumental role in healthcare.

Contents

APPENDICES:

TABLES:

FIGURES:

1   Introduction

1.1   The reason for this study

The motivation for this study of clinical communication pedagogy stems from my professional experience as a lecturer in clinical communication in a UK medical school; and particularly from a keen concern for how current educational practices are influencing the ways our future doctors perceive and develop this crucial aspect of medical practice. At an early stage in my previous career in general nursing, I was struck by the value of communication in developing genuine, caring relationships with patients – and its role in enabling the most effective clinical care to be delivered. It seemed that the clinicians I most aspired to emulate had a facility for communication that conveyed a tangible engagement with their patients, whilst competently attending to their medical needs. As I continued my clinical career, moving into the area of mental health nursing, I was introduced to the idea of a 'therapeutic relationship' and the constructive role that this could play in supporting patients. The need to communicate effectively and supportively highlighted particular skills and approaches, such as exploring each individual patient's circumstance and story; listening attentively; responding to emotions, which were central to developing positive relationships. Whilst some curricular time within the nursing course was dedicated to the development of these skills and approaches, the idea of clinical communication as a substantive subject in its own right was not recognized. It was only upon my sideways step into medical education in 2000 that this became a reality, being appointed as a lecturer in clinical communication. This was at a point where clinical communication was increasingly recognized as a distinct subject area in medical education and was being developed as a longitudinal strand (from first to final year) in the undergraduate curriculum of the medical school I had joined. I felt as though I had come home.

Quite aside from my professional interest in the subject, the matter of how the skills and attitudes required for effective clinical communication are cultivated in our future doctors is one which has relevance to us all, as users of the health service. For along with the requisite medical knowledge and technical skills, the ideals set out for the modern practicing doctor include a range of additional professional attributes,

including the ability to form ethical, patient-centred relationships with those that they care for (GMC, 2013). The centrality of communication to this ideal is well recognized and is illustrated by the multitude of published testimonies, reports and articles (for example Hagerty RG, 2005, Ellingson and Buzzanell, 1999, DoH, 2001) which attest to the profound role it plays in people's personal experiences of illness and healthcare. Indeed, it is often through personal experience of illness that health care professionals themselves come to appreciate the real significance of communication in the guise of empathy and patient-centredness in clinical practice (Woolf et al., 2007). Alongside the interpersonal satisfaction of good quality clinical communication (Williams et al., 1998), a growing body of evidence citing improved clinical outcomes where this is employed, is now widely recognized within medicine (Stewart, 1995). This, coupled with wider societal drivers for change in the profession, including the need to communicate openly and effectively, have led to the establishment of clinical communication in the medical curriculum and as a core requirement of good medical practice (GMC, 2013, GMC, 2009).

Over the last decade, my role in the teaching and assessment of clinical communication, mainly with undergraduate medical students, but also with qualified doctors and other health care professionals, has provided a rich and stimulating arena in which to consider how the subject and its pedagogy are evolving. Pedagogy has been increasingly dominated by a skills and competency discourse, primarily focused on specific, behavioural elements of clinical communication, which has proved a source of unease among some teachers and academics in the field (Skelton, 2008 p.140, Salmon and Young, 2011) and has been a growing source of concern to me on two fronts. The first is the way that such a discourse, with its tendency to construct clinical communication as a primarily skills-oriented activity, may be leading to a restricted view of the subject at the expense of its inherent richness and complexity. The dissection of communication into its component parts, necessitated by a skills approach, runs the risk of fragmenting its very form or essence; the intention and spirit of the communicative action. By extension, to describe the assessment of communication as something 'objective', however appealing this may be in terms of 'measurability' from a medico-scientific standpoint, may also be to dislocate it from its source, with all its influences of personal background, values and motivations.

This presents a troubling dichotomy between the objectively observable elements of communication and the less accessible personal, subjective elements. It allows for concentration on surface displays without overt reference to what underpins them. The tendency for students to be selective in their learning in order to focus on and succeed in assessment, at the expense of opportunities for deeper or wider learning, is recognised in many areas of education. I would argue however, that it is of particular concern in this field where the stakes of how learners come to consider the nature of clinical communication are heightened, in as much as it is directly related to the development of their professional being and the kind of engagement that will be afforded their future patients, colleagues and others. As such, it is of fundamental importance to the very nature of medical practice and must surely be founded on learning that exceeds the superficial and has at its heart the need to develop practitioners with a deep sense of the value of humanity and the role of clinical communication in manifesting this. Secondly, there is the concern that such a discourse may be influencing the pedagogy of the subject in ways that transmit a reductionist view of the subject to our students. The ways in which a competency-based approach to teaching and assessment are interpreted in terms of curriculum design and pedagogic practice have a significant part to play. Concerns regarding the potentially limiting effects of a competency-based approach, with its emphasis on the achievement of specific tasks are also recognized more widely in medical education (Brightwell and Grant, 2013, Talbot, 2004).The impetus for this study arises from the need to explore how far these concerns are founded in current pedagogic practice and why certain aspects of teaching and assessment may be given precedence over others.

In the remainder of this chapter I will outline how my personal experience as a teacher in the field has contributed to this study and how undertaking the Doctorate in Education (EdD) furthered my scholarly development and enabled me to crystallize my professional and academic concerns into a researchable format (section 1.2). I will then set out the aims for the study and how they are addressed in this thesis (section 1.3). I will conclude the chapter by outlining the contribution I hope to make to our existing knowledge in this field (section 1.4).

1.2 **The journey to the starting line**

I will begin this section by considering how my grounded *in-situ* knowledge and insights, gained from considerable experience as a teacher in the clinical communication field, have contributed to the formulation, undertaking and outcomes of this study. As previously stated, the impetus for this enquiry arose from my personal observations of the ways in which current assessment methods appeared to be influencing students' perceptions and engagement with clinical communication teaching. These observations came about through my direct engagement in the design, delivery and assessment of the subject over a period of several years, and as a result of my own development and maturation as a teacher in this field. My appointment as lecturer in clinical communication marked a transition in my professional trajectory from healthcare practitioner to full-time educationalist, which entailed a re-evaluation of my professional self-identity. Central to this process were questions bearing on what drew me to the field of healthcare education and more specifically to the subject area of clinical communication. Taking the first of these, I recognised that the teaching and supervision of students and junior colleagues were areas that I had always enjoyed in clinical practice. This practice-based pedagogy centred on the need to be confident in my own knowledge/ability of the area being taught in order to safely and competently teach others. I derived great satisfaction from seeing learners' increase their abilities and confidence through the guidance I provided and the opportunity to fully embrace teaching as my main area of practice greatly appealed to me. I felt it provided me with an intellectually stimulating career path which would utilise, and be enriched by, my pre-existing clinical and academic knowledge and experience.

Whilst the opportunity to take up a substantive educational role appealed to me for the reasons outlined above, the subject area of clinical communication was a decisive factor in drawing me to the post. The ways in which health care practitioners communicated with patients, their families and one another had always – instinctively – seemed to me to be central to the provision of humane and effective healthcare. This had struck me from my earliest exposure to clinical practice as a student and was reinforced through my continuing practice as a qualified nurse and

ward manager. First-hand examples of clinician-patient interactions that both reinforced the effects of 'good' and 'poor' communication on people's experience of healthcare, served as powerful illustrations as to why this area was so important. My personal and family experiences of clinical encounters served to further underline the profound impact of communication during times of vulnerability and difficult decision-making. These cumulative professional and personal experiences both prompted and enabled me to ask the kinds of questions that informed this study and reflect the grounded insights I have brought to the research process.

On appointment to the position of lecturer in clinical communication, my priorities lay in extending my subject knowledge in terms of the research evidence base and related theoretic material, alongside my development as a teacher, assessor and participant in associated academic activities. Whilst this presented a range of new challenges, I found that my previous experience as a clinician was a valuable resource for contextualising the research and theoretic underpinnings of the subject. It also enabled me to facilitate students' identification of the relevance of their learning for practice by relating it to examples that I had experienced or witnessed. This process can be related to Shulman's (1986) account of the types of knowledge required by the expert teacher, namely i) content knowledge (knowledge of the subject to be taught), ii) pedagogic knowledge (knowledge of how to teach in general terms) and iii) pedagogical content knowledge (formulating the subject to make it understandable to others). As such, Shulman recognises the interaction between the kind of disciplinary knowledge which experienced practitioners possess and which enhances their pedagogic knowledge in terms of being able to identify and deliver the most effective and cogent teaching methods for their subject. My expertise as a teacher was also developed through regular co-facilitation with other experienced clinical communication teachers, along with formal observation and feedback on my teaching from educationalists within the university department of medical education. This process, which provides the opportunity for peer review and discussion of practice, has been recognised as an effective means of developing work-place practice (Hendry and Oliver, 2012).

As I became established in my educational role and involved in the wider community of clinical communication teachers through the UK Council of Clinical Communication and participation in international medical education conferences, I was able to apply a more critical perspective to the teaching and assessment practices of my own institution. This accords with Schon's (1983) view of the reflective nature of professional practice whereby practitioners develop the capacity to critically appraise their activities in order to address challenges and concerns in practice. This reflective process involved consideration of how my own practice (and that of my institution) related to wider discourses of medical education and the need to meet regulatory requirements such as those set by the GMC. My decision to undertake the EdD, whilst daunting in terms of the commitment it would require, seemed a natural extension of this process and served as a means to validate my existing professional expertise whilst extending and building on this foundation. The premise of the EdD, in harnessing the relationship between professional and academic knowledge, also enabled me to inhabit the role of educator as researcher. This process, as championed by McNiff (1983), promotes an action research approach in which 'The use of educational enquiries [help] practitioners to bring about an improvement of practice through the development of critical awareness' (McNiff, p. 6). The initial taught modules of the programme were valuable in preparing me to formally investigate my research area, with the aim of generating new insights in the field of clinical communication pedagogy. My learning from the 'Foundations of Professionalism' module provided a range of theoretic perspectives concerning the nature of professional practice to develop my thinking in relation to my research idea. The 'Theory and Research in Educational Practice' module introduced me to current debates and tensions surrounding teaching and learning, whilst the Research Methods modules enabled me to consider the kind of approach that would best suit my own research aim. This led to my choice of a qualitative methodology as a means to further explore and illuminate the nature of clinical communication pedagogy.

The findings of my Institution Focused Study (IFS) (O'Neill, 2010), undertaken after the taught elements of the EdD, enabled me to develop my research skills in a number of areas. This included attending to the ethical issues raised by insider research, carrying out semi-structured interviews and undertaking thematic data

analysis. The findings of the IFS provided useful preliminary insights into the ways in which teaching and assessment practices within my own medical school were influencing students' approach to their learning of clinical communication. Through interviews with a sample of final year students, I was able to explore how they viewed clinical communication as a subject; how our curriculum may be shaping their perceptions of it and how they viewed its integration with the rest of their learning.

A particular area of concern that emerged from the study was how students' experience of clinical communication assessment, specifically in the form of Objective Structured Clinical Examinations (OSCEs)[1], was influencing their approach to learning. This took the form of learning to the test, in trying to display (verbally and non-verbally) what they thought the examiners were looking for on a predominantly checklist marking scheme. The danger it seemed to me, was that the checklist had become the focus of students' attention, rather than the patient (or more commonly simulated patient)[2] with whom they were interacting. This finding resonated with my observations of experiential teaching sessions at this time. These core curriculum sessions provide opportunity for students to practice clinical scenarios with simulated patients, relatives or health care professionals. The provision of feedback on these interactions is central to the learning process. However, it seemed that the focus of these learning opportunities was becoming skewed towards the OSCE assessment as students were increasingly preoccupied with what they ought to do or say in order to satisfy the marking criteria of their upcoming exams. This suggested that the behavioural, skills-based emphasis of the assessment process was having a limiting effect on the ways students were engaging with the subject and served as a distraction from the deeper learning opportunities

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[1] OSCEs comprise a series of simulated clinical scenarios (or 'stations') in an examination circuit, which students work their way around in strict timeslots (e.g. 10 minutes per station in a final year exam). They may involve a mannequin or more often a real or simulated patient; with an examiner present to assess the student undertake the clinical task.

[2] Simulated patients are widely used in the teaching and assessment of clinical communication. The term refers to individuals who assume the character of a patient (relative or health care professional) within a clinical scenario and are trained to provide students with feedback. Their performances are standardized for assessment purposes.

arising from the clinical simulations. Examples of the latter might include the opportunity to consider issues of personal attitudes, assumptions and belief systems in relation to their interactions, ethical dilemmas or what a patient-centred approach might mean in particular situations. This issue will be revisited in more depth in later chapters.

A further area of concern was a seeming lack of conscious integration between clinical communication and other areas of learning, despite efforts to promote this in the design of the curriculum. This raised questions about how formal clinical communication learning may be eroded if it is not supported in clinical practice, where the emphasis may be placed on activities such physical examination, history-taking and clinical reasoning, without due acknowledgment of the central role of communication in these activities.

These findings, particularly those relating to the impact of the assessment system on learning, were instrumental in the development of the current study. Situating this concern within the educational sphere of competency-based learning provided a lens through which to examine the ways that teaching and assessment processes have evolved within medical education and more specifically in the field of clinical communication. This also led me to contemplate how current pedagogic developments reflect more fundamentally the very substance of what we consider the subject of clinical communication to encompass, ranging from a composite of skills components (conveniently observable and measurable), to a much broader concept involving notions of values, beliefs, attitudes, self-awareness, along with the more visible aspect of demonstrable skills. The key research question arising from these issues and the study aim, objectives and context are set out in the next section.

1.3 The research question, aim and objectives

Consideration of the issues set out in the background above, gave rise to the following research question:

How does and how could current pedagogical practice embody the complexity of clinical communication in undergraduate medial education?

To address this question I have developed the following research aim and objectives:

Aim: To investigate the range of curriculum, pedagogical and assessment perspectives and practices deployed in clinical communication contexts and to explore which of these have the most potential for addressing the complexity of the field.

Objectives:

i)   To explore, through the use of semi- structured interviews, how clinical communication academics construct the nature of the subject and their views on how it contributes to the formation of future doctors.

ii)   To elicit, through survey and interview data, which elements of clinical communication predominate teaching in undergraduate curricula and how these relate to assessment practices.

iii)   To illuminate how supporting models or theoretic approaches are used to inform the teaching of clinical communication.

The context for this study is undergraduate medical education as the main area of my academic and professional practice and the arena in which my research focus has been developed. It is also during this early phase of professional development that our students establish ways of thinking and learning that may influence them well beyond initial qualification (Willis et al., 2003), which adds to the imperative to consider carefully the messages we transmit about the nature of our subject and what and how we learn about it.

To gain insight into current clinical communication curricula and pedagogic approaches, I have carried out a scoping survey across UK medical schools and

interviewed a sample of faculty with lead responsibility for this area in their institutions. This enabled me to explore their perspectives on the nature of clinical communication as a subject, how this influences the pedagogy and content of their curricula and to consider what part the wider climate of competency-based medical education plays. I was also able to explore which conceptual or theoretic models are used in the teaching of clinical communication and how they may contribute to students understanding or formulation of the subject. This, coupled with a critical review of the literature, has illuminated the differing discourses and tensions within the subject field.

The other key focus of this study considers how the broader sphere of 'competency-based education and training' (CBET) has influenced the realm of medical education in the form of 'competency based medical education' (CBME). This has been evidenced by the proliferation of skills and competency frameworks throughout undergraduate and, even more prominently, postgraduate medical education (Leung, 2002). Whilst this development has been welcomed in terms of increasing transparency of expected outcomes and proficiency at different levels of medical training, it has also garnered criticism for the potentially limiting or reductionist effects on learning that it may create. Whilst reviewing the background to this debate, I will focus more specifically on the influence this may be having on the area of clinical communication.

1.4   **Outline of the thesis**

To help develop and illustrate my argument I will begin in Chapter 2 by delineating the following areas. Firstly, I will provide an overview of the emergence and subsequent development of clinical communication as a formal subject in medical education. In doing so, I will highlight key determining dynamics, arising both from within the profession of medicine and externally from societal and governmental sources, along with the empirical evidence base which supports its value in clinical practice (2.2). I will go on to outline current pedagogical practice, including the recommended curricular content drawn from regulatory guidelines and published

recommendations, followed by a review of the literature pertaining to current pedagogic practice in terms of teaching and assessment (2.3).

Having established the background for the study, I will go on to examine the role of models (of the doctor-patient relationship), and whether other theoretic foundations are brought to bear on the subject. The implications of these for the ethos of clinical communication curricula will be considered, including their relation to pedagogic practice (2.4). In the following section, the discourse surrounding clinical communication as a subject will be discussed, including the differing terminologies of 'good' and 'effective' communication and the almost ubiquitous use of the term 'communication skills' as a subject descriptor. The relevance of these discourses for the way the subject is conceptualized will be considered, along a spectrum ranging from clinical communication as an instrumental, outcomes-based activity, to one of intrinsic worth to the doctor-patient relationship as the medium through which holistic, safe and compassionate care is enacted (2.5).

In Chapter 3, I will trace the rise of competency-based medical education (CBME), drawing on its origins from the wider educational sphere of competency-based education and training more broadly (CBET) (3.2). In doing so, I aim to illuminate the tensions and complexities that arise in attempting to delineate what constitutes skills and competencies (3.3). I will then present the most salient arguments surrounding the merits or otherwise of CBME and an analysis of how the development of a skill and competency approach is influencing the pedagogy of clinical communication (3.4). I will conclude Chapters 2 and 3 by summarising how the key issues arising from the literature have contributed to the formulation of this study.

In Chapter 4 I will outline how the study was conducted (4.2) and the theoretical perspectives which informed the methodology (4.3). Details of the research setting; recruitment of participants; data collection and analysis will be described (4.4 - 4.6). In doing so, I aim to illustrate the steps I took to ensure methodological rigour in the research process (4.7) and how I addressed the ethical considerations which arose (4.8).

In Chapters 5-8, I will present and discuss the findings of the study and their relation to the research question. The final Chapter 9 will draw together the different strands which have emerged from the findings and consider their implications for current and future teaching and assessment practices. A schematic framework which may be used as a model to enrich the pedagogy of clinical communication is also provided.

1.5   **The significance of the research**

This research makes a distinct and significant contribution to field of clinical communication pedagogy in the following ways. It draws on the first-hand accounts of clinical communication lead academics and tutors from ten different UK medical schools, to provide a current perspective on how the nature and scope of the subject is being constructed. This, to the best of my knowledge has not been previously done.

Additional insights into current teaching and assessment practices, to which a range of analytical perspectives have been applied, have illuminated a number of tensions in the field, which have implications for the future development of undergraduate clinical communication teaching and assessment. A further original contribution has been made through the formulation of a schematic framework which may be used as a model for the enrichment of clinical communication pedagogy. This sets out a theoretic and values-based vision of the subject which extends its scope beyond its instrumental role in healthcare. The research will be disseminated to a wider audience through presentation at medical education conferences and the submission of papers to academic journals for publication.

In this chapter I have presented the reasons for undertaking this enquiry, the research questions to be addressed and the context of the study. I have also provided an overview of the direction of the thesis and the anticipated contribution it may make to theory, practice and policy. I will begin in the next chapter by setting out the background to the emergence of clinical communication in the medical curriculum,

current pedagogical practices and the differing conceptualisations of the subject, drawing on a range of literature to support the discussion.

2 Clinical communication - background and literature

2.1 Introduction

The aim of chapters 2 and 3 is to establish the context for my enquiry by providing a critical overview and discussion of a range of relevant theoretic and empirical literature. In doing so, I will identify a number of central issues which contribute to the formation of my research aims. I will begin in 2.2 by providing an account of how clinical communication emerged as a distinct subject area in the medical curriculum and the factors which contributed to this. In 2.3 I will draw on a range of literature to illustrate current trends in the pedagogy of the subject, in relation to content, methods and assessment. Section 2.4 comprises an overview of the role of models and theory in the teaching of clinical communication and the final section 2.5 will outline how the subject is portrayed and conceptualised through differing discourses. In chapter 3, I will draw on the literature pertaining to the adoption of skills and competency frameworks in medical education and their relevance to the field of clinical communication.

I was aware of and had previously catalogued a considerable range of relevant literature from my professional role as lecturer in clinical communication and through the previous literature review undertaken for the IFS. This existing bank provided a rich resource for the current narrative review. Additional literature was accessed by searching electronic databases (MEDLINE and ASSIA), journal searching, sourcing secondary references and recommendations from my colleagues and supervisors. I will begin by tracing the emergence of clinical communication as a distinct subject.

2.2 The emergence of clinical communication in medical education

The teaching of clinical communication has become an increasingly core component of medical education in the UK over the last thirty years (Hargie et al., 1998:3, Brown, 2008, von Fragstein et al., 2008). Prior to this, the ability of doctors to

communicate effectively was a 'taken-for-granted' aspect of medical practice in what was traditionally a heavily bio-medically oriented curriculum. In addition, a historically paternalistic approach to healthcare had required little attention to the role of patients' ideas or expectations or the need for mutually negotiated care-planning (Baker, 2003). What then, gave rise to the emergence of clinical communication as a subject in the medical curriculum? Its emergence can be attributed to a number of factors, both intrinsic and external to the field of medicine itself. Externally, a number of societal and political shifts, concerning changes in professional-lay relationships, the status of the medical profession in particular and the rise of a more consumerist society, paved the way for policy and practice developments in which clinical communication began to feature as a component in its own right. Brown (2008) outlines these changes, including the impact of libertarian politics in the 1980s which promoted a societal culture of individualism and introduced market competition to the health service. With this came a climate of new managerialism which acted as a vehicle for reform (Salter, 2004) and resulted in a weakening of the established power of the medical profession in terms of internal performance monitoring and governance. Accompanying this was a rise in consumer expectation of the type of service that the NHS should provide and the demise of the historically passive and 'grateful' patient. More recently, the prevalence of the internet and widespread availability of medical information has helped shift the exclusivity of specialist knowledge away from the professional sphere into a publicly accessible zone, paving the way for a potentially more egalitarian lay-professional relationship (Brown, 2008, p. 273).

In addition, the fall-out from a number of high-profile cases of professional misconduct, such as the mismanagement of paediatric heart surgery at the Bristol Royal Infirmary and the retention of organs without consent at Alder Hey Hospital (Salter, 2004, p. 7-8 and 61-2), led to strong recommendations for improvements in the systems and delivery of patient care, including many relating to the doctor-patient relationship and clinical communication practices (Bristol Royal Infirmary Inquiry, 2001). Within this climate of increased scrutiny of professional standards, the central role of clinical communication was now more fully recognized (Ham and Alberti, 2002) and the need for formalized standards regarding doctor-patient relationships

was reflected in the Department of Health (DoH, 2007) and medical education policy and guidance (GMC, 2006, 2009).

Despite the emergence of clinical communication in medical education, more recent concerns about standards and practices within the health service highlight a growing concern for a re-emphasis on the role of humane and compassionate care in health service delivery (DoH, 2010, Abraham, 2011, Francis, 2013). The development of these traits, in which communication plays a key role, has been recognized as an under-emphasized aspect of medical education (Little, 1995, Hilton and Slotnick, 2005, MacLeod, 2000) and has provided a further impetus for the inclusion of these areas within the undergraduate medical curriculum. In addition to the above, a substantial evidence base supporting enhanced healthcare outcomes and patient satisfaction in response to effective clinical communication has been developed (see for example Silverman et al., 2013), providing an empirical justification for the inclusion of the subject in the medical curriculum.

In response to the influences outlined above, the emergence of clinical communication as a subject specialism necessary in medical education is evidenced by an increasing body of literature, including the development of curricular consensus statements (Makoul, 2001, Simpson et al., 1991, von Fragstein et al., 2008) and research into the pedagogy of clinical communication (Aspegren, 1999, Rees et al., 2004). As a subject, it is informed by a range of interdisciplinary research and literature, including for example, psychology (Parker and Coiera, 2000); medical sociology (Armstrong, 1984, Scambler, 1997); communication theory (Habermas, 1984, Habermas, 1987); discourse analysis (Mishler, 1984, Roberts et al., 2003) and conversation analysis (Silverman, 1987, Maynard and Heritage, 2005). In addition, the need to refer to a credible evidence-base (in terms of clinical outcome measures) to 'justify' the inclusion of clinical communication within a bio-medically dominated curriculum has led to a proliferation of empirical research on the effectiveness of specific communication interventions or models of doctor-patient interaction (Michie et al., 2003, Freeman J, 2000, Heisler M, 2002).

Historically, clinical communication had not featured in the medical curriculum, as psycho-social and interpersonal elements of medicine were not regarded as 'knowledge' in the formal sense of scientific knowledge and instead could 'be picked up in accordance with students' personalities, pre-dispositions and incidental role models' (Faldon et al., 2004). As such, though the factual information of the patient's medical history was recognised as important, the process of eliciting it was deemed a simple skill which did not require formal teaching (Benbassat and Baumal, 2001). However, this view was gradually challenged, as an international body of physicians and social scientists (most notably in the United States and Canada) argued for the importance of high quality clinical communication to enhance clinical outcomes and patient satisfaction, leading to its recognition as a subject entity in its own right (Simpson et al., 1991). Of key significance in ensuring its inclusion in the UK curriculum was the policy guidance issued by the General Medical Council in the form of the document 'Tomorrow's Doctors' (GMC, 1993, GMC, 2003), which set out the framework for undergraduate medical education from which medical schools develop their curricula. Within this guidance, explicit recommendation was made for the inclusion of clinical communication (although without guidance on how it should be taught). Prior to these stipulations, the acquisition of communication skills was less formalized and by and large left to personal discretion, as it was assumed that students would develop a good 'bedside manner' merely by osmosis or through 'role modelling' of senior clinicians (Brown, 2008, p. 271).

By 1998 its inclusion was evidenced in a survey of UK medical schools (Hargie et al. 1998) which at that point found nineteen respondent schools (out of a total of 26) had developed some formalized clinical communication teaching. While this varied widely in terms of timing, duration, content and assessment, it evidenced the establishment of the subject in a formalized way in the undergraduate curriculum.

2.3   The pedagogy of clinical communication

The following sections will consider the pedagogy of clinical communication in terms of curricular content, teaching methods and assessment and their relation to the concerns of this study.

2.3.1 What is taught?

Developed by a group of eminent medical faculty from the USA and Canada, the Kalamazoo Consensus Statement (Makoul, 2001) suggested an outline of content for developing clinical communication curricula. The statement, representative of thinking at that time, centred its recommendations on a set of core tasks of the medical interview. These comprised opening the discussion through eliciting information and the patient's perspective; sharing information; reaching agreement and closing the interview. Within each of these phases, sets of specific skills, such as question styles, active listening and checking for understanding were identified. It was thought that a task-focused approach, with clear applicability to clinical practice, would '… provide a purpose for learning communication skills' (Makoul, 2001 p.351). Whilst primarily skills- and task-focused, the authors make reference to additional knowledge and attitudes required for successful clinical communication learning, equating to the evidence-base for improved health outcomes resulting from effective communication and adopting a 'patient-centred' or 'relationship-centred' approach. The latter aspect requires an awareness of the patients (and their family/'significant others'), views and concerns and a spirit of partnership within the relationship.

In the UK, further guidance was provided through the GMC's 'Tomorrow's Doctors' (GMC 2009, GMC 1993, GMC 2003). The first guidance issued in 1993 signalled a shift away from an over-emphasis on factual biomedical content to include a range of skills and attitudinal objectives, including those concerning communication and relationships with patients. The 2003 version specified in clearer terms the knowledge, skills and attitudes that students would be expected to achieve in order to graduate, including a section pertaining to 'Communication Skills' (points 20-23, p.13) under the overarching aim of being able to communicate '…clearly, effectively and sensitively' with patients, families, other health care professionals and agencies. Additional outcomes concerning challenging areas of communication such as those whose first language is not English, patients with learning difficulties or mental health problems and areas such as breaking bad news were also included. Further

developed in 2009 into prescribed outcomes under the heading 'The doctor as a practitioner', specified communication outcomes included the need to 'elicit patients'… views, concerns, values and preferences' (Outcome 2; Section 13 b.). Additional outcomes under the rubric of 'The doctor as a professional' (Outcome 3) stipulated the understanding of '… legal, moral and ethical responsibilities' (GMC, 2009 p.26), respect for patients beliefs and '… recognis[ing] the principles of patient-centred care' (GMC, 2009 p.25). The detail of how this learning would be facilitated was left to the individual medical schools to decide, in the knowledge that they would be inspected and required to demonstrate how such learning is operationalized.

In response to this guidance and in an effort to promote a more unified approach to curricula development, the UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education (comprising representatives from all thirty-three UK medical schools), developed a UK curricula consensus document (von Fragstein et al., 2008). The statement sets out the key content and domains considered appropriate for the undergraduate medical curriculum and is diagrammatically represented in Figure 1 below. The curricular content is framed within five concentric rings, surrounding a central core into which 'Respect for others' is inserted as a guiding principle. The first ring encircling the core, refers to the 'Theory and evidence' of clinical communication, whilst the second ring refers to the 'Tasks of clinical communication' which are illustrated here by the stages of a medical interview. The remaining three outer rings identify specific groups (e.g. patients; relatives; colleagues), tasks (e.g. managing complaints; sensitive issues) and media of communication. It is designed to illustrate the inter-connectedness of the various elements, so that for example linking the task of explaining, with managing a complaint, by communicating with a relative, in writing. The circular representation rests on a backdrop of four underpinning elements: professionalism; evidence-based practice; ethical and legal principles and reflective practice. This aims to illustrate the role these elements play in medical practice including clinical communication. The consensus statement claims a '…strong theoretic and research evidence' base. The research evidence base here (as with the Kalamazoo Statement) refers to studies demonstrating improved health-outcomes, whilst the theoretic base refers to
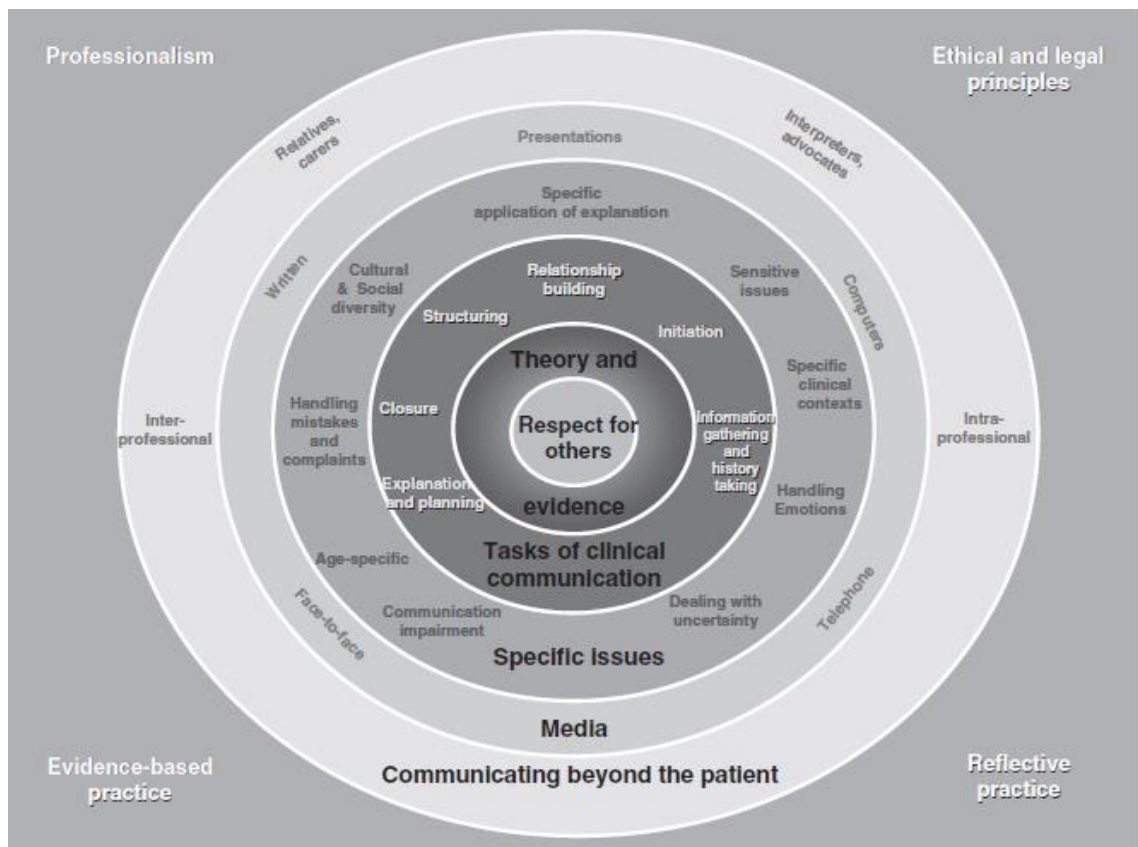
Figure 1: 'Communication Curriculum Wheel' (von Fragstein et al., 2008)

'patient-centredness' as a guiding model or approach to doctor-patient relationships. While recommending a central role for 'patient-centredness' in clinical communication curricula, the skills and task elements are described as the 'backbone', emphasising the purposive and instrumental nature of the subject in practice.

While Hargie et al's (1998) original survey of UK medical schools pointed to widespread variation in the content and form of clinical communication curricula, their follow-up survey (Hargie et al., 2010), with 21 medical school responses out of a possible 33, reflected the emerging consensus on the goals of clinical skills teaching (CST). This included the development of 'essential skills, knowledge, attitudes and awareness, that would enable [students] to communicate effectively and empathically with patients, relatives, professional colleagues and peers' (Hargie et al., 2010 p.386). This statement recognizes the complex nature of clinical

communication as a subject in which a range of cognitive, attitudinal and skills elements coalesce.

In summary, recent developments in determining the content of communication curricula retain a strong skills and task focus. This reflects the emphasis placed on the instrumental purpose of the subject in the practice-based discipline of medicine. The alignment of communication as a clinical skill can also be seen as a measure which helped garner its acceptance in the wider bio-medically oriented medical curriculum. Whilst acknowledging the central purpose of clinical communication teaching as equipping students to be competent in conducting a range of clinical tasks, a number of consensus statements recommend the subject be integrated with associated elements such as professionalism, ethics and patient-centredness (von Fragstein et al., 2008, Makoul and Schofield, 1999, Makoul, 2001). The question which arises from these recommendations is how the associated elements outlined above are being interpreted and incorporated into curricula and what weighting they are accorded, in relation to the skills / tasks component of the subject? This forms a key element of this enquiry and will be discussed in detail as a finding of the study.

2.3.2   How is it taught?

There is now a substantive body of research into the teaching of clinical communication in medical education. This confirms experiential learning (mostly with simulated patients – SPs) and practice-based learning, i.e. interacting with patients and others in the clinical area as the predominant methods. Additional approaches include portfolio development, generally in the form of reflective writing entries, e-learning packages and didactic instruction (Hargie et al., 2010).

Of particular note is Aspegren's (1999) Best Evidence in Medical Education review of the literature, with quality grading of research articles, which presents the evidence for experiential methods as most effective for teaching communication skills, above lectures or 'instructional' teaching. This comprises role-playing simulations of clinical interactions, most commonly with the use of simulated

patients. Hargie et al's more recent survey (2010) confirmed experiential, simulated learning of this kind this as the predominant teaching method in UK medical schools, and it was reported (along with learning in the practice area) as the favoured method among medical students (Rees et al., 2004).

Whilst the clinical area offers significant opportunity for students to further develop their communication skills and approaches, this is not always realised. Egnew & Wilson's (2010) study highlights that within hospital settings, students reported that much less emphasis was placed on relationship skills than on other clinical and data-gathering skills and they were generally not observed by senior doctors whilst interacting with patients, hence receiving little feedback on this aspect of their development (although experience in General Practice placements were much more helpful in this sense). As part of their study the authors also interviewed hospital faculty who reported competing workplace demands impacting on their teaching activity and lack of direct observation/feedback on students' interactions with patients. Whilst this study was conducted in New Zealand, their comparative approach to medical education bears relevance to similar findings from UK studies (O'Sullivan et al., 2000, O'Neill, 2010). This reported emphasis on medical content without regard for the interactional process of the clinical encounter continues to pose a challenge to the development and reinforcement of clinical communication teaching within clinical practice.

The use of portfolios for learning and assessment purposes has become prevalent in medical and other health care professional education, with some evidence that their use increases students' knowledge, understanding, self-awareness and engagement with reflection (Buckley et al., 2009). Their use in clinical communication teaching has been reported but there is little research to support their role or effectiveness in the field (Rees and Sheard, 2004). Further to this, where portfolios are used for assessment purposes, there is a suggestion that students may 'manipulate' their reflective entries to meet the perceived preferences of assessors (illustrated by Birden and Usherwood's (2013) artfully entitled study '"They liked it if you said you cried": How medical students perceive the teaching of professionalism'). Further concerns regarding the use of portfolios are provided by Ross et al. (2009) who found students

considered them more useful for practical purposes such as job applications rather than for their intrinsic learning benefit.

The overall style of medical curricula in which clinical communication teaching is situated, may also influence how the subject is taught and perceived by medical students. This was explored by Willis et al. (2003). They compared the views of final year medical students and newly qualified doctors who had experienced a revised clinical communication curriculum as part of a problem-based learning [PBL] curriculum, with a comparative cohort who had experienced a more traditional curriculum. They found the former group to have a more rounded conceptualization of clinical communication than the latter. The new curriculum cohort considered clinical communication as 'therapeutic', 'fundamental to medical practice' and as a means of 'negotiating' with patients, whereas the traditional curriculum cohort considered communication more paternalistically as a means of 'informing' patients. Accordingly, the authors suggest that the PBL curriculum instilled a broader understanding of the subject, with the aim of achieving an egalitarian 'partnership' style of doctor-patient relationship. This contrasted with the more one-dimensional and 'surface' knowledge approach instilled by the traditional curriculum in which doctor-patient interactions were likely to be dominated by the doctor's agenda, with less regard for patients' ideas, concerns or expectations. This study is useful in highlighting the role of the educational context in which clinical communication teaching and learning are enacted, and exemplifies the differing curriculum types within UK medical education, in which PBL may play a greater or lesser role. This study points to the advantage of a PBL style curriculum in inculcating a more sophisticated grasp of clinical communication, reflecting the more complex nature of the subject.

Given the range of possible teaching methods and differing curricular styles which exist across UK medical schools, it is unsurprising that Hargie et al (2010) reported that wide variation in terms of clinical communication pedagogy remained, along with difficulties in integrating the subject with other aspects of the medical curriculum. The importance of experiential learning in the form of role play and clinical simulation is well established and includes processes for the delivery of

feedback on students' performance (Pendleton et al., 1984). Yet how far this enables a balance between skills, attitudinal and knowledge development is not always clear. The impact curricular structure may have on the delivery of communication teaching is also a consideration and will be explored within this study. These issues require further consideration to illuminate the question of how far current pedagogical practice helps realize the complexity of clinical communication. In the next section, I will provide an overview of assessment methods and their relevance to this question.

2.3.3   How is it assessed?

The stipulation in 'Tomorrow's Doctors' (GMC, 2003) that assessment should reflect the learning outcomes of the curriculum heralded the formal inclusion of communication skills in the undergraduate assessment process (Brown, 2008, p. 275). During this time, a variety of assessment methods, both formative and summative, have been developed. These mainly comprise practical skills-based examinations in the form of Objective Structured Clinical Examinations (OSCEs), clinically-based assessment and less commonly written or computer-marked fixed choice response examinations and portfolio entries.

The use of portfolios in general (discussed in section 2.3.2) and in particular for the purpose of assessment is still being developed in medical education (Challis, 1999, Davis et al., 2001). The requirement to maintain a portfolio as part of the post-graduate assessment process has been established (UKFPO, 2014), but concerns remain about their role in summative undergraduate assessment due to a lack of consensus about their value and reliability (Rees and Sheard, 2004, Pitts et al., 2001). Hence, this method is little used for summative assessment of clinical communication. The use of written or computer-marked fixed choice response examinations appears to be the least used method of assessment. Though little has been published to indicate why this is so, it is likely that the testing of 'clinical communication knowledge' (e.g. familiarity with research findings, consultation frameworks or models of the doctor-patient relationship) is considered less crucial than testing students' communicative abilities in practice. While the latter is

justifiably given primacy to ensure standards of safe and effective practice, the inclusion of 'knowledge-based' clinical communication assessment may help to promote its academic status as 'on a par' with other subjects in the curriculum. It may also encourage students to engage with the supporting research or theoretic foundations of the subject.

Practice-based assessments are usually measured by completion of a log or record, whereby students are 'signed off' as achieving a range of skills to a satisfactory standard. For clinical communication this may be a specified task such as eliciting a medical history or explaining an investigation to a patient. While this method of assessment captures the real-time challenges of communicating in a clinical setting, issues of reliability and standardization arise given the inherent differences of patients, clinical settings and conditions that will be encountered. Concerns have also been raised regarding the quality of assessment that takes place in practice, as *actual* observation by senior clinical staff, with a focus on students' communication, is often variable. This problem, highlighted by Egnew & Wilson (2010), is echoed by the findings of my IFS (O'Neill, 2010) where students reported little direct observation of this aspect of practice, rendering the log-book 'sign-off' of dubious worth. Where direct observation and feedback to student does take place, it provides a valued source of formative assessment.

To address the inherent variability of assessment in clinical settings and to provide standardized and fair assessments appropriate to students' level of experience, the Objective Structured Clinical Examination (OSCE) was developed (Harden et al., 1975) and has become the favoured assessment tool for a range of clinical and practical skills throughout medical education (Reznick et al., 1992, Sloan et al., 1995, Davis, 2003, Newble, 2004). A key feature of OSCE development was to provide a high level of reliability (Harden and Gleeson, 2009), as candidates can be presented with standardised cases and scenarios, which are judged against specified criteria and are assessed by a range of different examiners, thereby reducing the possibility of examiner bias.

The practical nature of the OSCE readily lends itself to assessing the demonstrable skills component of clinical communication (using clinical scenarios in which students interact with simulated patients / others) and is used extensively for both formative and summative purposes (Humphris, 2002). Assimilating clinical communication assessment into this established format helped align it with other clinical skills assessment, facilitating its acceptance as a *bona fide* component of the medical curriculum that could be objectively observed and measured (Hodges et al., 1996). In this way, clinical communication assessment became predominantly communication *skills* assessment. The students' performance is most commonly assessed against a checklist of criteria (e.g. establishing rapport, demonstrating empathy, avoiding unexplained jargon), with additional global ratings for overall impression of areas such as effectiveness, sensitivity or patient-centredness. The breaking down of the interactional process into the format of pre-defined skills and behaviours has more recently been criticized as unhelpful to learning. Newble (2004 p. 201) reports the potential 'trivialising' effect of assessments whereby one develops:

> Detailed checklists that produce reliable scores but which do not truly reflect the examinee's performance of the task. Only criteria that are easy to define may be included on the marking sheet at the expense of equally or more important criteria that are more difficult to define or measure.

Such criticism has given rise to the development of domain-based and / or global-rating criteria as an alternative (Gupta et al., 2010). A domain-based approach can provide the examiner with a range of anchor statements or descriptors of the area being assessed across a spectrum from excellence to poor, against which to judge the student's performance. This allows the examiner more scope to judge the interactional process in a less fragmented way, reducing dependence on the behavioural and binary (did or didn't demonstrate X) approach. For example, exploring a patient's concerns could comprise a descriptor of 'Encourages and allows patient to share physical, emotional and social impact of problem on him/herself and family' at the excellent end of the scale, to 'Offers advice or reassurance before main problem has been identified. Does not encourage disclosure of concerns / makes assumptions' at the poorer end of the scale. This type of domain-based descriptive

parameter allows a more holistic assessment of the students' interactional approaches than the conventional checklist.

So what can be gleaned from the outline of assessment methods provided above? It would seem that by employing a mix of these approaches it may be possible to arrive at a reasonable assessment of students' clinical communication in the domains of:

- knowledge (via exam questions),
- attitudes (via reflective portfolios, observation in practice) and
- skills (via observation in practice / OSCEs).

However, each of these methods has its limitations. Devising single best answer or multiple choice questions for written exams that in any way capture the nuance and complexity of clinical communication is a challenging task, thus limiting their use to the assessment of factual content. The vagaries of observation in the practice area, as discussed above, render it a less reliable (if possibly more valid) means of assessment. Attempts to engender a reflective engagement with the subject, through the use of portfolios in which students might consider the role of their values and beliefs (as well as those of the patient) in clinical interactions, or on the relationship of wider cultural and societal systems with clinical practice, have also met with difficulty. This may be through lack of guidance on the process of reflection (not always a salient feature in the wider curriculum) or of reluctance to share in written format, genuine thoughts and feelings that may not be deemed professionally 'appropriate'. OSCEs have their strength in providing a fair and manageable means of capturing at least a surface picture of students' communicative style and effectiveness. However, the advantage of manageability, statistical reliability and the sense of reassurance (for examiners / students / GMC) gained from a purportedly 'objective' measurement brings its own discontents.

The OSCE, often part of high stakes end-of-year and graduating exams, may for some students become the end in itself, a classic case of 'learning to the test'. The quest to pass the OSCE may drive learning towards the surface, by focusing on the behavioural responses (verbal or non-verbal) that students believe they will be judged on. This can detract from engagement at a deeper level i.e. that extends

beyond the visible skills element, to consider more broadly notions of patient-centredness and how this is navigated in particular interactions, ethical issues and exploring the role of values, beliefs and attitudes in the formation of clinical relationships. Rushforth's (2007) overview of the perceived advantages and disadvantages of OSCEs in a nursing context acknowledged the success of the method in addressing inadequacies of previous assessments (including examiner bias and subjectivity, less consistency across assessments with lower levels of validity and reliability). It also highlighted the potential risk of OSCE-driven assessment 'fragmenting holistic patient care into discrete and unrelated elements' (Rushforth, 2007 p. 484), as the student moves through a set of unconnected 'stations' (or clinical tasks) within the exam. It has also raised the question of 'criterion validity', i.e. whether the test actually captures what it sets out to. In the case of clinical communication, this means we are able to capture the demonstration of a set of surface skills, but are left wanting as to how far this reflects the propositional knowledge base that underpins them (Burnard, 1987), or what influences the ways students relate to patients in real practice.

In conclusion, the OSCE, with its skills-focused emphasis on the observable, the easily definable and the measureable, sits neatly within the broader competency-based approach to assessment now prevalent in the wider scope of medical education. How far this approach is balanced with other assessment methods as outlined above remains variable, and how these variations impact on student perceptions and on the teaching of the subject warrants further investigation. The powerful influence of the skills and competency approach to assessment and its effects on the pedagogy of clinical communication will be returned to and re-examined through the findings of this thesis.

In the previous sections I have outlined the key features of clinical communication pedagogy in terms of curricular content, methods of teaching and assessment. Within this, the emphasis on the development of the subject as a skills-based activity has been highlighted, whilst other areas such as reflection, ethical issues and patient-centredness have been introduced as central to a wider view of the subject. The aim

of the next section is to examine the role of theory and models in clinical communication and their relevance to the current discourse surrounding it.

2.4 The role of models and theory in clinical communication

To consider the idea of clinical communication as more than a set of learnable skills, but rather as a fusion of components that address areas beyond the readily observable, it may be helpful to look at the models or theoretic frameworks that support it. An array of 'consultation models' have been published to guide the doctor-patient interaction. Of these, a number provide an organized structure (Bird and Cohen-Cole, 1990, Kurtz et al., 2003) for managing the process and content of the consultation. In this sense, they serve more as an organizational aid than a conceptual model and can otherwise be called consultation frameworks. A number of frameworks, such as those referenced above, provide details of communication skills considered useful at differing stages of the consultation.

In addition, a number of other models relating to the doctor-patient relationship have been developed, with more emphasis on the nature of the relationship than on the actual structuring of consultations. Influential among these is the 'Disease-Illness Model' (Stott and Davis, 1979) which emphasizes the need to understand and incorporate the patient's perspective of their condition (the illness) into the medical diagnostic perspective (the disease) in order to arrive at a shared understanding and treatment plan. The model is aligned to the ideal of 'Patient-Centredness' (Levenstein et al., 1986, Brown et al., 1986) which required a shift away from a doctor-centred or medico-centric approach to clinical relationships, to one in which the patient was to play a more active, even egalitarian role and in which the patients views were central to the consultation process (described by Stewart et al. (1995) as 'transforming the clinical method'). Mead and Bower (2000) sought to define the specific features of patient-centredness, partly to provide clarity to a much used but rarely defined concept and also to identify five dimensions of the model which could be used for research purposes. They define the five dimensions as: i) eliciting the patient's biopsychosocial perspective of their illness; ii) taking account of the

'patient-as-person' in terms of their unique biography and idiosyncrasies; iii) sharing power and responsibility to promote an egalitarian and mutualistic relationship; iv) developing a therapeutic alliance in which the quality of relationship between physician and patient is given primacy; and v) taking account of the 'doctor-as-person' in terms of their unique biography and idiosyncrasies, with regard to how these may impact on the relationship with the patient . Of particular note here is the attention given to the importance of the personal circumstances and values of *both* the doctor and patient, rather than the doctor being seen as somehow 'value-neutral' or an objective entity as in the traditional biomedical paradigm. The incorporation of a patient-centred approach is reinforced in the latest edition of 'Tomorrow's Doctors' (GMC, 2009) which states that the 'Doctor as Practitioner' will be able to carry out a consultation in which they '… [e]licit patients' questions, their understanding of their condition and treatment options, and their views, values and concerns' (GMC 2009, p. 19).

In a similar vein, Beach and Inui (2006) propose a model of 'relationship-centred care'. This comprises four principles as follows: i) dimensions of personhood – including the values and experiences of both the doctor and patient, along with the need for 'authenticity' on the doctor's part, i.e. to have a genuine (internalised) respect for the patient, rather than merely assuming a superficial (externalised) respectful manner; ii) recognition of the role of emotion (of either party) in the doctor-patient relationship; iii) the reciprocal influence of both parties on the doctor-patient relationship; and iv) the moral foundation to relationship-centred care, in so far as having a moral commitment to another human being is deemed beneficial to the quality of that relationship in terms of genuineness and commitment.

Though not explicitly stated, both Mead and Bower's (2000) patient-centredness and Beach and Inui's (2006) relationship-centredness are dependent on the quality of the communicative process between doctor and patient, as the medium through which such relationships may be developed and enacted. As a result, a range of physician attitudes and skills have been identified as representative of a patient-centred approach and form the basis of numerous research studies (see Mead and Bower 2000 for a summary of these). Whilst skills will play their part in the enactment of

these processes, the elements introduced in the above models suggest a landscape of clinical communication as something much richer than simply a portfolio of skills. Rather, they emphasise the complex inter-subjectivity of the doctor-patient relationship, the need for dialogical negotiation and mutuality, founded on a moral imperative to do the best for patients.

Aside from patient-centred models, there is little reference to theoretical foundations in the clinical communication literature. A notable exception is the work of Balint (1954) who incorporated the use of psycho-dynamic theory (particularly in relation to transference /countertransference) into General Practice consultations and established training for GPs in this method in the 1960s. More recently, Salmon and Young (2009) have drawn on a number of psychological theories as a grounding for the practice of clinical communication. Although links to associated areas such as medical ethics, medical sociology or psychology are made in some clinical communication curricula, in general there is little reference to theoretic foundations for the subject. More commonly, the empirical evidence base for improved clinical outcomes and models of the doctor-patient consultation are cited as informing curricula content and teaching. The role of theory within teaching and the potential for strengthening the theoretic base for clinical communication will be revisited later in the thesis, in light of the study findings. In the next section I will consider the differing discourses surrounding clinical communication and the relation of these to current conceptualisations of the subject.

2.5   Conceptualisations of clinical communication

Examining the current discourse surrounding clinical communication may help to illuminate how it is viewed and conceptualised as a subject. A formal definition provided by the Association for Medical Education in Europe (AMEE) makes reference to cognitive and affective elements and the aim of mutual understanding as follows:

> The process by which information and feelings are shared by
> people through an exchange of verbal and non-verbal
> messages. In the context of medical education, its primary

function is to establish understanding between patient and doctor. (Wojtczak, 2003 AMEE Occasional Paper 3)

Hargie et al's (2010) survey of communication leads in UK undergraduate medical programmes found 'communication skills training' (CST):

Was defined consistently as a way of developing students' essential skills, knowledge, attitudes and awareness that would enable them to communicate effectively and empathetically with patients, relatives, professional colleagues and peers. (Hargie et al., 2010 p. 386)

This definition emphasises the attitudinal, knowledge and skills elements of the subject as necessary for the development of effective and sensitive communication. Yet interestingly, the published article in which this is reported is entitled 'Current trends in communication skills training in UK schools of medicine' and is representative of the prominence of a 'communication skills' discourse in the field. This focus on the skills element of the subject, rather than the additional elements included in the stated goal of CST above is evident in much of the literature and has been noted as an area of concern (Skelton, 2008, Salmon and Young, 2011). It also raises the question as to why the emphasis on skills acquisition has potentially taken precedence over other elements of clinical communication development. This will be investigated as a key element of the current study.

 The title and focus of a number of recent key texts illustrate this further, including 'Skills for Communicating with Patients' (Silverman et al., 2013); 'Commuunication Skills' (Washer, 2009) and 'Communication Skills for Medicine' (Lloyd and Bor, 2009). The aim of these texts is to provide practical, skills-based guides to assist clinicians in carrying out medical interviews and tasks, from the more routine tasks of eliciting a patient history or explaining a procedure, through to more challenging situations such as breaking bad news. Their purpose can be summarised as intrumental, with a focus on specified sets of skills, tasks and processes deemed necessary for the accomplishment of particular clinical objectives. Silverman et al. (2013) provide a consultation framework – 'The Calgary-Cambridge Guide' - that has been widely adopted in the UK as a framework for teaching of clinical communcation skills. It is robustly researched and provides a sound evidence base

(in terms of improved health outcomes and patient satisfaction) for the utilisation of specified skills relevent to the different stages of the medical onsultation. Whilst acknowledging additional elements, such as the doctor's attitude, self-awarness, emotions and motivations – grouped under the label of 'perceptual skills' – these are not addressed in any depth, other than to note that they also play a role in communicating with patients. This contrasts with the very detailed exposition of the observable and demonstrable skills elements.

The discourse of 'communication skills', may also be associated with a discourse of 'effectiveness', as discussed in relation to Silverman et al. (2013) above. The term 'effective communication' is most commonly used by those (clinicians; researchers or teachers) within the field in the context of evaluative studies of the effects of clinical communication teaching or of clinical outcomes associated with particular communicative practices. In this way, effective communication represents the extent to which it is proven to be 'effective' in instrumental terms (for example where physiological improvements such as the lowering of raised blood pressure (Kaplan et al., 1989) or blood glucose levels (Rost et al., 1991) have been attributed to effective communication). While these findings are of great significance, the predominant discourse of 'effectiveness' and 'outcomes' may overshadow the intrinsic importance of humane, relationship-centred clinical communication or its wider role in the systems and culture of health care delivery. In line with this, Scambler and Britten (2001) offer some critiques of the instrumental approach. They refer to recent trends in the discussion of doctor-patient relationships, or increasingly, doctor-patient interactions, as tending to move away from broader sociological conceptualizations such as those of Parsons (1951) and Freidson (1970). Parson's seminal work outlining the 'sick role' proposed a structural-functionalist view of the doctor-patient relationship which has remained influential. This accentuated the role of the patient as largely passive and the doctor as active in the relationship. Freidson's post-structuralist account challenged this view of the status quo, identifying situations (e.g. chronic disease or psychological disorders) which did not fit with Parson's model and which suggested a more dynamic range of doctor-patient relations. In this way, both authors offered substantive sociological accounts in which to contextualise doctor-patient relationships and provided alternative lenses through which to explore

this area of practice. Scambler and Britten (2001) refer to the growing tendency to focus on empirical accounts in the form of:

> Descriptions, of 'typification' or of a (positivist) search for those interactive or communicative 'qualities' of the doctor-patient relationship that are predictive of positive outcomes for health, for future health-related behaviours or for patient satisfaction' (Scambler and Britten, 2001 p.46).

They also note that recent research examines doctor-patient encounters in a de-contextualized way, '…each one displaying an assembly or mix of predefined positive or negative characteristics' (Scambler and Britten, 2001 p.47). An example of this is provided by Stewart's (1995a) review of a sample of studies (n. 21) in which patient health was an outcome variable. It involved classification of physician and patient statements (e.g. physician encouraging patient to ask questions, being supportive and empathic or patient expressing themselves fully) which she found suggested a correlation between positive communication elements and improved health outcomes. A further example of the movement towards a systematic coding of medical dialogue can be found in the Roter Interaction Analysis System (RIAS) (Roter and Larson, 2002).The elaborate system (applied to audio-visual recordings of health care practitioner – patient dialogues) identifies features of physician and patient talk that can be classified broadly under the headings of 'task-focused communication' and 'socio-emotional' communication. In a similar vein (though from a differing disciplinary perspective), Roberts et al. (2003) applied a discourse-analytic approach by examining a selection of video-recorded final year medical student OSCEs. These were transcribed, allowing for analysis of 'each interactional episode and how it came to be produced' (Roberts et al., 2003 p.193). Their coding of the dialogue between medical students and simulated patients identified particular communicative strategies used by the students as more, or less, effective. Positive features included, for example, demonstrating empathy, while less effective strategies included use of medical jargon and failing to register what the patient has said. While the authors also referred to the 'impact of values and assumptions on the outcome of the consultation' (Roberts et al., 2003 p.192) their role was not elaborated on in the context of their study.

The above examples illustrate how micro-analysis and coding of clinical interactions are being utilized in research. While these methods succeed in identifying specific communicative features of consultations (in some instances mapped against a patient-centred model), they may be seen, as Scambler and Britten (2001) suggest, to dislocate doctor-patient interactions from the wider context and systems in which they are situated, be they cultural, institutional or political. The question also arises as to how such behavioural analyses with an emphasis on coding and quantification sit in relation to the broader aspects of clinical communication that may give rise to them, such as personal beliefs, values or attitudes. Indeed Roter (2002), whilst defending the benefits of careful analysis, makes the point that:

> Just because a variable can be measured does not mean to say it can provide meaning; conversely failing to capture a phenomenon does not mean that it lacks significance. Before we can specify what can and should be measured, we must ask ourselves why particular communication variables merit measurement, and where do the variables fit in a broader conceptual and theoretic framework.' (Roter and Larson, 2002 p.251)

Thus she acknowledges a wider sphere of clinical communication, beyond the minutiae of doctor-patient interactions.

So far in this section, I have outlined how a skills discourse has come to dominate the clinical communication literature and how a focus on outcomes (physical, psychological or patient-centred) has given rise to a related discourse of effective communication. Whilst effective communication may also be viewed as good communication, in as far as it meets desired instrumental ends or outcomes; it is of note that 'good communication' may also have additional or differing connotations. Whilst the term 'good' communication is more likely to be used in a lay context 's/he is a good communicator' / 'has a good bedside manner', 'good' may also be considered to have a moral or ethical dimension or an association with virtue. Duncan et al's (2003) exploration of what constitutes a 'good healthcare practitioner' (HCP) is helpful here in offering some insights into what we might mean by 'good' in the healthcare context. They discuss the role of virtue ethics (often thought of as "Aristotelian ethics") as a guiding principle for HCP-patient relationships, but make

the point that a theoretic knowledge of virtue ethics does not necessarily translate into virtuous (or good) practice. They acknowledge the difficulty of 'pinning down' the additional attributes that practitioners possess or develop that embody a way of being, and of being in relation to others, that exceed technical competence and knowledge and that situate these latter elements within a holism of practice. This discussion may be extended to explore ideas of what might underpin the practice of good communication and will be explored in the context of the current study. In addition, the idea of medical practice as a values-based activity (Little, 2002) can be seen to bear relevance to clinical communication. Initially advocating for humane medicine in the form of empathy and sympathetic understanding as central to medical training and practice, Little (1995) was critical of a reductionist approach in medical education as inappropriate to the complexity of human experience. Instead, he promoted holism as a means of integrating bio-science teaching with consideration of values, ethics and existentialism (Little, 1995 p.162). In developing his thesis, Little (2002) considers that the terms humane medicine or humanistic medicine have been used in part to counter the reductionist tendencies of scientific or evidence-based care, but that they may not be sufficiently 'corrective' to this trait. While acknowledging the ethical principles that underpin humanistic practice (such as beneficence, non-maleficence, justice and respect for autonomy), he stresses the role of values and beliefs in the development of such principles. Little's view on the nature of medical practice – of which communication is a core component – provides a further arena in which to situate the concerns of the current study.

In this section I have sketched out how the particular discourses of 'communication skills', 'effective communication' and' good communication' – from a values-based perspective – contribute to the ways in which the subject may be conceptualized. This provides a basis for further exploration within this study of the perspectives held by those responsible for the design and delivery of clinical communication teaching and the extent to which their perspectives may influence the pedagogy of the subject within their medical schools. In the next chapter, I will move our focus to that of competency-based education and training, with the aim of appraising how this approach is further influencing the pedagogy of clinical communication.

2.6   **Conclusion**

In undertaking this review, I have traced the emergence of clinical communication into the medical curriculum and outlined current approaches to its pedagogy in terms of content, teaching and assessment methods and the role of theory. I have considered how differing models and theories underpin the subject, and how it is conceptualised, ranging from a skills-based focus to a broader, more holistic view that takes account of a range of personal and professional attributes of those involved. In addition, I have considered the differing discourses surrounding clinical communication in terms of skills, effectiveness and values and how these may influence the design and delivery of clinical communication pedagogy. In the next chapter, I will set out the current status of competency-based medical education and its relation to the pedagogy of clinical communication.

3 Competency-based medical education and its relation to the pedagogy of clinical communication

3.1 Introduction

A key aim of this study is to explore how skills and competency frameworks may be affecting the pedagogy of clinical communication. To provide the context for this, I will outline the origins of competency-based medical education (CBME) and present the current debate surrounding its appropriateness in this field. I will go on to discuss the differing perspectives of what skills and competencies are taken to mean and conclude by considering the effects of CBME on the pedagogy of clinical communication.

3.2 The origins, development and discontents of CBME

Beyond the somewhat introspective world of medical education, competency-based education and training (CBET) had been incorporated into the wider education and training sphere since the 1970s (Hodges and Lingard, 2012, ten Cate and Billett, 2014). Drawing on Grant's (1979) work, Hodges and Lingard (2012 p. 2) define "competence-based" education as:

> A form of education that derives a curriculum from a prospective or actual role in modern society and attempts to certify student progress on the basis of demonstrated performance in some or all of the aspects of that role.

The movement was centred on behavioural objectives in which skills were broken down into specific elements that could be assessed in the workplace. Leung (2002) traces the development of this approach, which took the form of National Vocational Qualifications (NVQs) in the UK, to parallel developments in the wider sphere of vocational training across a number of countries including the United States, Australia and New Zealand with the aim of developing national standards of skills attainment. The initial motivation for this development was the 'up-skilling' of the

workforce to be more competitive in the global market place, to provide greater accountability in training processes and to ensure that the outcomes of training programmes more closely met the needs of society (Leung, 2002, McAshan, 1979). CBET has since been adopted (and adapted) across a range of education and training settings.

An early appeal for a competency-based medical curriculum was made in a report by McGaghie et al. (1978) entitled 'Competency-based Curriculum Development in Medical Education', which they deemed a necessary development to match the education of health care professionals with the service needs of the NHS. Despite this early recommendation, it was not until the 1990s that a competency approach was widely adopted in UK medical education, driven primarily by public and governmental pressure for a more transparent and accountable system of medical regulation (Davis and Harden, 2003), particularly in the context of high profile lapses in probity over the past decade. Having now reached an almost ubiquitous status, CBME has been acknowledged as providing clearly defined outcomes and assessment standards for both learners and assessors across the spectrum of undergraduate and postgraduate training (Leung, 2002). An example of how this is operationalized can be found in the 'Foundation Programme Curriculum Document' (UKFPO, 2014) designed to cover the required educational and professional development of junior doctors in the initial two years of post-graduate training (F1 and F2). This contains 11 domains of activity, each of which contains the specified learning outcomes to be achieved at F1 and F2, which are further specified into lists of competencies necessary to achieve the outcomes. However, despite the clarity this type of schema provides in setting out the expected standards of a doctor / learner at a particular stage of training and the guidance it provides to trainees, the adoption of CBME has given rise to considerable disquiet. Much of this has centred on the concern that a paradigm initially developed on behaviourist learning principles is both inappropriate and inadequate to capture the complexity of medical practice (Grant, 1999). This has been voiced most strongly in the realm of post-graduate medical education, as exemplified by Talbot's (2004, p. 587) concern that:

> This model or discourse has a tendency to limit the reflection, intuition, experience and higher order competence necessary

for expert, holistic, or well developed practice (the practicum).

This concern is echoed by Bleakley (2003) who challenges the minimal achievement of pre-set criteria as an acceptable aim for undergraduate medical students. Instead, he calls for a more 'educative culture' that can tolerate the ambiguity inherent in clinical practice and aims higher than minimal standards of attainment. In a similar vein Saunders (2006) summarises Norris's (1991) earlier argument that competency-based approaches:

> Tend to reduce the job-competence to atomised, observable behaviours, which may not embody competence in the sense of generalisable or holistic capability or, indeed, situated competence. (Saunders, 2006 p. 14)

Despite these criticisms, the perceived benefits of CBME in terms of clarity and accountability have garnered it considerable support (Davis and Harden, 2003, Harden et al., 1999). This has engendered something of an anti-reductionist discourse of competence in medical education. This is reflected, for example, in Epstein and Hundert's (2002) definition of the development of physician competence as:

> The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and the community being served. (Epstein and Hundert, 2002 p. 226)

It would be difficult to level an accusation of 'narrow reductionism' at this entirely holistic vision of medical practice. It seems such a definition has been arrived at in the spirit of Harden et al.'s (1999) argument that competency-based approaches are not inherently reductionist. To counter this premise, they propose a framework within which higher level competencies, or what they describe as 'meta-competencies', are incorporated into the specification of learning outcomes necessary for a 'reflective and competent' practitioner. These are divided under the three headings of i) 'technical intelligences'; ii) 'intellectual / emotional / analytical intelligences' and iii) 'personal intelligences' (of which categories ii) and iii) comprise the meta-competencies). The first category comprises elements which are termed technical competencies (including history-taking, practical procedures and

communication skills), the second category refers to *how* the doctor approaches these tasks, including understanding of 'basic, clinical and social sciences' along with attitudinal and ethical considerations, whilst the third category refers to the doctor as a professional which focuses on their capacity for self-development, reflection and learning. The proposal assumes that the level of achievement in meta-competency categories will manifest in how the technical competencies are carried out, including the possession of underpinning knowledge and appropriate ethical and attitudinal qualities. From this example, it is possible to trace the envelopment of higher order professional attributes within a competency framework that was originally limited to, and intended for, the realm of technical skills mastery. This development has been described by Lum (2009) as the creep of vocationalist tendencies into the wider educational sphere. This, he posits, is sometimes achieved by a 'terminological sleight of hand' (Lum, 2009 p. 2), for example where higher order cognitive reasoning is re-defined as 'thinking skills'. This type of 're-branding' can be seen to resonate with the 'meta-competency' model outlined above. Lum suggests that this tendency has been driven by the increasing requirements of standardization and accountability in the spheres of training and education. This move to subsume higher order personal and professional functions and attributes into a competency framework also serves to fuel the concern that these higher order elements risk deconstruction into such component parts that they undo the essence of their meaning and may restrict their conceptualization into the observable and measurable.

The quest to capture these non-technical elements of practice, using 'stock-in-trade' criteria-based assessment methods common to competency approaches, remains problematic. Harden et al. (1999 p. 549) describe the 'technical competencies' as being teachable and assessable in 'discrete components' which are 'visible' in nature and therefore amenable to observable assessments such as OSCEs, whilst the higher order 'emotional / self-reflective' competencies are more difficult to capture through such means. Related to this is Talbot's (2004, p. 588) concern for assessment processes in which '… the danger is always that we ask questions related to those things that may be more easily measured, instead of asking the more difficult questions'. Such concerns are elaborated by Skelton (2008) in his consideration of assessment methods linked to skills and competency approaches which, he contends,

have been driven to an increasingly surface approach by societal demands for professional activity to be made accountable through 'objective looking criteria' (Skelton, 2008 p. 140). He posits that this trend, coupled with the long-standing preoccupation of medicine with the 'scientific method', has permeated medical education, including clinical communication, to the point that:

> We seek to objectify what ought not to be objectified, we measure the measurable with too little regard to whether it tells us what we need, we are naïve about what such measurements tell us. (Skelton, 2008 p.140)

The tendency to objectify clinical practice in the form of skills and competencies and to seek to measure these elements against pre-set criteria have become the hallmark of CBME assessment and, as highlighted by the above comments, add a further layer of discontent to the adoption of this approach. So far, I have outlined the rise of a competency-based approach in medical education and briefly sketched its perceived advantages and disadvantages. Before going on to examine the relationship of CBME to clinical communication teaching and assessment, some further analysis of how skills and competencies are conceptualized may help in this process and follows in the next section.

3.3   **Skills, competency and ambiguity**

As considering the role of skills and competencies in relation to clinical communication is important to this thesis, I will attempt to clarify what is meant by these terms, which sometimes appear to be used interchangeably. I will begin with two examples from the medical education literature to illustrate how clinical skills may be defined. The first, taken from an undergraduate clinical skills curriculum 'over-view map', offers a succinct definition as follows:

> A clinical skill is defined as any discrete and observable act within the overall process of patient care. (University of Otago, Wilkinson et al., 2013 p. 4)

The authors include the areas of communication skills, procedural skills and clinical reasoning under the rubric of clinical skills and state the need for psychomotor

abilities, background knowledge and the exercise of reasoning and judgment in order to enact these skills. This expansive conceptualisation of clinical skills (CS) is echoed in the following description, arrived at through a consensus process involving a sample of UK medically qualified educators:

> A CS may contain one or several different domains such as: physical examination skills, practical procedure, communication skills, and management. Acquiring CSs includes three components: learning how to perform certain movements (procedural knowledge), why one should do so (underlying basic science knowledge), and what the findings might mean (clinical reasoning). (Michels et al., 2012 p. 573)

These examples suggest that at least within the field of clinical education, the concept of skills is applied to a wide range of activities that include technical, cognitive and affective domains. Whilst the accomplishment of techniques or procedures, underpinned by the necessary knowledge base may fit reasonably within this view of skills, the example of clinical communication raises a number of issues. The inclusion of communication as a clinical skill (referred to above as communication skills), may be acceptable in terms of its central and instrumental role in the accomplishment of clinical activities and tasks. These may range from exchanging information with colleagues, explaining a treatment plan to a patient or as part of a physical examination or procedure. However, the execution of these tasks draws upon a range of knowledge, attributes, judgments and professional orientations that fall under a broader construct of clinical communication. Broader conceptualisations of the subject have been introduced in the previous background chapter and will be returned to in the findings chapters, so I will limit my commentary at this point to questioning both the suitability and sufficiency of a skills construct to the field. This rests on the premise that clinical communication also encompasses aspects such as attitudes, values and emotions which are beyond reduction to 'discrete, observable acts' (as per the definition above).

Winch's (2010) analysis of how skills are conceptualised is helpful in illuminating how the term skill has come to be used so freely. Winch (2010 p. 41-3) describes skill as 'knowing how' to do something, (i.e. the ability to do the thing rather than just describe how to do it) and to act in a certain way in relation to a task. He also

notes that the designation of actions into skills renders them amenable to 'normative appraisal' – a feature which readily lends itself to assessment processes. Whilst the development of skills often involves the use of learned techniques and methods, Winch also notes that they may involve more than this, including for example, physical attributes (such as dexterity), propositional knowledge and the application of judgment. In essence, the true acquisition of skill is a complex process rather than merely the development of a particular habit. Winch (2010 p.45) describes a spectrum of skill conceptualisations, ranging from a restricted behaviourist view to an inappropriately expansive view, which I have summarized in Table 1 below.

Table 1: Summary of Winch's conceptualization of skill.

Conceptual deflation of the skill concept: A largely behaviourist view in which skills are considered in terms of technique, habit or overt task performance.
Moderate conceptual inflation of the skill concept: Takes into account non-physical abilities (i.e. cognitive skills) and the notion of transferable skills, so that skills learnt in one situation (e.g. classroom) may be applied in another setting. However, skills may need further enhancement to transfer successfully to other situations.
Immoderate conceptual conflation of the skill concept: The notion of 'general skills' (e.g. thinking, problem-solving) and whether this has legitimacy. May be difficult to differentiate from 'transferable skills' (above).
Immoderate conceptual inflation of the skill concept: Where skills are associated with personal attributes and interpersonal activities, whereby skills intended for instrumental ends, i.e. accomplishment of specific tasks, are applied to situations of moral worth involving people. The risk being that the priority of task accomplishment may 'distort our proper moral orientation towards other people', e.g. through manipulative communication practices.

Adapted from Winch (2010 Ch.3).

This analysis illustrates the widely varying conceptions of skill that are at play in the field of training and education and provides a useful lens through which to consider the matter of communication skills. For example, the deflation of skill into the mastery of techniques alone would be an unlikely occurrence, in so far as any health care student or clinician would apply some greater sense of meaning or judgment to the skill being enacted (e.g. the use of eye contact would be judged in terms of its appropriateness to the particular patient and with a sense of purpose for the action itself such as demonstrating interest or developing rapport). Moderate conflation of skill may be considered in relation to the transfer of learning from a simulated clinical environment to the clinical workplace, which may require considerable

adaptation to be successful. An example of immoderate conceptual conflation of skills may be seen in the notion of 'generic communication skills' which may be applied in any clinical (or non-clinical) situation. However, as with the previous case of 'transferable skills', adjustments based on judgment and reasoning would be necessary, such that 'establishing rapport' with a paediatric patient, or in a mental health setting, may require modification from 'general' skills of rapport building. Finally, Winch's category of 'immoderate conceptual inflation of the skill concept' is of particular note in this enquiry because of its concern with the idea of 'social skills' or interpersonal skills. He cautions against skills relating to the accomplishment of tasks (of an instrumental nature / something which serves our purpose) being applied to situations that involve 'moral worth', i.e. that involve relations with other human beings. Whilst acknowledging that in certain vocational occupations or professional settings the application of skills in an interpersonal capacity (e.g. offering a clear explanation) may be applicable, he flags the potential for 'manipulative communication' and the risk that a skills application to this realm may '… distort our proper moral orientation towards other people' (Winch, 2010 p.54). This view highlights the need for careful consideration of how a skills approach may be applied to the area of inter-personal relationships.

Lum (2009) offers additional insights into the conceptualisation of skills. He also challenges the idea that a skills-approach, traditionally associated with vocational training, necessarily equates to an impoverished view of learning. In particular, he challenges the idea that 'knowing how' (associated with skills acquisition) and 'knowing that' (associated with a broader knowledge base, including the rationale for actions) are two "epistemologically distinct" kinds of knowledge (Lum, 2009 p.7). While skills may be viewed as 'discrete capacities such as might be procured individually and in isolation from any wider programme of study' Lum (2009 p. 176) refutes the idea that people learn in such a fragmented or un-contextualised way. Far from achieving competency through the acquisition of a set of disembodied skills derived from behaviourist learning principles, Lum promotes the notion of vocational 'capability'. This includes the development of a much wider frame of understanding and perceptions. He refers to the case of a medical doctor, by way of illustration, of someone who is trained in the requisite technical skills, but who needs to '… adopt

the values appropriate to medical practice and come to care for what he or she is doing' (Lum, 2009 p. 18), thus pinpointing a need to develop both skills and values in order to become a fully formed medical professional.

So far, we can see that there are differing interpretations of what constitutes skill, ranging from a narrowly technicist conceptualisation to a wider view incorporating the agency of the doer (in terms of propositional knowledge and their approach to the task). Such epistemological and terminological differences are important to note given their centrality to the notion of 'communication skills' and skills-based approaches more generally in medical education. The relationship of skill to competency and indeed the notion of what competency itself comprises will now be considered.

Khan and Ramachandran (2012) note that the terms 'competency' and 'competence' can be used interchangeably in the English language, but that in the realm of medical education 'the term "competency" should strictly be used as a descriptor of the "skill" itself, while competence is the ability to perform the skill and the attribute of the performer'. They give the example of the skill of inserting a naso-gastric tube as a 'competency', while the person who is able to successfully perform this has the 'competence' to do so, therefore '… an assessment tool designed to test the ability to insert the naso-gastric tube is a competency-based assessment tool, which assesses the competence of the person performing it' (Khan and Ramachandran, 2012 p. 2). In summary, it can be said that one learns skills (which may be designated as competencies), along with propositional knowledge and professional judgment, in order to become 'competent' or achieve 'competency' in particular areas of practice. Sanson-Fisher et al. (2005) stress that it is the achievement of specified outcomes rather than being exposed to learning opportunities that is of importance in this regard as follows:

> The appropriate measure of whether a student has satisfactory knowledge and skills relating to clinical issues should be the attainment of clinical competency rather than reaching the end of a clinical rotation. (Sanson-Fisher et al., 2005 p. 32)

However, as with the notion of skill, regardless of attempted definitions, what is deemed to comprise competence is also open to (to use Winch's terminology) conceptual inflation, conflation and deflation with a resulting lack of consensus as to its meaning. Diwakar (2002) describes traditional medical teaching as having a narrow view of competence, focusing only on doctors' abilities to solve predictable problems. By contrast he states that:

> Professional practice requires an education which recognizes that patients are treated as individuals. Clinical problems are personal and unique. To solve them, we make informed, but ultimately value-based, judgments that are founded on intelligent reflection on previous experience (expertise).
> (Diwakar, 2002 p. 695)

Here, Diwakar highlights the tension between restricted conceptualisations of competence and the 'higher order' capabilities required for the 'realities of clinical practice'.

This brief excursion into the discourse surrounding skills and competency serves to illustrate the complexity and ambiguity associated with these terms. It appears that the terminology used to describe these concepts and their epistemological bases are liable to differing interpretations, along a spectrum from a narrow technicism to a more expansive construal. Whichever version is adopted has implications for the kind of pedagogy and assessment to be employed and I will now outline how the adoption of CBME has been characterised in relation to clinical communication pedagogy.

3.3.1 *Effects of CBME on clinical communication pedagogy*

Bleakley (2003 p. 186) has noted the tendency 'to reduce the complexities of communication to an instrumental discourse of "competencies"' within the current educational climate. As a result, clinical communication is now widely considered in terms of skills and competencies. The concern arising from an overly skills-focused approach to the teaching and assessment of the subject is elaborated by Hanna and Fins (2006 p. 267) as follows:

> A medical student may, through practice in simulation
> encounters, be able to master all the skills and tricks of
> surface communication and be able to use them very
> effectively in an OSCE and in later practice effectively …
> [But] does he or she ever learn to master the discursive and
> ontological power that makes the physician-patient
> relationship an invigorated, productive lived reality rather
> than a set of acting techniques?

Their question highlights the risk that an inauthentic approach to clinical relationships may inadvertently be engendered through a process of performing 'as if one cares' in order to satisfy check-list style criteria commonly used in undergraduate competency / skills-based assessments. This view is endorsed by ten Cate and Billett (2014) who make the point that certain professional qualities or attributes, such as ethical practice and professionalism (we might add compassion, the role of beliefs, values or motivations), cannot easily be translated into measurable outcomes, so that:

> Proxies to these constructs are then devised to enable the
> development of checklists that eventually miss the critical
> core of the construct to be measured' (ten Cate and Billett,
> 2014 p. 327).

This reasoning might also be considered in relation to clinical communication, where the essence of the interactive relational process runs the risk of being lost in the quest for observable measures of interaction. This is not, however, to negate the benefits that are gained from a simulated learning environment, where students can develop and practice communicative strategies (including skills) in preparation for actual clinical practice. Rather, it points to the need for vigilance, that markers of surface performance do not outweigh the meaningful consideration of the very nature of the clinical relationship (McNaughton and LeBlanc, 2012).

In summary, it seems that in order to satisfy demands for rigorous and transparent modes of assessment (a not unreasonable demand on the part of the public and regulators), competency-based teaching and assessment methods are likely to remain a key feature of medical education. Given the momentum that CBME has gathered over the last decade, it is worth pausing to consider the following point made by Lum (2009). Reflecting on Dewey's 'Democracy and Education' (1966), Lum elucidates

the principle '… of focusing the educational process on persons and their understandings rather than on the concrete manifestations of these understandings – even when learning is through occupations and its content is specifically vocational' (Lum, 2009 p. 183). This suggests the need for a robust interrogation and understanding of the ways in which skills and competence-based approaches are shaping the very nature of medical education and, within this, the way clinical communication is being taught and assessed.

3.4 Conclusion

In this chapter, I have briefly traced the origins of competency based education and training and the subsequent emergence competency-based medical education. I have reviewed the role of CBME, emphasizing the tensions and ambiguities surrounding notions of skill and competency and how differing interpretations affect their use in medical educational and, by extension, the pedagogy of clinical communication. I have considered the impact that skill and competency discourses may have on clinical communication teaching and assessment and what is problematic with the current state of affairs in relation to these issues. This centres primarily on the risk that competency-based approaches pose to the area of clinical communication, by imposing a reductive set of standards and behaviours by which it is taught and assessed. By focusing on the more easily defined and observable aspects of clinical communication, the danger is we lose sight of its fundamental role in helping to form professionals with a deep sense of the value of humanity, which requires a broader and deeper engagement with the subject.

It is hoped that the background and literature presented in Chapters 2 and 3 have set the context for this study. Issues pertaining to the differing discourses surrounding the nature of clinical communication as a subject and the role of theory within this, have given rise to the specific research objectives of: i) Exploring how clinical communication academics construct the nature of the subject and their views on how it contributes to the formation of future doctors and ii) To illuminate how supporting models or theoretic approaches are used to inform the teaching of clinical communication. Issues pertaining to prevailing competency and skills-based

approaches in medical education, has given rise to the final research objective: iii) To explore which elements of clinical communication predominate teaching in undergraduate curricula and how these relate to assessment practices. In addressing these objectives, I aim to meet the over-arching study aim of investigating the range of curriculum, pedagogical and assessment perspectives and practices deployed in clinical communication contexts and to explore which of these have the most potential for addressing the complexity of the field. In the next chapter I will discuss the methodology employed in conducting the study.

4   Methodology

4.1   Introduction

I will begin this chapter with a brief overview of the study methodology, to serve as a baseline map for the reader. This will be followed by a detailed account, starting with the epistemological and methodological reasoning which have informed the nature and conduct of the study and a description of how it was conducted, including the setting, recruitment of participants, data collection and analysis. I will also highlight the ethical issues raised by the research process and how I sought to address them.

4.2   Brief study overview

To address my key research aim and questions, I wanted to gain insights from those responsible for the design and delivery of clinical communication teaching at an institutional level, for undergraduate medical students. This involved identifying and approaching the leads for clinical communication in each of the thirty-three UK medical schools, with the aim of recruiting a minimum of ten respondents whom I could interview. I adopted a qualitative approach for the study (the basis and reasoning for this is discussed in section 4.3 below), as I wanted to gain in-depth insights into respondents' views of the subject area .I chose to interview them on an individual basis to enable this. Prior to the interviews I circulated a questionnaire to all 33 subject leads to gain an overview of the teaching and assessment features of their curricula and their perspectives on the scope of clinical communication teaching. Twenty one questionnaires were returned, representing two thirds of UK medical schools and these helped to inform the content of the subsequent interviews and provide basic numeric data. I conducted ten semi-structured interviews, which were audio-recorded, transcribed and analysed using thematic analysis. The study findings are discussed in the remaining chapters. I will now provide a more detailed account of how each stage of the research was conducted.

4.3 Epistemological and theoretical perspectives

I adopted a social constructionist approach to the study as it was well suited to my key research aim of achieving in-depth insight into how clinical communication teachers construct the nature of their subject and how this relates to their practice in the field. This approach derives from an epistemology which supports the notion that knowledge and meaning are socially mediated and an acceptance that there is not a 'single, exhaustive or definitive account' that captures 'social reality' (Ball, 1990 p.167). Applying an interpretive lens to the data collection and analysis process enabled me to explore the 'sense-making' processes of my respondents in terms of the interplay between the institutional and governance requirements for curricular content and assessment and their own beliefs and views about the subject.

Creswell (2007) outlines the key features of qualitative, interpretive enquiry as most appropriate for capturing the kinds of phenomena outlined above. He suggests the interpretive paradigm provides a 'theoretic lens' to explore how people ascribe meaning to a particular phenomenon, whereby '…the goal of the research is to rely as much as possible on the participants' views of the situation' (Creswell, 2007 p. 20) and in which 'it is the researcher's intent… to make sense of (or interpret) the meanings others have about the world' (Creswell, 2007 p. 21). Applied to my own study, this endorsed the centrality of the respondents' views and my responsibility to make sense of these in a way that would accurately reflect their expression. The collection of data in the respondents' own environments, the use of inductive data analysis to establish themes; my own reflexivity within the research process and representing the voice of the participants in the resulting report, all reflect additional features of an interpretivist approach as identified by Creswell (2007) and contribute to the validity of the findings.

Situating the study in an interpretivist paradigm guided me to a phenomenological orientation. This emphasised the relationship between the phenomena being explored and how participants attribute meaning to the phenomena. I related this to how clinical communication teachers construct the subject of clinical communication and associated pedagogical practices. Crotty (1998 p. 79) emphasises the inter-

relationship by proposing that neither object nor subject '… can be described adequately without reference to the other'. Furthermore, a phenomenological methodology aims to facilitate enquiry that is marked by critical reflection (Larrabee, 1990). Crotty (1998) states that this requires (a not easily achieved) laying aside or 'bracketing' of our pre-existing understandings of phenomena that have been learnt and assimilated from our cultural backgrounds. By doing so, he suggests that phenomenology provides '…possibilities for new meanings to emerge for us or we witness at least an authentification and enhancement of former meaning' (Crotty, 1998 p.78). This stance fits well with my wish to interrogate current representations of clinical communication pedagogy and to re-examine what has become 'everyday' practice in relation to the subject, in the hope of extending and generating new understandings.

So far, I have outlined the epistemological and theoretic approach that I have assumed, the reasoning for these choices and how they have informed the study methodology. I will continue in section 4.4 to discuss how the study was conducted.

4.4   The research setting, participants and access

I decided to focus my enquiry on the lead academics for clinical communication teaching in UK medical schools, as this group has a significant role in shaping the pedagogic approach to the subject in their institutions – a key focus of the study. As an 'expert' group, they have considerable insights into the subject itself and its relation to the wider medical curriculum. My previous Institution-focused Study (IFS) in the earlier phase of the EdD programme had provided some insights into student perspectives of how clinical communication was taught and assessed in my own medical school. This revealed a tendency to view the subject in isolation from other aspects of learning (most strikingly in terms of clinical practice and ethics teaching) and a marked pre-occupation with how they needed to develop their communication to succeed in the Objective Structured Clinical Examinations (OSCEs). The findings suggested that the skills-based emphasis of the OSCE was engendering a potentially limited engagement with the subject, focused on what students thought they needed to do or say in order to satisfy the OSCE marking

criteria. I was concerned that this served to detract from students' developing a richer understanding of clinical communication as a subject, encompassing values, ethics, self-reflection and models of the doctor-patient relationship. This led me to further consider how current curricula and pedagogic practice both in my own institution and more widely may be contributing to this situation and to the decision to examine the issues raised by the IFS from a faculty perspective.

The thirty-three UK medical schools provided the pool of potential participants. This also set a workable boundary for the scale of the project. While there is usually a small team of faculty with a key role in clinical communication teaching in each school, I approached the named lead for the subject as a starting point, on the premise that they would be most influential in shaping the pedagogic approach to the subject in their institution.

Access to the prospective participants was facilitated by my membership of the UK Council of Clinical Communication in Undergraduate Medical Education (UKCCC). This is a representative body comprised of the clinical communication teaching leads (or nominated representative/s) of all UK medical schools. Its aim is to enable good teaching practice to be shared and to encourage research and development in the field. The UKCCC portal holds the university contact details for all members. To ensure the Council was aware of my wish to contact members for recruitment purposes and to gain their support, I contacted the Chair and Secretary with an outline of the study aims. This was positively received, with the Chair posting a blog on my behalf on the UKCCC website to help publicise it (see Appendix 1). I then contacted the lead tutor in each medical school via their institutional e-mail, to invite them to participate in the study. Further detail of the data collection process follows.

4.5   Data Collection

4.5.1   The scoping survey

The first element of data collection was a small scale scoping survey. The primary aim of the survey was to gather initial insights into curricular features and respondent

views on specific aspects of clinical communication pedagogy, to help inform the development of the interview guide. A secondary gain would be the collection of some basic numeric data in relation to these areas. Although more commonly associated with quantitative methodology, the use of basic numerical data has been recognised as having a place in qualitative enquiry. For example, Silverman (1993 p.169-170) supports the use of 'simple methods of counting in largely qualitative research' to provide basic descriptive statistics or 'straightforward' correlations. This view is also more widely reflected in the growing use of mixed methods social science research (Creswell, 2009).

I used the 'SurveyMonkey' software package to develop an easily administered web-based questionnaire. The benefits of the on-line system, as identified by Murthy (2008), included ease of data storage and retrieval, and the facility to transfer data to data analysis packages. I sought feedback on the draft questionnaire in terms of layout, flow, clarity and content from colleagues in my own school who facilitate clinical communication teaching, which enabled me to refine a number of features. I then piloted it using the on-line facility to a group of six colleagues, which enabled further fine-tuning. A recruitment e-mail which contained the link to the survey was sent to the lead tutor in each medical school (n. = 33) (see Appendix 2). A maximum of two reminder e-mails were sent to encourage participation and each contained an 'opt-out' link for those who did not wish to receive any further correspondence. The survey was prefaced by an information sheet (see Appendix 3) which included the basis for consent and details of data storage and management.

The questionnaire comprised a mix of fixed choice response options, Likert style rating scales and open-ended questions for free text responses and was divided into three sections (see Appendix 4). Section 1 comprised demographic type data. Section 2 focused on teaching and included teaching methods; integration with other areas of learning and theoretic frameworks. This section also comprised a number of Likert scale questions on the nature and scope of clinical communication teaching including skills acquisition; the role of attitudes; beliefs and self-reflection and their presence in the curriculum. The final section focused on assessment methods; the role of OSCEs; marking criteria and whether / how respondents would like to make changes

to current assessment practices. The final question invited respondents to be interviewed, with the aim of recruiting a minimum of ten participants for the next element of the study. Whilst previous survey studies (e.g. Hargie et al., 2010) had enquired more broadly into clinical communication curricular features, they had not focused on the key issues pertinent to this study (i.e. conceptions of clinical communication in relation to balance of skills-based activity with broader components of subject area and emphasis on assessment methods). Furthermore, this information is not readily accessible in any existing database or format. A total of twenty-one respondents completed the survey, providing data for two thirds (66%) of all UK medical schools.

Whilst the survey provided additional numeric and free text data from a wider range of respondents than I would otherwise have accessed, the limitations this method are well recognised and are outlined by Silverman (2011). Foremost is the potential disparity between how people respond to survey questions and how they behave in naturally occurring settings. As such, the survey method '… may neglect the social and cultural construction of the "variables" which quantitative research seeks to correlate' (Silverman, 2011 p.13). Such limitations are particularly pertinent within the context of a qualitative study, which by its nature seeks to illuminate social construction and meaning. For example, I was aware that the use of fixed-choice response questions limited the options available to respondents and how the wording or intent of the questions were subject to differing interpretations (despite their high level of subject expertise and familiarity with terminology). These concerns are summarised by Kiely et al. (2005) with reference to the use of Likert scales (utilised in my survey) which even when adopting a multi-point scale '… cannot provide information on what people mean by these categories and what sort of decision-making process they use in opting for one category over another' (Kiely et al., 2005 p. 66) [quoted in Silverman (2011 p. 14)] On balance, however, I felt that the value of the data collected in helping to inform the interview schedule out-weighed the limitations of the survey method. I will now go on to discuss the interview stage of the study.

4.5.2 The interview process

The central element of data collection took place through a series of semi-structured interviews. I aimed to interview at least ten lead tutors (in separate UK medical schools) who had responsibility for the design or delivery of clinical communication teaching. In doing so, I hoped to gain in-depth insights into their views on the nature of clinical communication as a subject; the influences that shape the content and delivery of their curricula; the emphases placed on differing aspects of the subject; how they assess it and their reasoning for these practices. The use of interviews as a means to '… incite the production of meanings that address issues relating to particular research concerns' (Silverman, 1998 p. 122) is well recognised. Further, as Kvale and Brinkman note, a phenomenological approach to interviewing:

> Points to an interest in understanding social phenomena from the actors' own perspectives and describing the world as experienced by the subjects, with the assumption that the important reality is what people perceive it to be. (Kvale and Brinkmann, 2009 p.26)

In this way, interviewing as a research method matched the epistemological basis of my study and was arrived at after consideration of different options. One such option would have been to adopt an ethnographic approach, spending extensive periods of time observing teaching in action in one or more institutions, to gain first hand insight into the study phenomena. This approach would certainly yield valuable information into my research area and add an element of observational data to participant accounts, but I could not commit to such extensive fieldwork within the constraints of the current study and as a part-time researcher.

As I had previously gained some student insights into clinical communication pedagogy from my preliminary Institution-focused Study (as outlined in section 4.4), I reasoned that exploring the views of the lead tutors, with their role in shaping the design and delivery of teaching and assessment, would provide valuable insights into how the subject pedagogy is formulated. Through the interview process I hoped to gain access to the ways in which current discourses around skills, competencies and assessment process may be influencing practice, so that, as Rapley (2004 p. 16) notes "…[i]n this sense interview-talk speaks to and emerges from the contemporary ways

of understanding, experiencing and talking about that specific interview topic". How far respondents' accounts of their curricula represent the 'shop floor' delivery of teaching in their institution is not possible to verify without additional observational methods (as suggested above). Whilst such additional measures would provide other insights, the key aim of this study - to explore the views of those playing a significant role in the subject's pedagogy – was met through the interview process and yielded a rich seam of data.

I devised an interview guide (see Appendix 7) which served as a prompt to raise core areas of enquiry with participants, whilst allowing flexibility to pursue areas raised by them. Feedback from my supervisors helped curb my enthusiasm for including multiple follow up questions and led to revision of some questions to be more open and less directive in nature. I piloted the guide with a senior clinical communication colleague which enabled further refinement and paring of content, so that it was feasible to complete the interview within a one hour timeframe.

A study information sheet (see Appendix 5) was sent to those who expressed interest in being interviewed in response to the initial invitation posted on the UKCCC website or through participation in the survey. It included the study aims; requirements (one in-depth interview with the researcher, at a time and place convenient to the respondent) and details regarding the storage and anonymisation of data. One respondent opted just to be interviewed and another nine were recruited via the survey. The respondents came from a variety of disciplinary backgrounds including medicine, nursing and other allied professions, humanities and psychology. Four were based in medical schools with cohorts of less than 200 students per year, with the remaining six schools having cohorts of 300 – 450 per year. Schools also varied in curriculum structure and orientation (e.g. split into pre-clinical and clinical phases or integrated clinically throughout, more or less strongly research oriented). An overview of the interview respondents, each of whom has been assigned a code number for anonymization purposes, is provided in Table 2 below.

Table 2: Overview of interview respondents.

- *Int. 01:* Has a full-time role as lead for clinical communication in their medical school, which has a yearly cohort of in the region of 300 – 450 students. They come from a healthcare (non-medical) disciplinary background.

- *Int. 02:* Has a part-time role as clinical communication lead in their medical school, with the remainder of their time in clinical practice. The school has a yearly cohort of 150- 200 students. Their disciplinary background is medicine.

- *Int. 03:* Has a full-time role in clinical education with lead responsibility for clinical communication. Their medical school has a yearly cohort of in the region of 300 – 450 students. They come from a healthcare (non-medical) disciplinary background.

- *Int. 04:* Has a full-time role in medical education and a lead role for clinical communication. Their medical school has a yearly cohort of in the region of 300 – 450 students. They come from a psychology / humanities disciplinary background.

- *Int. 05:* Has a full-time role as lead for clinical communication in their medical school, which has a yearly cohort of in the region of 300 – 450 students. They come from a psychology / humanities disciplinary background.

- *Int. 06:* Has a full-time role in clinical education with lead responsibility for clinical communication. Their medical school has a yearly cohort of in the region of 300 – 450 students. Their disciplinary background is medicine.

- *Int. 07:* Has a full-time role as a researcher and lead for clinical communication. Their medical school has a yearly cohort of in the region of 300 – 450 students. They come from a psychology / humanities disciplinary background.

- *Int. 08:* Has a part-time role as clinical communication lead in their medical school, with the remainder of their time in clinical practice. The school has a yearly cohort in the region of 150 - 200 students. Their disciplinary background is medicine.

- *Int. 09:* Has a full-time role as lead for clinical communication in their medical school, which has a yearly cohort in the region of 150 - 200 students. They come from a psychology / humanities disciplinary background.

- *Int.10:* Has a full-time role as lead for clinical communication in their medical school, which has a yearly cohort in the region of 150 - 200 students. Their disciplinary background is medicine.

Protecting the identity of respondents and data anonymisation was particularly pertinent as they were drawn from a relatively small pool of subject leads. This meant that particular institutional features coupled with the respondent's disciplinary background could potentially lead to their identification, an issue I needed to be mindful of throughout the research process. For this reason, in providing an overview of my interviewees, I combined psychology and humanities disciplinary backgrounds and used the descriptor 'non-medical healthcare disciplinary background' to avoid potential identification of individuals. Arrangements were made to conduct the interviews in person, at a convenient date and time. In all but one case I travelled to

the respondent's medical school (all had kindly arranged a quiet meeting room on campus for the interviews to take place).The other respondent was visiting London on business and suggested carrying out the interview at my campus instead.

My preference for face to face interviews was based on the idea that it would be easier to establish a rapport in person than via a computer mediated or telephone link and that the dynamic of the interview would benefit from the immediacy of the personal interaction. Physically visiting the respondents' medical school campus also helped me to situate the discussion in its natural setting. Written consent was obtained prior to the interview along with permission for audio recording to enable accurate transcription. The opportunity for respondents to withdraw from the study, or to have their data withdrawn, up to a specified time (the point that the thesis was being written up) was also offered. In this section I have accounted for my choice of data collection methods and described how these were employed. I will now go on to discuss the process of data analysis.

4.6   **Data analysis**

I was fortunate to have access to a small fund[3] which enabled me to have my interview recordings professionally transcribed. While Kvale and Brinkman (2009) state that the act of transcribing interview data can be described as an interpretive process in itself, I found the benefits of professional transcribing for accuracy and speed was pragmatically expedient. Respondents were invited to review their interview transcript, to check it accurately represented their views, with the option to add any further thoughts on the areas discussed. Five respondents took up the offer and none requested any changes or additions.

In reviewing the transcripts I was mindful of Kvale's (1996 p.182) concern that the conversion of audio-recorded interview data into typed transcripts may result in the original sense of the message conveyed within the interactive process of the

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[3] This was provided by King's College London School of Social Science and Public Policy 'Small Grants for Post Graduate Research', following a successful competitive application process.

interview being lost. This has the potential to occur where data is atomised into discrete units in the quest for a rigorous coding system and in which the 'social creation' of these units (including the role of the interviewer) may not be apparent. To help counter this, I listened to the recorded interviews on a number of occasions, before receiving the transcripts which helped with familiarisation with the content as well as re-visiting the interactive sense of the interview, for example through the nuances of verbalisation, hesitancies and laughter (where this occurred). These helped convey the flow and tenor of the interaction (as outlined by Kvale and Brinkmann, 2009 p.178). I also referred to notes made at the time of conducting the interviews, which attempted to capture the sense of the respondents' accounts, in terms of overall impression or particular points of note.

The transcribed interview data were processed using thematic analysis. This has been described by Braun and Clarke (2006 p. 79) as '…a method for identifying, analyzing and reporting patterns (themes) within the data'. They make a case for thematic analysis as a distinctive method in its own right, not wedded to a particular theoretic framework (as in the case of, for example, conversation analysis or grounded theory), which allows it to be used more flexibly. It enables a rich, detailed and complex account of the data to be developed with scope for both inductive and deductive analysis in its use. I found this prospect, along with the structured but not overly complex process of thematic analysis more suited to the aim of the study and to my approach to analysis, than a classic grounded theory approach such as that set out by Strauss and Corbin (1998). It was also consistent with a constructionist epistemology which explores the relationship between the meanings respondents' ascribe to their experiences and the relationship of this to wider discourses.

Braun and Clarke (2006 p. 87) outline a six phase process of thematic analysis as follows, which I used to guide the analysis process:

1) *Familiarization with the data:* Transcribing, reading and re-reading data, initial notes.
2) *Generating initial codes:* Coding interesting features of the data systematically and across the entire data set.

3) *Searching for themes:* Collating codes into possible themes, creating themes and gathering all data relevant to these.

4) *Reviewing the themes:* Iterating and checking if the themes work in relation to the coded extracts across the data.

5) *Defining and naming the themes:* On-going analysis to refine each theme with clear definitions. Considering the story the data will tell.

6) *Reporting the findings:* The final analysis using selected extracts, relating analysis to research question and literature, resulting in scholarly report of the analysis.

I familiarized myself with the data by listening to the recorded interviews and reading through the transcripts, jotting down initial notes and impressions. I then set about generating preliminary codes by reading through each transcript and selecting particular statements or words that appeared of interest or significance, or what Boyatziz (1998 p. 1) refers to as 'codable moments'. In doing so I began to label and categorise the content of my data. I mined the full transcripts of all the interviews in this way, so that the initial coding was exhaustive and to guard against selecting only statements that more readily stood out as relevant. Such an inductive approach helped me cultivate an openness to the data from which themes could be developed, rather than trying to 'fit' the data into any pre-existing thematic concerns which might stifle or narrow the analytic process. I began by hand coding four of the transcripts to create an initial code list and to get a further feel for the data. I then used the NVivo software package to store, organize and complete the coding of all the transcripts. The codes were refined through a process of merging and deleting to arrive at a final version. Using these, I began to formulate a number of provisional themes to capture the meaning of the data at a broader level. This proved a complex process, requiring repeated iteration between the transcripts, codes and the themes themselves, resulting in further merging and refinement until I arrived at a finalized set of themes, which form the basis of my analysis and discussion. Survey data was analysed by thematic analysis of free text comments and utilising the survey software package to generate simple numeric tables of results. So far in this chapter, I have outlined the congruence of my epistemological perspective to the nature of this enquiry and discussed the data collection and analysis processes. The findings

generated from this process will be discussed in Chapters 5-8 in relation to a range of analytical and theoretic perspectives. I will now describe how I attempted to achieve methodological rigour during the research process.

4.7 Methodological rigour

Throughout this report my aim has been to demonstrate a logical and accountable process in conducting this study. This reflects Patton's (2002) view that 'The qualitative researcher has an obligation to be methodical in reporting sufficient details of the data collection and the process of analysis to permit others to judge the quality of the resulting product' (Patton, 2002p. 462). So far, I have attempted to meet this standard by providing the rationale for my approach and providing details of the methods used for data collection and analysis in order to arrive at the final themes, which form the basis of my findings and discussion. I will now discuss the measures I have taken to enhance the rigour of the study.

The use of the terms reliability and validity as markers of research rigour have been historically associated with a positivist scientific paradigm, which has raised questions as to their appropriateness in the context of qualitative enquiry (Kvale and Brinkmann, 2009). This has resulted in a re-framing of these concepts into a language and approach deemed more appropriate to qualitative enquiry, such as credibility; dependability and trustworthiness (Lincoln and Guba, 1985). As such, validity is taken to mean '… the truth, the correctness and the strength of a statement … A valid inference is correctly derived from its premises … A valid argument is sound, well-grounded, justifiable' (Kvale and Brinkmann, 2009 p. 246). The concept of reliability has been re-framed as 'pertaining to the consistency and trustworthiness of research findings' Kvale and Brinkmann (2009 p. 245) and point to it having a moral as well as a methodological role. I will now describe how I have attempted to apply these principles in conducting this study. I attempted to develop consistency in my coding, by using the 'NVivo' facility to describe what facet of the data a particular code refers to and where it should and shouldn't be applied. By providing a transparent account of how I derived my final themes through the grouping and refinement of codes, I have sought to demonstrate a logical process which can be

traced back to the original data source. By providing a 'process map' in this sense –
others can review and evaluate its coherence.

I have sought to illustrate how the inferences drawn from my findings can be traced
back to the data itself, through a process of analytic induction (Silverman, 2011). I
have done so by providing a sort of qualitative 'audit trail', demonstrating the
development of initial themes from coded data and memos and how these themes
were further refined, collapsed and combined (see Appendix 8). I have also provided
examples, through verbatim quotes from respondents, to illustrate how the findings
have been firmly grounded within the data. To counter the possibility of
anecdotalism, i.e. the selective use of data to illustrate particular themes or findings,
at the expense of other less 'interesting' or supportive data (Fielding and Fielding,
1986), I took care to code and consider the whole data set, described by Silverman
(2011) as 'comprehensive data treatment'. This helped with identifying instances of
data that might be considered as 'disconfirming cases' (Mays and Pope, 2000), so
that I could consider not only data which appeared to form part of an emerging
pattern or theme, but also that which offered more singular or contradictory
perspectives. To further strengthen the validity of the inferences drawn from the
findings, I was conscientious in moving iteratively between the data, identified
themes and analysis to check for coherence and verification. Implicit in a
constructionist approach is the active role of the researcher (Holstein and Gubrium,
1998). This is considered in the next section in terms of my own reflexivity and
potential for bias, aspects which are essential to the quality of the research.

4.7.1   *Researcher role - bias and reflexivity*

Kvale and Brinkmann (2009) stress the importance of acknowledging one's own
position in relation to the research process to avoid unintentional bias and as such, it
is important to acknowledge the motivations, views and position I brought to the
research process. Further to this, Janesick (1998) notes:

> The qualitative researcher early on identifies his or her biases
> and articulates the ideology or conceptual frame for the

study. By identifying one's biases, one can see easily where the questions that guide the study are crafted. (p.41)

My motivation for the study arose from my growing concern that the subject of clinical communication is being predominantly construed as skills-based activity, at the expense of a set of wider and more fundamental elements related to students' personal and professional development. Linked to this is the question of how the dominant discourse of skills and competencies prevalent in medical education might be contributing to this development. My personal standpoint supports a more encompassing approach to the subject, in which the key aim of developing humane and compassionate practitioners can be facilitated through the teaching of clinical communication and that this is not lost in the quest for producing 'easily measurable' markers of clinical competence. This position is reflected in the questions formulated for the study. Whilst acknowledging the role of my personal beliefs and professional experience in motivating and shaping the study I was aware of the need to be open and receptive to alternative constructions of current practice that would emerge during the study, formulated by colleagues with differing personal and professional backgrounds, who have developed their own perspectives and meanings. I was also aware that the extent to which I was embedded in the subject area, left me open to the bias of my own interpretations and presuppositions and that this would need to be carefully monitored and registered wherever possible, as a form of 'critical awareness' (Kvale and Brinkmann, 2009 p. 31). To counter this, Kvale and Brinkmann (2009) also propose that an acknowledged 'subjective perspective may…come to highlight specific aspects of the phenomenon investigated, bringing new dimensions forward, contributing to a multi-perspectival construction of knowledge' (Kvale and Brinkmann, 2009 p. 170). This taps into the potential advantage of my having a shared knowledge of clinical communication pedagogy, which at times may have served to enrich and develop the interview dialogue.

Given the centrality of interviews as my main method of data collection, I was mindful of the role I played in this process, in terms of the sorts of questions I asked, how they were framed and how I responded to participants. This was particularly important as the interpretivist approach differs from a positivist standardised survey interview technique, which seeks to minimise the role of the interviewer to that of a

'neutral' enquirer, utilising a set of pre-determined questions, without deviation (Silverman, 1998 p. 116). The interptretivist approach also challenges the view of respondents as somewhat passive 'repositories of facts and the related details of experiences' (Silverman, 1998 p. 116) waiting to be mined by the interviewer. By acknowledging the subject and agency behind both the interviewer and the respondent, the notion of bias can be more openly addressed. This is summarised by Silverman (1998) as follows:

> Any interview situation, no matter how formalized, restricted or standardized - relies upon the interaction between participants. Because meaning construction is unavoidably collaborative…it is virtually impossible to free any interaction from those factors that could be construed as contaminants. All participants in an interview are inevitably implicated in making meaning. (Silverman, 1998 p. 126).

This was reflected in my own interviews, which varied in the emphasis I placed on different aspects of the interview guide, in response to the accounts generated by the respondents and allowing flexibility within the interaction for deviations from the specified areas.

Given that respondents were aware of my own professional role, I wondered about be the possibility of institutional 'comparison' arising (either consciously or unconsciously) in wanting to present one's own curriculum or pedagogical practices in a favourable light, or not wanting to be openly critical of one's own institution or practices. On the other hand, as participation was voluntary, it may be that those who chose to respond were likely to be supportive of the exploration of current pedagogic practices and would engage with the process openly and non-defensively. In this section I have discussed the measures I took to meet acceptable standards of research rigour and accountability. I have also tried to incorporate a level of reflexivity to help raise awareness of my own role in conducting the study and in presenting the findings. I will finish this chapter by discussing the ethical considerations which arose during the research.

4.8 Ethical considerations

Prior to undertaking any data collection, I applied to the Education and Management Research Ethics Panel at King's College London University to seek approval for the study, which was granted in full. As my respondent group comprised lead faculty for clinical communication across UK medical schools, they were by nature, an articulate and expert group. This did not however detract from the need to provide clear and adequate information regarding the study to enable them to make a fully informed choice as to whether to participate. This involved the production of information sheets for both elements of the data collection process, i.e. the scoping survey and the semi-structured interviews (see Appendices 3 and 5) along with consent forms. The information sheets were designed to explain the purpose of the study to prospective respondents, the level of engagement required of them, information on data storage and use and how to seek further information if required.

My own status as a clinical communication teacher in a UK medical school also required consideration. As I was known to a number of them, I felt this might predispose them to help in my research effort. On the other hand, I did not want potential participants to feel personally 'targeted' to respond. The use of the UK Council blog to make a generalised request for participants prior to sending individual invitations helped demonstrate that all leads were being invited, rather than specific individuals being selected and helped ensure no pressure was put on them. As respondents were all established senior academics / clinicians, I felt this reduced the potential for power asymmetry between us, other than the fact that they were inevitably led by my research agenda in terms of the focus of the interview dialogue.

The issue of assuring respondents that they would not be personally identifiable in the reporting of the study required careful attention, as a combination of, for example, disciplinary background and medical school features could inadvertently lead to individuals being identified. For this reason, I have 'clustered' particular respondent features to safeguard individual anonymity. While some respondents

signalled that they would not mind being identified, this was not the case with all, hence the need to take the above measures.

4.9 **Conclusion**

In this chapter I have described the research process including my methodological strategy, the study design, access to and recruitment of participants and the methods used to collect and analyse the data. I have accounted for why I selected these methods over other potential options and discussed the measures taken to ensure a rigorous and accountable approach to conducting the study. I have attempted to demonstrate my reflexivity in the research process and how I have addressed the ethical issues which arose during the study.

In Chapters 5-8 which follow, I present the findings of the study, supported by relevant data extracts. Each chapter centres on an overarching category which has emerged from the data analysis as follows: Chapter 5) The nature and scope of clinical communication as a subject; Chapter 6) The aims of clinical communication teaching and key attributes of the graduating doctor; Chapter 7) Pedagogic practice - teaching and Chapter 8) Pedagogic practice - assessment. Each chapter comprises a number of sections reflecting the sub-themes of each category, derived from thematic analysis and supported by relevant data. In the final Chapter 9 I will synthesise the findings of the study and elucidate its contribution to the subject and implications for practice.

5 The nature and scope of clinical communication as a subject

5.1 Introduction

This is the first of four chapters in which the study findings are presented and discussed as outlined above. They are organised by category with their constituent sub-themes and are supported by illustrative data extracts. In this chapter I will discuss the findings which address the research objective of how clinical communication academics understand and construct the nature of clinical communication as a subject. To explore this area, respondents were asked during interview to describe what clinical communication, in their view, encompasses as a subject. Their responses are presented under the following themes which emerged from the analysis:

i. Clinical communication as tasks and skills
ii. Clinical communication as development of the personal and professional self
iii. The balance between skills / tasks and development of the professional self
iv. Authenticity and the counterpoise of the 'professional carapace'

Each theme is discussed in turn, along with their implications for pedagogic practice.

5.1.1 i) Clinical communication as tasks and skills

When asked to describe the scope of clinical communication as a subject, the majority of respondents [Int. 1-6 and 10] referred to a tasks and skills component, as exemplified in the following accounts:

> Well it starts off with doctor-patient communication, if you like, and the core skills and tasks of that process. And … it's particularly related to making the most use of that consultation in terms of both diagnostic accuracy and patient support and effective explanations. [Int.10]

A further example was provided by Int. 03:

> So there's a whole range; well, it's all the tasks, really. I
> often think about the sort of tasks, what's the task of this
> interaction at this particular point in time … So I think there's
> a whole variety of things that people might be doing at
> different times in different contexts.

These comments reflect the applied nature of communication within a clinical context, as the means through which a broad range of what are termed as clinical 'tasks' are accomplished through interpersonal interactions. They also reflect the 'tasks of clinical communication' element of the UK Council for Clinical Communication's curriculum consensus statement (von Fragstein et al., 2008), as part of the core recommended content for undergraduate curricula. Intrinsic to the task element identified by respondents was the acquisition of communication skills. These were described in the following terms:

> What we're trying to do is get them [students] to think about
> what they're saying and how they're saying it. And I guess
> that's where the skills come in because that is a tool, if you
> like, that they can use. We talk about cognitive schema. So
> you have a set of responses that you could make and they are
> the skills that you can draw upon. I could use reflection here,
> I could use summarising here, I could use checking here. [Int.
> 09]

Cognitive schema referred to by this respondent concerns the way knowledge about a particular concept is organised (Sims and Lorenzi, 1992). Schema are developed from experiences and may start relatively simply to grow into a complex network which includes how a person responds to particular stimulus (e.g. decision-making), by drawing on a learned response in the form of action or behaviour. What seems crucial here, as promoted by Int. 09, is the mindful application of such schema – which range along a continuum from flexible to more rigid. The application of a rigid schematic response, applied in this context, could result in a rote style of questioning or responding on the student's part (by way of a behavioural script), undermining attempts of personalised engagement and responsiveness to the patient. By contrast, a flexible schematic approach would allow for a more responsive mode of interaction. The following respondent described the skills component in more reductive, behavioural terms:

> The skills are a very different thing [to tasks]. They're … the
> very simple things that we teach students that we could
> probably teach them in six months. Which is the kind of
> building blocks of how you get there, so it's the know-how,
> it's the process of how you, kind of, get there … you know,
> the signposting, the open and closed questions, all those
> things that, frankly, a trained monkey can do. [Int. 01]

Despite this down-playing of skills as a relatively simple component of the subject, Int. 01 went on to acknowledge their essential role:

> But, if you don't have that [skills], you can't move on. And I
> accept that in the past people just didn't even have those
> building blocks. So they're important. [Int. 01]

These perspectives can be seen to resonate with differing conceptions of skills. For example Lum (2009 p. 41) cites Collins' (1991) view that the orthodox conception of skills has centred on 'simplistic behavioural objectives' as alluded to by Int. 01 above. This view tends to separate out 'know how' (the performance of X) from 'knowing that' which relates to underpinning knowledge (about X). However, Winch (2013) points to a more comprehensive view of skills which acknowledges the agency of the doer, and which resists the separation of performance from character attributes (such as judgment). This latter view accords with the application of cognitive schema to the performance of skills described by Int. 09 above. Whichever views of skills has been subscribed to, findings so far illustrate the central role that they are seen to play in the accomplishment of the instrumental function of clinical communication – i.e. conducting a range of clinical tasks. As further accounts will demonstrate, the skills element is not only viewed in instrumental terms, but also as a means of focusing attention on the patient as the centre of care, so that:

> At one level, you can take it [clinical communication] as a
> bunch of skills and techniques that you can teach students to
> make the whole thing easier for them … so that when they
> have to break bad news or deal with someone who's really
> cross with them…they're not all at sea. [Int. 02]

While on the other hand:

> There's also part of it which is about emphasising the patient
> perspective and thinking about actually what we are doing
> and what the purpose of what we're doing is. And, sort of,
> bringing them [students] back sometimes from …what is
> quite a doctor-centric process of hospital medicine … So
> that's the kind of … I wouldn't say hidden agenda but less
> overt than the other one. [Int.02]

In this instance we see how the skills agenda is presented as a more overt rationale for teaching the subject (i.e. equipping students to undertake the tasks of medicine), while the inculcation of a patient-centred approach as a professional value is made less explicit. How far this approach reflects the 'doctor-centric' ethos of this particular institution (as it is described by Int. 02) or is representative of a more pervasive approach in medical education will be considered further as the findings are discussed. I will finish this section with a final example of the situating of skills within a broader patient-centred approach:

> Yeah, and if they've [students] got the skills, which hopefully
> we've taught them, about how to do it and a wee bit about
> ICE[4] and perception of what's going on in a consultation,
> then hopefully they'll be able to be more holistic in how they
> do it. [Int. 08]

The extent to which students are able to marry these two components is not unproblematic however and cannot be assumed. For example, the holism referred to above can be seen to encompass the biopsychosocial approach advocated by Mead and Bower (2000), which may be outweighed by a more powerful biomedical focus within curricula (Hilton and Slotnick, 2005), or through assessment methods such as OSCEs, which by their nature privilege the demonstration of skills as a mark of learning.

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[4] The acronym 'ICE' stands for 'Ideas, concerns and expectations' and is a recognised framework for exploring the patient's perspective during a medical consultation. A concise summary of its use for this purpose is provided by TATE, P. 2005. Ideas, concerns and expectations. *Medicine,* 33**,** 26-27.

A differing perspective was offered on the association of skills with patient-centredness in this account:

> They [students] don't have a lot of teaching about patient-centredness. As I say, I'm more interested in teaching them about the skills, which … I know would demonstrate patient-centredness. In a way, I'm not that bothered whether they know whether it's demonstrating patient-centredness or not, I just want them … to use the skills. [Int. 06]

Int. 06 elaborated the rationale for this stance on the basis that knowing about patient-centredness, but not having the skills to operationalise it is not helpful for patients. So prioritising the skills aspect aims to ensure a patient-centred style of interaction – with the recognition of it belonging to a patient centred model of practice seen as a bonus. It is a salient point that theoretic knowledge - in this case of a patient-centred model of care – will not benefit patients if students are unable to translate it into practice through skilled communication.

So far, clinical communication as a subject has been expressly identified as central to a range of clinical activities described as tasks (such as gathering information, exploring ideas and concerns, explaining, gaining consent). Further to this, a skills element (in terms of tools and techniques) has been identified as necessary for the successful accomplishment of these tasks. As such, the subject has been described as having a practice-focused and instrumental purpose. It also appears, as illustrated in the examples presented above, that respondents tend to situate the task and skills element within a patient-centred model of care. Alongside this conceptualisation, a parallel theme emerged concerning the role of the subject in relation to the development of the personal and professional self and this is presented below.

5.1.2   ii) Clinical communication as development of the personal and professional self

Having identified a tasks and skills construct of the subject, respondents also described a number of other areas which they viewed as intrinsic to clinical communication, which I have grouped under the analytical category of 'development

of the personal and professional self'. These are presented in this section, drawing on findings from both the scoping survey and interview data. As part of the preliminary scoping survey, distributed to lead tutors for clinical communication in each UK medical school, respondents were asked the following questions:

Q.12 To what extent do you agree that clinical communication teaching should address areas beyond communication skills acquisition (such as attitude formation, development of self-reflection, exploration of the effects of personal values)?
Responses, on a five point scale ranging from 'strongly agree' to 'strongly disagree', were as follows: Out of twenty-one responses, 9 strongly agreed, 10 agreed, 1 was neutral and 1 strongly disagreed.

And:

Q.13 To what extent do you think your clinical communication curriculum currently addresses areas beyond communication skills acquisition?
Responses, on a five point scale ranging from 'minimally' to 'fully', were as follows: Out of twenty-one responses 7 thought teaching areas beyond skills acquisition was addressed to a good extent, 8 thought it was adequately addressed, 5 somewhat and 1 minimally.

While these results provided only a crude indication of respondents thinking around these areas, the data from Q. 12 did suggest very strong support (19 positive responses out of 21) for the idea that clinical communication should encompass a wider remit than skills development, such as attitude formation, reflection and the role of values and beliefs. The data from Q. 13 also suggested that a majority of respondents (15 out of 21) believed that these areas were being addressed to an adequate or good extent within their current communication curricula. The findings encouraged further exploration of these areas during interviews, both in terms of the sorts of areas deemed legitimate within the subject and the ways in which they are framed and constructed. The key themes arising from the interviews are presented below and include a number of challenges and reservations voiced by respondents in relation to a broader conceptualisation of clinical communication.

A range of elements deemed important for students' development of sensitive and capable communication, were identified by a number of respondents during interview (i.e. six of the ten). These included the role that attitudes, values, beliefs and emotions play in the development of the professional self and in day to day clinical interactions, as summarised in this comment:

> I think that clinical communication is not just about displaying a certain number of communicative skills. It's also about…one's attitude and one's thoughts and one's understanding. It's that whole package. And one's developing sense of your role as a professional and, well, what does that mean. Yes, so it's all part and parcel of that. [Int. 05]

This was echoed in the following comment:

> Clinical communication for me is very firmly associated with development of professional identity. And, for me, that's what's at the heart of it … which includes the whole piece on respect, Francis report outcomes, medical ethics, all of those sorts of areas. [Int. 04]

The role of beliefs was highlighted by this respondent:

> It's about your attitude, it's about your professional skills, it's about your worldview and your beliefs about what a patient and what this relationship is really about. [Int. 01]

And in these final examples, we see a reference to clinical communication as a vehicle for the development of insight, firstly into the role of personal values:

> So we need to find a focus through which students can think about their attitudes and their values, kind of almost discover them and work them out for themselves. [Int. 07]

And secondly, the impact of emotions:

> I think there are not very many places within the curriculum where students are encouraged to think about what they feel. And I actually think it's … clearly is a hugely important part of how you relate to patients, is how you feel about it. [Int. 02]

This selection of views provides a sense of a broader subject conceptualisation held by several respondents, encompassing professionalism, beliefs, attitudes, values and emotions. While the centrality of these areas to clinical communication was strongly voiced by some respondents, others were more ambivalent [Int. 02 and 06] as to how far the role of students' attitudes, values and beliefs should be questioned, as illustrated in this example:

> But if, fundamentally, they [students] think their patients are a waste of space and time, which they might, some of them, about some patients, to a certain extent I'd like to question that but that is their business. As long as they can do it right for the patient. [Int. 02]

This view resonates with Int. 06's previously cited view that students' intrinsic motivations or attitudes are of secondary concern provided they are seen to behave acceptably (in a professional sense) towards patients. These comments raise a discomforting point that while students may harbour negative or judgmental views towards patients or fail to relate empathically to others, these may not be addressed provided they are able to behave to a minimally 'acceptable' standard. This was further reflected in the following comment:

> Well, it's difficult to have a conversation with a student along the lines of "I don't like your attitude" … to me … that's not going to be very productive. Whereas saying "In the teaching session today … you didn't demonstrate the skills that we were focussing on" is a conversation I could have with a student. Now, whether you're not doing the skills is because of an attitude or a whatever … to some extent I don't particularly care. What I care about is that they start demonstrating the skills. [Int. 06]

On the one hand, this position can be viewed as pragmatic in that discussing observable behaviours with students is a transparent approach and may be sufficient in helping them amend unhelpful actions or incorporate missing elements into their interactions. On the other hand, not exploring the reasons which underlie students' behaviours may be to neglect an opportunity to open up discussion and reflection about the issues that give rise to the interactional difficulty. This stance was

congruent with the respondent's view that clinical communication should not be 'wrapped up' with areas such as attitudinal development, instead favouring a "*skills-based/task-based approach to the communication skills*" [Int. 06]. This preference for separating clinical communication (or communication skills) from a broader conceptualisation can be seen as contrary to that of other respondents whose views position the subject as integral to the development of a holistic professional identity and practice.

A further view that students need to be taught communication skills, as they are less likely to develop them though experience, whereas "*… we have to, to some extent, hope that the attitudes come along"* [Int. 06] was also expressed. While this reflects the reality that skills are eminently teachable whilst professionally or humanistically desirable attitudes may be less easily inculcated, the statement emphasizes the role of skills over attitudinal development. Such an approach may serve to further reinforce an educational culture that privileges the observable and measurable over the development of less overt but equally important elements of professional development. This privileging of skills has been promoted in terms of its perceived benefits for patients, based on the premise that however well-intentioned a clinician may be, if they are not possessed of communication skills, they will do their patients a disservice. Whilst there is merit in this argument, the counterpoint that a clinician schooled in communication skills but lacking in insight, reflectivity or a values-based approach may also do their patients a disservice may also be considered.

In this section, the findings related to clinical communication as a subject that encompasses the development of personal and professional insight, including the roles of values, attitudes, beliefs and emotions, have been presented. The findings reveal a tension between the balance accorded to a skills-based view of the subject and a broader values-based view, both between respondents and within individual respondents' accounts. They also raise the question as to whether the demonstration of 'acceptable' behaviour alone is too minimal a standard to aim for, where the stakes of humane medical care are so high. If so, the role of 'non-skills' elements (as identified above), assume significant importance. As this debate is of particular relevance to the study objectives of a) how clinical communication academics

understand and construct the nature of the subject and b) which elements of clinical communication predominate in undergraduate curricula, further data pertaining to the origins and nature of this debate are presented in the next section.

5.1.3 *iii) The balance between skills/tasks & the development of the person as professional*

The nature of clinical communication as comprising both a skills-base and a range of broader components relating to the personal and professional self has emerged so far as a notable feature in the data. The following accounts lend context to how these differing elements may have become separated, by tracing the trajectory of the subject from its emergence in the medical curriculum. The early adoption of a skills approach to the subject was seen by this respondent as a pragmatic strategy in order to achieve its acceptance in the wider medical curriculum, as stated thus:

> It's also become a skills agenda, which is superficial. It isn't about skills. Skills are a tiny part of what we do and I suspect that it was hooked onto a skills agenda because it also made it acceptable to the medical education community if you talk about skills learning rather than all this other stuff [i.e. values, beliefs; attitudes] [Int. 01]

The situation described above can be seen as symptomatic of a traditional culture in medical education which promoted an ethos of detachment and objectivity, over what Coulehan and Williams (2001) classify as the 'values of doctoring', including notions of empathy, compassion and altruism. The acquisition of skills, associated with techniques and processes, sits more comfortably within the former paradigm, removed from the less easily regulated areas of personal subjectivity. A further rationale for the adoption of a skills approach was offered in terms of its perceived efficacy of bringing about change in practice, described thus:

> Well, it's easier to get people to buy in through skills than through attitudes. And so perhaps people saw if you had skills that … they might change their attitudes but if you tell people to change your attitudes they don't necessarily change their skills. And that's where we were coming from while we were promoting this very heavily skills-based approach. [Int. 10]

This respondent also explained favouring a skills-approach as a result of previous teaching experience with post-graduate doctors. This had involved regular discussions of how to better 'understand patients', but these were not deemed productive in achieving this aim, largely because of a lack of skills or 'know-how' to operationalise the intention. In other words, attitude or intention alone was not sufficient to develop communicative ability, whereas training in communication skills could bring about overt changes to the process of the clinical interaction. This underlines a tension between acknowledging the role of attitudes (and other values-based elements) and a desire to effect tangible change in practice through the development of skills.

The concerns outlined previously in Chapter 3 (Hanna and Fins, 2006, Talbot, 2004) that a skills-based approach risks superficiality (such as indicated by Int. 01above), was countered by Int.10, who argued that the promotion of patient-centredness – in this case via a skills route – lends the skills approach a moral foundation:

> After all, the skills that we propose are - would be very
> different if you were running a paternalistic medicine course.
> Now, of course we happen to think that the evidence is on our
> side, which it is, but there is a moral view of what we should
> be teaching – a patient-centred approach – which does have a
> lot of evidence attached to it. [Int. 10]

As suggested here, many of the 'skills' which are taught implicitly promote a patient-centred style of consulting (e.g. question styles to explore patients' perspectives; attentive listening; demonstrating empathy). Having emphasised the evidence-base supporting a patient-centred approach (in terms of clinical outcomes / patient satisfaction) Int. 10 further commented that even if there was a lack of evidence:

> I sort of still would take the moral position it's the right thing
> to do and so there must be some attitudinal issue that
> underlies what we do.

And a similar view was voiced by Int. 02:

> I think there's an underpinning set of values that you run the
> sessions on … And those sets of values are implicit, and
> sometimes explicit, in communication skills teaching.

The implication of these statements is that a skills-based approach to clinical communication, when situated within a patient-centred model, confers a more complex construct than that of behaviourism, grounded in a moral basis. However, the implicit nature of this grounding, as indicated in the preceding accounts, may risk it being obscured or eclipsed by the focus on skills and tasks outcomes. This issue will be returned to in the discussion section of this chapter.

The findings reported in this section suggest that respondents align themselves more or less strongly to a skills / tasks-based view of the subject or to one which incorporates the development of the person as professional. However, they all acknowledge the role that both these elements play in their construction of the subject. What is at variance is the weighting respondents accorded to these elements which may be influenced by their personal, professional or institutional preferences and values. This variation has implications within the subject field as to how curricula and pedagogy are determined and, by extension, how the subject is perceived in the wider sphere of medical education. The extent to which these differing alignments are seen to influence curricula and pedagogic practice will be reported and discussed in chapters 7 and 8. To complete this chapter I will present the findings relating to the notions of authenticity and engagement in clinical relationships and how these aspects contribute to respondents' views of clinical communication as a subject.

5.1.4   iv) Authenticity and the counterpoise of the 'professional carapace'

In this section I will present respondents' views on the notion of clinician engagement and authenticity in their relations with patients and how this relates to the nature of clinical communication itself. I have used an 'in vivo' quotation – 'the professional carapace' - from Int. 02's transcript as it seemed to capture the sense of a protective guise assumed by clinicians when interacting with patients. In the data presented here, the carapace serves as a means of 'shielding' patients from the

vagaries of clinicians' moods; emotions and instinctive responses. Although not a feature in the current data, it can also be seen as a mechanism to limit the perceived risks of emotional engagement in the clinical encounter. The insights gleaned from this theme further contribute to the research objective of capturing respondents' views on the nature and scope of clinical communication, particularly in relation to the role that exploring and incorporating dispositional elements (including emotions and self-awareness) can play.

I will begin with this account which illustrates how the notion of the professional carapace is formulated:

> I quite often talk to them [students] about the fact that a lot of
> it [how they respond to patients] has to be deliberate. Your
> heartfelt empathy is going to be so much better when you're
> well-rested and not stressed and have had some food … than
> it is half an hour after a shift is meant to end, when you've
> missed the canteen…and this patient is yet another one who's
> taken an overdose. And, yeah, actually you can't rely on
> what you feel. You have to wear the things that make the
> patient see you as an empathetic, listening, caring doctor.
> That has to be a professional carapace almost. [Int. 02]

The rationale for the carapace is founded on the premise that a patient's experience of their doctor's communication should not be compromised by the doctor's mood or mind-set on any given day. The reference to the 'wearing of' responses that are seen to denote caring and empathy suggest the use of surface displays (or acting in a patient-centred way as discussed in 5.1.1) rather than the development of embodied responses (or being patient-centred). This points to a disjuncture of sorts between the doctor's behaviour and their underlying emotions or engagement. Int. 02 elaborated this issue:

> That has to be something that you project [i.e. caring;
> empathy], even when you don't feel it. It's great if you do
> feel it, and feeling it is going to make you be able to do it so
> much better but, nevertheless, you've got to know how you
> are doing it, how to do it, so that you can always do it.
> Because it's far too important to be dependent on your mood
> and your mood will change … And I'm not sure I always
> manage to get that across but that's, kind of, what I feel, that
> I'm teaching them some skills about how to appear.

The idea of the carapace was echoed by Int. 10:

> To a certain extent what we do day-in, day-out is put on this
> face to the outside world. Whether you, you know, you come
> to work, your child is in trouble at school or something, and
> you actually you just, put on a Disney World public face.
> And to a certain extent that is acting, isn't it?

While at times the projection of certain responses (whether genuinely felt or not) may well be necessary for a doctor to be able to function professionally in challenging circumstances, notions concerning the wearing of appearances or acting require careful consideration so as not to become unchallenged norms of how clinicians may relate to patients. The risk of such an approach lies in masking a dissonance between how the clinician feels and how they learn to appear, which may not be a constructive long-term approach to managing the challenges of clinical practice. The question also arises as to whether the adoption of a carapace by clinicians is apparent to patients, as suggested in this example:

> And that classic one of students saying, "That must be really
> hard" [to a patient] and then, you know…"I've shown
> empathy by saying 'that must be really hard,'" but the way in
> which they do it couldn't be less empathic, really. [Int. 08]

This illustrates how a 'learned' empathic response can be undermined if the patient perceives it to lack authenticity. The potential disparity between skills acquisition and the development of authentic engagement with patients is further illustrated in this account:

> The more concrete example, to me, is things like how much
> should we be teaching them [students] about empathy and
> being empathic. Now, I feel like we can teach them skills, if
> you like, to appear to be empathic, like we teach our students
> to use summaries, so that they are demonstrating that they
> understand the patient. Now, of course, whether or not, they
> truly understand? [Int. 06]

Int. 06 also discussed the ways in which students are encouraged to develop empathic insights into patients' circumstances, for example by visiting them at home to get a keener sense of their situation. However, there was a sense that the

development of genuine empathy was more of a 'hoped for' than anticipated outcome and was deemed less crucial than the ability to behave in ways that attempt to convey empathy (felt or otherwise).The risk of inauthenticity incurred through 'coaching' in communication skills without genuine engagement was recognised in the following example:

> But you can also see people doing the steps and you can tell
> that they don't mean it, and I'm sure the patients can tell that
> as well. [Int. 10]

This highlights the risk of framing teaching in terms of 'how to appear', in that the surface element is emphasised over the development of genuine engagement. A different perspective, which emphasised the importance of students developing their own personal styles of communication in relation to the kind of doctor they want to become, is offered in this account:

> To think about how this works with who they are and their
> personality and what sort of clinician they want to be. And I
> suspect that derives from a kind of fundamental idea that the
> way that people communicate has to be right for them and
> otherwise it's just not going to work. People are going to see
> through it. It's going to come across as forced and artificial.
> [Int. 07]

This view that patients are sensitive to the authenticity of clinicians' communication calls into question the proposed benefits of the professional carapace. Instead, it favours an approach to communication that takes account of the personal disposition of the student and how this can be melded with the development of their professional self. This may require more focus on self-awareness and consideration of the nature of clinical relationships, than that of adopting a specified skill set.

In summary, the findings presented in this section highlight the tension which exists between the notion of the professional carapace and that of developing students' sense of genuine and authentic clinical communication. While the rationale presented for the use of a skills / carapace approach, is that it aims to ensure a consistent and 'appropriate' response to patients, it may give rise to the unhelpful consequences outlined above. An alternative view has also been presented, whereby students

consider both their personal traits and professional identity in order to foster a less formulaic approach to communicating with patients.

5.2 **Discussion**

A key issue to emerge from the findings presented in this chapter is the tension between two key constructs concerning the nature and scope of clinical communication. The first, described in terms of the development of communication skills in order to accomplish a range of clinical tasks, may be termed an instrumental construct. The second, pertaining to clinical communication as a facet of personal and professional development presents a wider construct, which includes consideration of the role of values, beliefs, attitudes and emotions. The tension arises where the instrumental construct - associated with a skills approach - is seen to outweigh the broader construct, and is seen to give rise to a superficial view of the subject (as expressed by Int. 01 & 10). This resonates with the wider educational debate, sketched out in Chapter 3, concerning the epistemological nature of skills. For example Winch (2010) outlines differing conceptualisations of skills, from an impoverished 'deflated' technical view through to an 'immoderately inflated' view in which, he argues, skills are inappropriately applied to interpersonal situations of 'moral worth'. Lum (2009) points to the dual requirement in vocational education that the acquisition of skills is set within a wider adoption of professional values, whereby clinicians comes to care about what they do. This position was echoed in relation to the teaching of communication in the following comment:

> I do think there's a danger of just being so skills-ish that it
> becomes reductionist. But I don't think ever anybody who
> did skills teaching really felt that they were not doing
> intentions and attitudes and beliefs, it was just a way in there,
> I think. [Int. 10]

The situating of communication skills within a patient-centred paradigm may also be seen as a means to counter a superficial view of a skills approach, by associating it with the enactment of a certain kind of doctor-patient relationship that is not devoid of concern for participants' values and perspectives. Furthermore, the idea of patient-centredness (as a repository of associated skills) was also mooted as a moral

imperative for clinical practice [Int. 10]. What might be helpful here, is to consider what could strengthen the claim for a moral basis to patient-centredness and make more apparent the 'underlying set of values' [Int. 02] that underpin the skills element of teaching.

Duggan et al. (2006), concerned with the lack of explicit moral grounding for patient-centredness, provide a theoretically oriented suggestion for how this might be cultivated. They argue that 'It is only through understanding *why* we ought to behave in a certain way that we can fully embrace it' (Duggan et al., 2006 p. 275). They suggest a number of theoretical bases for the justification of patient-centredness as a moral concept, namely: a) consequentialism; b) deontology or c) virtue theory. The implicit application of consequentialist moral theory can be seen in Int. 10's reference to the 'evidence-base' for the use of patient-centredness and the notion that it is morally justifiable because its consequences are proven to be (clinically) beneficial. Duggan et al. (2006) point to the parallel of a consequentialist approach with 'evidence-based medicine' in terms of clinical outcomes being the key influence in decision-making. This however may not fully satisfy our justification for attributing a moral basis to patient-centredness, for what if (as suggested by Int. 10) evidence – in terms of clinical outcomes – were not available; would we abandon it as an approach? This suggests that a consequentialist approach may not be adequate in offering a full enough justification for its adoption.

So what of an argument for the intrinsic good of patient-centredness in terms of the kind of relationship it aspires to between doctor and patient? The use of deontological theory could be applied here in favouring actions for their intrinsic 'rightness', rather than their consequences per se. This theory can be seen to underpin current codes of ethics and professionalism in healthcare in as far as they set out accepted (or normative) standards for inter-personal care and 'doing the right thing'. The idea of the doctor-patient relationship being of intrinsic worth (beyond overt clinical outcomes) fits with the ideal of the 'therapeutic alliance' identified by (Mead and Bower, 2000) as a feature of patient-centredness which is of value in and of itself, embodying respect for others, and informed by a moral duty of care on the doctor's part.

The third approach suggested by Duggan et al. (2006) is virtue theory and is presented as something of a 'middle ground' between consequentialist and deontological theories as it does not prioritise consequences as a determinant of right and wrong, nor does it impose compliance with rules out of a sense of duty. Instead, virtue theory encourages the development of attitudes and qualities which inform the enactment of 'good' and 'right' through behaviours. As such, it recognises the interplay of attitudes and behaviours, which is salient to the current attributes and values / skills discussion. They posit that in order to be truly patient-centred, one needs to possess certain attitudes and values. These include, for example, the belief that all patients are unique individuals of worth; that they should be treated with respect and dignity; that their preferences and values should be sought and acknowledged and so forth. Possession of these attitudes and values can then be enacted in one's dealings with patients. On the other hand, they suggest one may act in a patient-centred way (e.g. through applying learned skills and strategies) without assuming such attitudes, but this is not *being* patient-centred – a point which resonates with the adoption of the 'professional carapace'.

What emerges from this discussion is that a cogent case can be made for a moral foundation for the relational model of patient-centredness. This can be drawn upon to frame the 'broader' construct of clinical communication involving the role of values and personal qualities and in which to situate the skills component of the subject. In this way, students may develop ways of 'being' patient-centred, with the acquisition and application of interactional skills as the means through which it is enacted. A further perspective pertaining to 'skills' / 'character formation' constructs (or the 'development of the professional self' as I have coined it), can be found in McNaughton & LeBlanc's (2012) discussion of the role of emotions in medical practice:

> A character formation perspective describes emotion and its management as a component of an individual's values, attitudes and beliefs. Internalised attributes and characteristics defined according to professional ideals are nurtured and abstracted into competencies. The idea of competency as a set of skills focuses on 'doing the right thing', while the idea of emotion as a unique aspect of one's

character focuses on remediating the internal moral ethical
landscape of the individual, or 'being the right thing.
(McNaughton & LeBlanc, 2012 p. 88)

This perspective has relevance for the interplay between skills and values-based elements (the latter being central to the development of the professional self), identified as core constructs of clinical communication. It can also be read as endorsing a virtue theory approach, as outlined by Duggan et al. (2006) above, which promotes the development of personal qualities and dispositions to inform behaviours and actions.

5.3 Conclusion

In this chapter I have presented the findings relating to how respondents construct the nature and scope of clinical communication as a subject. We have seen how respondents' views fall broadly under two themes. The first reflects an instrumental view of the subject, which centres on its role in the accomplishment of a range of clinical skills and tasks and which was cited by all respondents. This element was also associated with the model of patient-centredness, although differences in emphases emerged as to the balancing of this concept against skills acquisition. The second theme, emerging from the majority of respondents' accounts, simultaneously situates the subject within a broader conceptual framework than that of task-accomplishment. This broader construct encompasses a range of elements (including values; attitudes and beliefs) and their role in the development of professional identity. Findings also suggest a complex interaction between these two constructs, with both being acknowledged as constitutive of the subject. An additional theme, presented under the rubric of 'authenticity and the counterpoise of the professional carapace' has also been discussed and feeds into the debate concerning the balance between skill and character-formation approaches. The role of patient-centredness in harnessing attitudinal and values-based elements of practice and within which the skills element may be nested was also discussed.

The sum of these themes raises a fundamental question as to how far clinical communication as an academic subject is, or should be, concerned with the

development of personal and professional values as well as equipping future clinicians to be proficient across a range of clinical tasks. The work of Duggan et al. (2006) and McNaughton and LeBlanc (2012) have been drawn upon to illustrate the potential of ethics theory and character-formation perspectives to enrich conceptualisations of patient-centredness and clinical communication. This challenges the view of communication as a competency derived from a set of skills that enable a 'doing' of clinical communication, in favour of the idea of clinical communication as a form of practice born of the individuals' attitudes, values and beliefs, that can be examined and refined through the exercise of ethical and moral reasoning. In the next chapter I will discuss the study findings relating to the aims of clinical communication teaching and what respondents identified as the key attributes of the graduating doctor.

6 The aims of clinical communication teaching and key attributes of the graduating doctor

6.1 Introduction

So far, findings related to the research objective of exploring how lead tutors formulate and construct the nature of the subject have been presented in Chapter 5. In exploring this area, a further category was identified relating to what respondents considered to be the aims of clinical communication teaching. Though not directly asked to identify teaching aims, they arose naturally during discussion of the nature and scope of the subject and are presented here as additional insights to the subject field. Respondents were also asked about the attributes they would want their graduating doctor to possess and how clinical communication teaching might contribute to their development. The resulting findings, presented in this chapter, shed light on the role that clinical communication is seen to play in the overall formation of our future doctors and allows for the relationship between i) identified teaching aims and ii) key graduate attributes, to be examined.

6.2 Aims of clinical communication teaching

The key aims of clinical communication teaching identified by interview respondents were grouped under two main themes as follows:

To help students learn to:
   A. Manage clinical situations
   B. Develop communicative capability marked by:
      a. A responsive and flexible approach to communicating with others
      b. An analytical perspective
      c. The judicious application of learning to practice

These are discussed in further detail below.

6.2.1 A) Learn to manage clinical situations

One of the primary aims of teaching cited by respondents was enabling students to develop strategies and approaches to manage a range of clinical communication tasks, which accords with the instrumental construct of the subject identified in the previous chapter (5.1.1). These included, for example, the ability to elicit an accurate medical history from patients; explaining or giving information about diagnoses and treatments; communicating with patients who have a sensory impairment or whose first language is not English; negotiating with patients and colleagues. This range of tasks corresponds with curricular recommendations from the GMC (2009) and the UK Council for Clinical Communication (von Fragstein et al., 2008). In particular, preparing students to respond to more challenging communicative situations was cited by a number of respondents [Int. 2-6 & 8-9], for example:

> Where they're [students] dealing with situations that are
> difficult for them, like it's a sensitive situation or it's
> embarrassing or there are strong emotions because there's a
> kind of a category of situations which are difficult for
> students to deal with. [Int. 05]

Teaching was viewed as providing an opportunity for students to prepare themselves for such difficult encounters, as in this example:

> So … it's about how you learn to manage certain situations.
> And often they [students] will then choose to do something
> like that in the breaking of bad news course; they want to try
> out a situation because they don't know how they'd handle it.
> [Int. 03]

This comment highlights the interplay between the tasks element of the subject and the development of personal and professional resources to deal with the emotional challenges this may present. The aim of preparing students for these situations might therefore include consideration of the role of emotions and of empathy, as described below:

> I quite often challenge them [students]: 'Why do you think –
> you know, you were saying that you sensed that the patient
> was anxious about something – why do you think you then
> said, "Have you got any allergies?" And they often say,
> "Because actually I was terrified of exploring that." And then

there can be a very nice discussion about why do we think
we're scared about talking about these kind of things. [Int.
09]

Learning to 'manage' these types of situations and tasks was seen to require the
development of particular capabilities and helping students to achieve these was
described as a further aim of teaching. Respondents' views concerning this aspect are
collated under the heading 'developing communicative capability' and are presented
below.

6.2.2 B) Develop communicative capability

A number of themes emerged concerning how teaching aimed to help students
achieve capability to manage the clinical tasks and situations outlined in the previous
section. These have been grouped under the following sub-themes: i) developing
flexible approaches to communicating with others; ii) developing an analytical
perspective on clinical communication and iii) the ability to judiciously apply
knowledge and learning of clinical communication to practice. Each sub-theme will
be discussed in turn below.

i) Developing flexibility

The aim of helping students to develop a flexible approach when communicating
with others was explicitly articulated by half of the respondents [Int. 03-4; 7; 9; 10]
during interview, as in this example:

Teaching flexibility, actually, if you want to sum it up in two
words, is our challenge actually. [Int. 04]

The notion of flexibility centred on students being responsive to the individuality of
each patient and the communicative situations they encounter. This fits with a
patient-centred approach (Mead and Bower, 2000) in which patients' concerns,
wishes and preferences are central to the clinical interaction and require a
personalised response on the part of the clinician. The following example describes
how this tutor tries to instil such an approach:

You [the student] could have this conversation with six different patients and actually take six different types of approach and all of them could potentially be appropriate and plausible. And I try and put it to them in that way … 'If you actually stop and think about what you might do with that person in front of you' … if you're thinking about the other person's needs, that you will come up with something that's thoughtful. [Int. 04]

This emphasis on flexibility was reiterated in this comment:

That message is kind of getting through a bit. We're not trying to turn you [students] into robots that all trots out the same phrase at the same point in a consultation. That's not what we're trying to do. What we're trying to do is make you think about how you're communicating so you can do it flexibly. [Int. 09]

The focus on developing a flexible and thoughtful approach expressed in these accounts can be seen as a reaction to a formulaic style of communicating that is sometimes apparent in students' interactions. This may emanate from 'recipe-book' style learning (alluded to by Int. 09), gleaned from overly skills-oriented instruction or from OSCE revision type texts. One means of cultivating a flexible approach in students was deemed to be the development of an analytical perspective towards their own and others communication. This was identified as a further aim of teaching and is discussed below.

ii) Developing an analytical perspective:

A further aspect of communicative capability, identified by three respondents [Int. 2; 3 & 9] was couched in terms of encouraging students to be analytical of their own and others' approaches, as exemplified here:

I'd like to get them [students] to go away from the sessions and be critical, critical as in analytical. So that when they are sitting in a clinic and they think, "That was so skilled," I'd like them to think what is it, what did the doctor do that was skilled, what made that consultation really work? … Or, if they're in a clinic and they cringe, then what made them cringe? Why did the communication misfire at that point? And to really think about what they will do themselves when they're in a similar situation. [Int. 02]

The following statement illustrates how teaching methods, in this case experiential, aim to foster this sort of analytic approach:

> And the workshops with simulated patients are partly getting
> them to go through the process of thinking about what they're
> seeing and why they're seeing it and how they're seeing it.
> To actually get them to do that so that when they go and
> speak to somebody they're not just reeling out something.
> [Int. 09]

A further respondent referred to teaching as providing a 'language' with which students can analyse communication [Int. 02]. Differing tools of analysis have been developed for this purpose, such as the Roter Interactional Analysis System (Roter and Larson, 2002) or the application of discourse analysis (Roberts and Surangi, 2005), though these have not been widely utilized within undergraduate medical education, most probably because their application is relatively complex and time intensive, making them more suited for applied research purposes. However, a more recent innovation, in the form of an e-learning package (Li et al., 2014) for applying sociolinguistic analysis to the medical consultation has been developed for use in undergraduate teaching. Cultivating this analytic bent can be seen as necessary to the wider goal of reflective practice, as a facet of professional development (Schon, 1983, GMC, 2009).

iii) The judicious application of learning to practice.

The application of learning to practice can be seen to cover two areas identified by respondents. The first concerns the application of knowledge (either theoretical or evidence-based) and the second, the transfer of 'practice' developed through experiential learning. The question of what constitutes clinical communication knowledge can be considered something of a moot point. As discussed in 2.4, the subject tends to draw on differing disciplinary sources to provide theoretic perspectives applicable to the area, particularly from the field of psychology. The application of a conceptual model from that source is described in this account:

> There are several lectures on like Prochaska and
> DiClemente's stages of change model. And there's some
> elements of motivational interviewing in some lectures as

> well. And we're getting them to explicitly bring that
> information along to the sessions and think about that and use
> it. [Int. 09]

One other respondent (Int. 07), also from a psychology background, made reference to introducing students to models from that field within communication teaching. Otherwise, the prevailing model of patient-centredness (as outlined by, for example, Mead and Bower, 2000) and consultation models - primarily the 'Calgary-Cambridge Guide' (Kurtz et al., 2003) – were reportedly used in teaching. Experiential teaching (which will be discussed further in 7.4.1), was identified as the predominant mode of teaching across the survey and interview data. It was used to provide students with opportunities to experience and practice strategies that would enable them to carry out specific communication tasks in practice. This was exemplified in the following statement:

> And if they are that rabbit in the headlights and their mind
> goes blank and they can't think what to say next, then they've
> been through the process of thinking about it and hearing
> other people's views on it. And maybe that modifying how
> they're thinking and so that they know, okay, this is what I
> could do next. It might work; it might lead me somewhere
> else. [Int. 09]

While the aim of teaching presented here centred on enabling students to apply their learning in clinical practice, barriers to this transfer of learning were also identified and will be discussed in section 7.4.2.

6.3   Summary of the aims of teaching

In summary, two aims of teaching emerged from the data. These were: A) preparing students to manage clinical communication tasks and challenges that they will meet in practice and B) developing communication capability marked by i) flexibility; ii) an analytical perspective and iii) a judicious application of learning. The aims associated with theme A) accord with the instrumental construct of the subject identified in the previous chapter. The main method of achieving this was through experiential teaching, involving simulated patients (or others) and clinical scenarios.

The potential of this method for addressing the broader aspects of clinical communication, such as the role of emotion and attitudes, which will directly impact the manner in which students undertake particular tasks, will be discussed in the next chapter. The aims associated with theme B) can be viewed as achieving higher order communicative capability (i.e. more complex than the acquisition of basic performative skills), including an analytic and flexible approach and a conscious application of learning in practice. In the next section I will present respondents' views of the key attributes of the graduating doctor, within which the role of clinical communication can be identified. This allows us to consider the relationship between the identified aims of teaching and the outcome in terms of the attributes of the graduate.

6.4   The key attributes of the graduating doctor

The findings presented in this section aim to address the research objective of eliciting how clinical communication was seen to contribute to the formation of future doctors. To this end, I explored during interviews which attributes respondents thought most important for their graduating doctors to embody. Their responses were grouped under five headings. These are set out in Table 3 along with the constituent elements of each attribute.

Table 3: Key attributes of the graduating doctor:

A well-rounded doctor embodying the following attributes:

a) *Clinically competent* – 'able' (including ability to communicate effectively – see below for specific communicative attributes); knowledgeable; able to manage time effectively; knows how to find things out.

b) *Communicates effectively* - able to relate to people; flexible (not formulaic); aware; exercises judgment; listens well; shares decision-making; explains in understandable way; thoughtful application of learning in clinical situation.

c) *Patient-centred* – able to 'walk alongside a patient'; empathic; kind; sensitive, understanding. Antithesis of doctor-centred or bio-medically centred.

d) *Personal qualities* – insightful of own beliefs and attitudes and effect of these; self-aware; reflective - able to learn from experiences; resourceful; confident; resilient.

e) *Professional integrity* – sense of commitment to do the best; honest; aware of own limitations; accountable; a role model of good practice for others.

These elements are discussed below.

6.4.1 a - c) The well-rounded doctor – competent and patient-centred

The overarching ideal of a 'well-rounded' doctor who embodies knowledge, competence and patient-centredness was conveyed by a number of respondents. This 'ideal type' was captured in the following description:

> It's someone who is … kind of well-rounded in that they are a genuinely helpful person, they know their stuff, they are confident and fluid and empathic … They will look after people and also they have this professional sense that they want to do the best. [Int. 05]

This vision captures a number of key attributes. As might be expected, it assumes a graduate who has achieved a sufficient level of knowledge and who is able to conduct his / her duties in a proficient manner. It also points to a number of qualities that were discussed in the previous chapter, under the theme of 'Clinical communication as development of the personal and professional self' (5.1.3 iii). The reference to a 'genuinely helpful' and 'empathic' person can be seen to fall within the suggested broader remit of the subject and its interplay with professionalism in having the patient as the priority of care and 'doing the best' for them.

Allied to communicating effectively, being 'patient-centred' was identified as a desired attribute, as in this example:

> So ideally they would be clinically competent but that would be wrapped up in the fact that they can communicate effectively with the patient and be very patient-centred. [Int. 08]

Comments relating to this aspect were associated with kindness, sensitivity and responsiveness to individual patient preferences. Int.01 likened it to accompanying the patient on their journey, which involved:

> Exploring and working and walking alongside a patient to help them to explore and manage their health and illness or disease or disability, or whatever it is.

Related to this, the ability to be 'flexible' rather than 'formulaic' and to be responsive to individual situations was reflected in this comment:

> I think someone who feels able to use their judgement and kind of step outside of – if the situation demands it – actually step out of what might be received wisdom and actually think through the situation for themselves, given what they see of the patient in front of them and being able to adapt and respond to that. [Int. 07]

Taking a critical (as in analytical) approach to the application of learning alluded to in this comment, reflects the higher order communicative capability set out in the previous section 5.2.1 B) as an aim of teaching.

6.4.2   d - e) The person as professional – attributes and qualities

The boundary between what might be considered personal qualities (such as possessing insight, or being reflective) and those considered as professional qualities (such as commitment to excellence or honesty) may be somewhat blurred and reflect the close inter-relationship between personal and professional qualities. Whichever category attributes are assigned to, these aspects have taken on greater significance within the rising profile of professionalism in medical education. This has been made all the more pertinent in light of recent lapses in standards of care and professional accountability, as exemplified by events in The Mid Staffordshire NHS Foundation Trust (Francis, 2013). Pertaining to this, having courage to report poor practice and to act as a positive role model for students and colleagues was identified and articulated by this respondent:

A resilient doctor, that's got the courage and confidence,
when appropriate, to stand up to or do something about
culturally ingrained poor role models. [Int. 04]

The need for resilience, couched as the ability to *'... stay committed to it without getting burnt out'* [Int. 03], was echoed by other respondents [Int. 3; 4 & 10] and thought necessary for doctors to learn to *'protect themselves'* from the demands of rising patient expectations and a 'creaking' NHS system.

Being insightful of their own beliefs and attitudes and the effect of these on their practice was also identified as a desirable graduate attribute, as described in this example:

And that's about somebody being a patient-centred doctor
who's sensitive to the needs of the patients but who's also
sensitive and has insight into their own beliefs about the
world. So it's not about pretending they're not there and it's
not about saying you're wrong, it's about saying you must be
aware of them because actually they're colouring everything
you do. [Int. 01]

Aligned with this, was the quality of being a reflective practitioner, articulated as follows:

I think an awareness of what might be going on and some
ability to reflect on that and to learn from things that go well
and things that don't go well. [Int. 03]

And finally, being resourceful and aware of one's professional limitations was also deemed desirable:

And, you know, ideally you have someone who is extremely
knowledgeable, up to date with their factual learning and
aware of the limits of their learning and … of where they get
more information from. [Int. 02]

These examples illustrate the wide range of attributes articulated by respondents and which are summarised below.

6.5 Summary of desired attributes of the graduating doctor

In summary, a composite view of respondents' ideal graduating doctor is one who, as well as 'knowing their stuff' in the sense of being medically competent, practices medicine in a patient-centred and professional way, which includes the ability to communicate effectively. Additional traits of self-awareness; sensitivity to the situation of others; reflexivity; the ability to learn from experience; honesty; accountability and resilience, were also deemed desirable. The classification of these traits as distinctly professional or personal is challenging and highlights the need to build the development of the professional self in relation to pre-existing personal traits and qualities.

6.6 Discussion

As outlined in the previous chapter (5.1.2), nineteen out of 21 survey respondents positively supported the idea that clinical communication should encompass a wider remit than skills development, such as attitude formation, reflection and the role of values and beliefs, while a slightly lesser number - fifteen out of 21 - believed these areas were being addressed to an adequate or good extent within their current teaching. Respondents discussed these wider elements at some length during the interview process but only one aspect was framed in terms of a teaching aim per se. This is quoted below in relation to teaching on diversity:

> So it's about awareness-raising and what we hope we're
> doing is raising thought to a higher level. [Int. 01]

Another respondent referred to nurturing students' sense of professional identity as an aim of teaching in these terms:

> We need to find a space for them to be able to do that. So I do
> … think of what we deliver as providing a structure for
> students to go through that process. [Int. 07]

So despite being identified as a core construct of the subject, teaching aims relating to the development of the person as professional, were minimally articulated. While

respondents were not directly asked to identify teaching aims, aims relating to preparing students to manage clinical situations and developing communicative capabilities, emerged organically during interview. This may suggest that while increasing awareness of the personal and professional self is recognised among respondents as intrinsic to the subject of clinical communication, its translation into explicit teaching aims is not as well developed as those relating to instrumental outcomes and higher order communicative capability.

The range of graduate attributes identified by respondents corresponds closely with those in the medical education literature pertaining to professionalism (see for example Hilton and Slotnick, 2005, Epstein and Hundert, 2002). As well as the requirement for competence in the domains of knowledge and skills, additional attributes associated with personal and professional qualities and traits are emphasised. In addition to the synergistic relationship between professionalism and communication suggested by respondents, the notion of a values-based approach to healthcare also bears relevance to this characterisation of the graduate. Rider et al. (2014) propose a set of five fundamental values (populated with relevant sub-values) as *'fundamental to the practice of compassionate, ethical and safe relationship centred care'* (Rider et al., 2014 p. 273). The five core values are: 1) Compassion; 2) Respect for Persons; 3) Commitment to Integrity and Ethical Practice; 4) Commitment to Excellence and 5) Justice in Healthcare. A number of areas referred to by respondents above are present within the associated sub-values, including self-awareness and reflective practice, flexibility, respect for others viewpoints / opinions / beliefs along with other facets of ethical and professional conduct. Furthermore, the authors make the case that skilled communication is intrinsic to the delivery of human values in healthcare:

> Values are realized and manifested in language and the interaction process. Skilled communication underpins healthcare interactions and relationships and, plays an essential role in making values visible. (Rider et al., 2014 p. 276)

As such, a values perspective may be considered a unifying construct for the 'broader' personal and professional attributes identified by respondents in this

chapter as integral to the development of patient-centred medical practice and which affirms clinical communication as essential to this process.

6.7   Conclusion

In this chapter the findings related to two categories were presented as a) the aims of clinical communication teaching and b) the key attributes of the graduating doctor. Exploring these areas contributes to the research objective of how lead clinical communication teachers understand and construct the nature of the subject and how it contributes to the formation of future doctors. In relation to the former, two key teaching aims emerged: i) developing students' communicative capabilities and ii) equipping students to manage a range of clinical communication tasks and processes. It was noted that despite the clear identification of both an instrumental (skills / tasks) element and a broader 'person as professional' element within the subject, the teaching aims which emerged from the data related more strongly to the former than the latter elements. This feature will be explored further in the next chapter.

The key attributes of the graduating doctor were embodied in a 'rounded' clinician, possessing a range of personal and professional qualities, who is clinically competent, incorporating the ability to communicate effectively and practice in a patient-centred and professional way. The mutually constitutive roles of clinical communication and professionalism have been highlighted. Further to this, the role of a values-based approach to healthcare in which clinical communication is central, has been suggested as a unifying construct within which to situate the broader (non-instrumental) elements of the subject which have emerged from the findings presented thus far. The following two chapters will focus on the findings related to current pedagogic practice in terms of teaching (Ch. 7) and assessment (Ch. 8).

7 Pedagogic practice - teaching

7.1 Introduction

So far have I presented the study findings relating to the nature and scope of clinical communication as a subject: specifically focusing on the aims of teaching and the key attributes of the medical graduate. These have illustrated the multi-faceted and complex nature of clinical communication in terms of both its instrumental value for clinical practice, its wider role in the professional formation of medical students and how it is perceived as a subject entity by teachers in the field. In this chapter and the next, I will present and discuss the findings relating to the broad analytic category of pedagogic practice. In doing so, I aim to address a key aim of this enquiry, i.e. how does and how could current pedagogical practice embody the complexity of clinical communication in undergraduate medical education? I have divided the category into two themes a) teaching and b) assessment. Under the heading of teaching the following sub-themes have been identified:

- Curricular structure and content
- The role of theory in clinical communication pedagogy
- Teaching methods:

    Formal classroom-based learning

    Practice-based learning – formal and informal

    Reflection and portfolios

The findings relating to these sub-themes are presented below.

As in the previous findings chapters (5 and 6), I have utilised selected data from the scoping survey (Appendix 4) to provide additional information to that elicited through interviews. This conveys a greater sense of the prevalence of particular curricular features and respondent views across the wider sample of twenty-two medical schools. Nine of those who completed the survey also participated in the interviews, allowing more in-depth insights to be drawn from their accounts. I will begin by presenting the findings relating to the first theme of curricular structure and content.

7.2   Curricular structure and content

Although respondents were not directly asked during interview to describe the structure and content of their curricula, a picture of this emerged as a 'by-product' in their responses to other areas of enquiry – most notably when they were asked what they considered to be the nature and scope of clinical communication. Additional information was gained through the scoping survey circulated prior to the interviews. I will discuss findings relating to the timing; duration and degree of curricular integration in section 7.2.1 and I will address findings relating to curricular content in section 7.2.2.

7.2.1   Curricular structure

Differing models of communication curricula were described by respondents, from a longitudinal mode of delivery (running through all years of the medical degree programme as a vertical strand (e.g. Int. 01; Int. 05), to what was described as 'front-loaded' – taking place mainly in the years 1-3 of the medical degree (Int. 02; 08; 09]. The latter cases tended to be in schools where the students completed the initial years of the medical degree at their 'home' institution, whilst completing the remaining, more clinically focused years at other selected medical schools in the UK. The distinct separation of a predominantly science-based 'pre-clinical' period, followed by immersion in clinically based learning has been described by Armstrong (1980) as typical of a traditional medical curriculum structure. Further to this, Atkinson (1977) identified markedly different pedagogic learning experiences for students within the 'pre-clinical' and 'clinical phases'. This can still be found where students in these 'split' curricula join in with the communication program of the second medical school, leading to a variable overall experience with differing emphases on formal clinical communication teaching in the 'clinical years'. This variation in structure persists despite evidence that longitudinal and helical structures, in which material is revisited and built upon over the span of the curriculum results in more effective and sustained learning outcomes than shorter, concentrated models (Bruner, 1977, Van Dalen et al., 1989, van Dalen et al., 2002a). It also reflects how the wider medical

curriculum structure may dictate that of the communication curriculum and how educational practice is dependent on wider institutional arrangements and constraints.

The degree to which communication curricula were described as integrated with other areas of learning also varied across respondent accounts. Here, Bernstein's theory concerning what he describes as classification and framing within curricula (Bernstein, 1971), can be applied as an analytic lens. Applied at a micro level to organizational structures such as curricula, Bernstein's notion of classification refers to the (symbolic) boundary strength which separates subject and knowledge domains. He posits that the degree of boundary strength indicates the degree of separateness between domains. While traditional style medical curricula have been associated with strongly bounded and segmented subject divisions, Atkinson and Delamont (2009) describe an increasing shift towards integration of differing subjects and domains, through a weakening of subject boundaries. This takes the form of horizontal integration, referring to integration across disciplines or specialisms occurring at any stage in the curriculum and vertical integration referring to the weakening or elimination of the pre-clinical/clinical split outlined above. One reason for this development can be seen to arise from regulatory recommendation by the GMC (2003) to lessen the division between clinical practice and biomedical science learning and the promotion of inter-professional education (IPE). This has resulted in the mixing of previously separate domains on a number of levels, for example at an interdisciplinary level – with medical students undergoing learning with other health care students. Such diffusion of subject boundaries between 'allied' areas such as clinical communication, professionalism, ethics, psychology and medical humanities is also now taking place. The challenge remains to further lessen the boundaries so that clinical communication becomes a visible and embedded part of clinical 'bedside teaching' where it frequently remains segmented from bio-medically focused instruction. Yet despite a wish for this type of integration, the concern that a softening of boundaries may result in loss of subject identity remain. This point is further elaborated in the following data.

Survey responses (n. 18) to the question of whether communication teaching was linked (a potentially 'looser' affiliation than integrated) to other areas of learning, are presented in Table 4.a) below. This revealed the highest levels of perceived linkage to be with clinical learning in terms of medical specialties and procedural and examination skills development, medical ethics and IPE, followed by psychology and sociology, with medical humanities being the lowest with five affirmative responses. The inclusion of IPE in the curriculum has been recognised as essential for the development of effective and collaborative clinical care (WHO, 2010, Thistlethwaite, 2012) and provides an avenue for the development of inter-disciplinary understanding and communication.

Table 4.a): Survey Q. 8 'Please select any subject areas from the list below that are linked with clinical communication teaching in your undergraduate medical curriculum:

LINKED - YES / NO	YES	NO	Total
Clinical skills – practical procedures (e.g. venepuncture, catheterisation)	83.33% 15	16.67% 3	18
Clinical skills – physical examination	83.33% 15	16.67% 3	18
Clinical specialities (e.g. paediatrics, obs. & gynae., A&E, General Practice)	88.89% 16	11.11% 2	18
Medical ethics	82.35% 14	17.65% 3	17
Psychology	83.33% 10	16.67% 2	12
Sociology	75% 9	25% 3	12
Interprofessional education	93.33% 14	6.67% 1	15
Medical humanities	55.56% 5	44.44% 4	9
Other	0% 0	100% 2	2

The interplay of communication with other subject areas was also reflected in interview accounts [Int. 5; 8; 9; 10] and was articulated thus:

> Communication in our curriculum is, it's partly a sort of a
> separate strand … You know, I can track its development
> through the course of the five years. But it's partly a subject
> that relates to other subjects, either because there's an overlap
> or because there is an overarching kind of concept that relates

to everything. So, for example, some aspects of professionalism. [Int. 5]

Returning to the survey data, when asked (Q. 8) whether subject linkage was explicit (i.e. joint teaching sessions – explicit linkage by tutor/lecturer) or implicit (taught separately – linkage may be minimal or assumed or tutor dependent), responses (n.16) were as follows in Table 4.b) below:

Table 4.b): Survey Q. 8 (continued) 'Please select any subject areas from the list below that are linked with clinical communication teaching in your undergraduate medical curriculum and whether this is explicit (i.e. joint teaching sessions – explicit linkage by tutor/lecturer) or implicit (taught separately – linkage may be minimal or assumed or tutor dependent):

LINKAGE EXPLICIT / IMPLICIT	EXPLICIT	IMPLICIT	Total
Clinical skills – practical procedures (e.g. venepuncture, catheterisation)	62.50% 10	37.50% 6	16
Clinical skills – physical examination	56.25% 9	43.75% 7	16
Clinical specialities (e.g. paediatrics, obs. & gynae., A&E, General Practice)	93.33% 14	6.67% 1	15
Medical ethics	66.67% 10	33.33% 5	15
Psychology	75% 9	25% 3	12
Sociology	55.56% 5	44.44% 4	9
Interprofessional education	69.23% 9	30.77% 4	13
Medical humanities	60% 3	40% 2	5
Other	100% 1	0% 0	1

These results illustrate that in this sample, certain subject areas deemed to be linked with clinical communication are not explicitly linked in the actual delivery of teaching. This is exemplified in the case of clinical skills teaching (both practical skills and physical examination) with only 10 out of 16 and 9 out of 16 (respectively) responses identifying teaching as explicitly linked; with 10 out of 15 for medical ethics and 5 out of 9 for sociology being explicitly linked. Similarly, though to a lesser extent, the other listed subjects showed deficits in explicit linkage to communication teaching, meaning across all areas an implicit assumption of integration is taking place, varying from 7% to 44% across the 'linked' subject areas

above. The disparity between perceived areas of linked learning and what is actually being delivered in an integrated way is of note, as illustrated in the following statement:

> And one thing that's come out time and time again when you ask students what's the most memorable, what has the most meaning, what's the most useful, or you ask them at post-qualification, looking back, what aspects prepared you and what didn't, the highest rated feedback came back from communication components that were embedded in something closely related to a clinical context. [Int. 04]

This resonates with previous research regarding the importance of integrating communication teaching with other areas of the undergraduate medical curriculum, particularly in shaping students' perception of the subject's relevance for clinical practice, rather than as a separate strand of learning (van Dalen et al., 2002a, Brown, 2012).

However, developing integrated curricula was reported to have its challenges in terms of finding out what is being delivered in other areas of the curriculum, in order to try to integrate it with communication [Int. 08]. Also, finding clinicians who place enough value on the communication component of clinical practice to integrate it overtly into their teaching [Int. 02] was reported as challenging. The findings in this area suggest that despite recommendations for 'best practice' in terms of curricular structure and integration of clinical communication within the wider medical curriculum, considerable variations exist in the extent to which they are met. It also raises questions as to how much actual integration is taking place in practice, rather than being assumed or aspired to, as reflected in the following statement:

> There is, you know, quite a substantive emphasis on professionalism these days and I think we need to think more about how we … how we map and link to that. At the moment we're largely expecting students to make the links, I think. [Int. 07]

This implies that the benefits of integration in terms of engaging students more meaningfully with communication teaching that is seen as relevant to clinical practice are not being fully met. Additionally, opportunities for fostering a broader

conception of the subject with associated areas such as ethics and professionalism may not be fully realised in current practice. Concerns were raised however [Int. 5; 10] that in adopting very integrated curricula, clinical communication may become less distinct as a subject:

> I mean, my worry is almost that it then becomes therefore invisible by becoming too – by becoming integrated, which is what we'd wanted, because there was a point when it wasn't. By becoming integrated it therefore becomes invisible. And my worry is that we actually then stop the focus on that conversation between that person and that patient, which you sit and you look at and you talk about. [Int. 05]

This illustrates the tension which exists between developing highly integrated curricula to enhance the relevance and scope of the subject and that of maintaining its distinctive profile (which has taken over two decades to establish). It also raises questions as to what is happening pedagogically in the field and the nature of clinical communication learning itself. I refer here to the idea that communication may be seen as a form of tacit learning (Eraut, 2000), woven into other areas of clinical learning (for example how the doctor communicates with the patient is implicit in carrying out a physical examination or gaining consent for surgery). In this way communication may be seen primarily as a form of embedded know-how, which is 'picked-up' throughout all aspects of clinical learning. The alternative is a view of clinical communication as a subject that requires its own propositional knowledge (theoretic or research-based) and conscious deliberation and reasoning in the mind of the learner (facilitated by the teacher) for them to be able to act efficiently on a communicative level in the field. This view of tacit learning can be related to the anxiety expressed above, that explicit clinical communication learning may be 'lost' in a fully integrated curriculum. Eraut (2000) also makes the case that explicit (rather than tacit) professional learning is necessary to improve future performance by critically evaluating the outcome of ones actions and to be able to communicate knowledge to another person. Therefore, it would seem that our pedagogic challenge remains one of integrating clinical communication learning in ways which illustrate its core relevance to clinical practice whilst maintaining its explicit subject identity.

7.2.2   Curricular content

An overview of curricular content gleaned from interview data is presented in this section. While the data does not constitute a formalised or exhaustive review of curricula content, it provides a sense of the material currently being delivered in this sample of UK medical schools. Much of the content referred to by respondents could be mapped to the content recommended in the UK Council for Clinical Communication (UKCCC) Teaching in Undergraduate Medical Education curriculum consensus statement (von Fragstein et al., 2008) (see Figure 1 p. 28 for illustrative diagram). While other consensus statements and guidance exists regarding the content of communication teaching (Makoul, 2001, Bachmann et al., 2013) I have selected the UKCCC statement on the basis of its specificity to the UK undergraduate medical education setting. A summary of the content referred to by respondents as delivered in their curricula is presented in Table 5 below and is mapped against the content domain headings of the consensus statement. The content relating to domains 1) – 4) i.e. 'Tasks of clinical communication'; 'Specific issues'; 'Communicating through different media' and 'Communicating beyond the patient', relate to the tasks and processes required of a medical graduate, thereby preparing them for the instrumental goals of clinical communication. The content assigned to domain 5) 'Theory and evidence', was referred to by respondents in terms of the consultation models, the evidence-base of clinical outcomes associated with effective communication and patient-centredness as a conceptual model of the doctor-patient relationship. These aspects are discussed more fully in the next section. The final domain 6) 'Supporting Principles', refers to the four elements which von Fragstein et al. (2008) cite as underpinning clinical communication, namely: reflective practice; professionalism (specified as probity, integrity and honesty); ethics and evidence-based practice. Each of these was referred to as forming part of curricula content across the span of respondents' accounts. Specific content relating to 'awareness-raising' in relation to teaching on diversity [Int. 1; 3; 8], may be situated within reflective practice, by for example, providing opportunity for students to consider how their own beliefs intersect with those of others, or how unexamined prejudices might impact their relationships with patients. It can also be related to the central tenet of the consensus statement, i.e. 'Respect for others'.

Table 5: Summary of clinical communication curricula content as outlined by respondents mapped to UKCCC curriculum consensus statement (von Fragstein et al., 2008)

Curricular content identified by respondents	UKCCC recommended undergraduate curricular content domains
- How to structure a consultation - Information-gathering - Diagnostic process / clinical reasoning - Explaining / information-giving (diagnosis, treatment etc.) - Shared decision-making	1) Tasks of clinical communication: (relating to the medical consultation)
- Responding to emotions - Responding to challenging patients - Breaking Bad News - Communicating with particular patient groups (e.g. sensory impairment, post-stroke, end –of-life care) - Obtaining consent - Handovers - Promoting self-care/ motivational interviewing - Flexible content - based on experiences in practice	2) Specific issues
- Face-to-face; written; electronic; telephone; presentations	3) Communicating through different media
- Working with interpreters / patients with limited English - Communicating with colleagues /team-working	4) Communicating beyond the patient
- Patient-centredness - Consultation models - Reference to research evidence to support specific communication approaches.	5) Theory and evidence
- Reflective practice - Professionalism - Ethics - Evidence-based practice	6) Supporting principles

In this section I have presented the findings relating to curricular structure and content. Structurally, variations from recommended curricular models (i.e. longitudinal and helical) persist, largely due to wider institutional constraints. The value of integrated curricula appears to be widely recognised although there are variations in the extent to which this is achieved. The benefits of embedding communication within the learning of all aspects of clinical practice, to prevent it being perceived as peripheral or separate, was acknowledged. However, we have seen a newly emerging concern that in being fully integrated, clinical communication may lose its distinct profile and instead become a form of unarticulated tacit learning. This suggests a current need for a renegotiation of subject boundaries whereby the benefits of integration may be achieved without threat to the value and contribution of component subject areas. Curricular content reported by respondents closely matched that outlined in the UKCCC curriculum consensus statement (von Fragstein et al., 2008). This included content related to instrumental task / process-based domains; theory and evidence for the subject and underpinning elements (reflective and evidence-based practice, ethics and professionalism).

7.3 How and to what extent does theory guide what is taught?

In this section I will address the research objective of illuminating how models or theories are used to inform the teaching of clinical communication. This in turn will contribute to the wider research aim of how the nature of clinical communication as a subject is constructed.

Two questions included in the scoping survey (Appendix 4) are of relevance to this area:

- Q. 10) Which consultation models / frameworks are utilised in your clinical communication teaching?
- Q. 11) Do any theoretic frameworks or perspectives (not included in Q. 10) inform your communication curriculum or teaching? (e.g. Patient-centredness', 'Relationship-centredness')

Responses to these questions along with further insights gleaned from the interviews are discussed below.

Consultation models:

Out of 21 survey responses to Q. 10, eighteen medical schools reported using the 'Calgary-Cambridge Guide' (Silverman et al., 2013) and six cited the 'Disease-Illness' model (also known as McWhinney's (1989) 'two-agenda model'). The latter, while outlining a basic structure for a consultation, may be more accurately described as a model of the doctor-patient relationship. As such, it emphasises a patient-centred approach through active elicitation and incorporation of the patient perspective, as a shift away from the previously dominant biomedical model:

> This two-fold [consultation] task is described in terms of two agendas: the physician's and the patient's. The key to an understanding of the patient's agenda is the physician's receptivity to cues offered by the patient, and behaviour which encourages him to express his expectations, feelings and fears. The physician's agenda is the explanation of the patient's illness in terms of a taxonomy of disease. In the patient-centred clinical method, both agendas are addressed by the physician and any conflict between them dealt with by negotiation. This is contrasted with the disease-centred method in which only the doctor's agenda is addressed. (Levenstein et al., 1986 p. 24)

The use of the model is illustrated in this respondent's account:

> We introduce it to them [students] right at the beginning in year one, in the first lecture, and it's the McWhinney model of doctors' and patients' perspectives and agenda, understanding the patient, understanding the illness, bringing it together, thinking about management. So – and the skills in the middle that help you get there – so we use it and we come back to it over and over again. [Int. 03]

And is further endorsed by this comment:

> We also use McWhinney because – and I really like McWhinney because I really like this kind of marriage of two agendas. [Int. 01]

By contrast, the Calgary-Cambridge Guide provides a detailed structure of the consultation processes and associated skills, outlined in brief in Figure 2 below. It too espouses a patient-centred underpinning, which is reflected more through the exposition of process and skills to carry out a patient-centred style of consultation, rather than emphasising the model itself. Kurtz et al.'s (1998) influential text on teaching communication skills in medicine is closely allied to the Calgary-Cambridge guide and identifies a set of 'perceptual skills' alongside process and content skills. These are classified as what the clinician is thinking or feeling, including for example, decision-making; reflection; attitudes and emotions. The classification of these latter areas as skills is epistemologically questionable as discussed in Chapter 3. The authors suggest that opportunities to address these areas will arise in experiential skills based teaching and / or can be attended to in seminar type discussions. However, this aspect of learning receives little more elaboration in the text, with the focus instead (purposefully) placed on process and content relating to the stages and tasks of the consultation. The use of the Calgary-Cambridge guide for the 'perceptual skills' element of teaching was explicitly referred to by one respondent [Int. 08] as being incorporated into experiential teaching sessions. More commonly, the guide was described as a vehicle to help students learn how to structure a consultation with a strong focus on specific process skills (e.g. initiating the session, explanation and planning), as in this example:

> Calgary-Cambridge is a useful framework to get students to
> think about, particularly in first year. It's just easy for them
> to visualise, I just think it's a useful way for them to see a
> consultation … because in first year it is very skills based, so
> they're hearing about skills, they're seeing why they're
> useful. You know, we're giving them the theory of why
> these skills … where they come from and why they're useful.
> And then they can put them within a framework and say,
> "Oh, I can see how, in particular parts of a consultation, I
> could use this particular skill." [Int. 09]

One other consultation model was referred to thus:

> There is the Stott and Davis model … which is about you
> know the presenting complaint and then other issues and the
> patient's help-seeking behaviour, modifying help-seeking

Figure 2: 'Marrying Content and Process in Clinical Method Teaching: Enhancing the Calgary-Cambridge Guides' (Kurtz et al., 2003 p. 806)
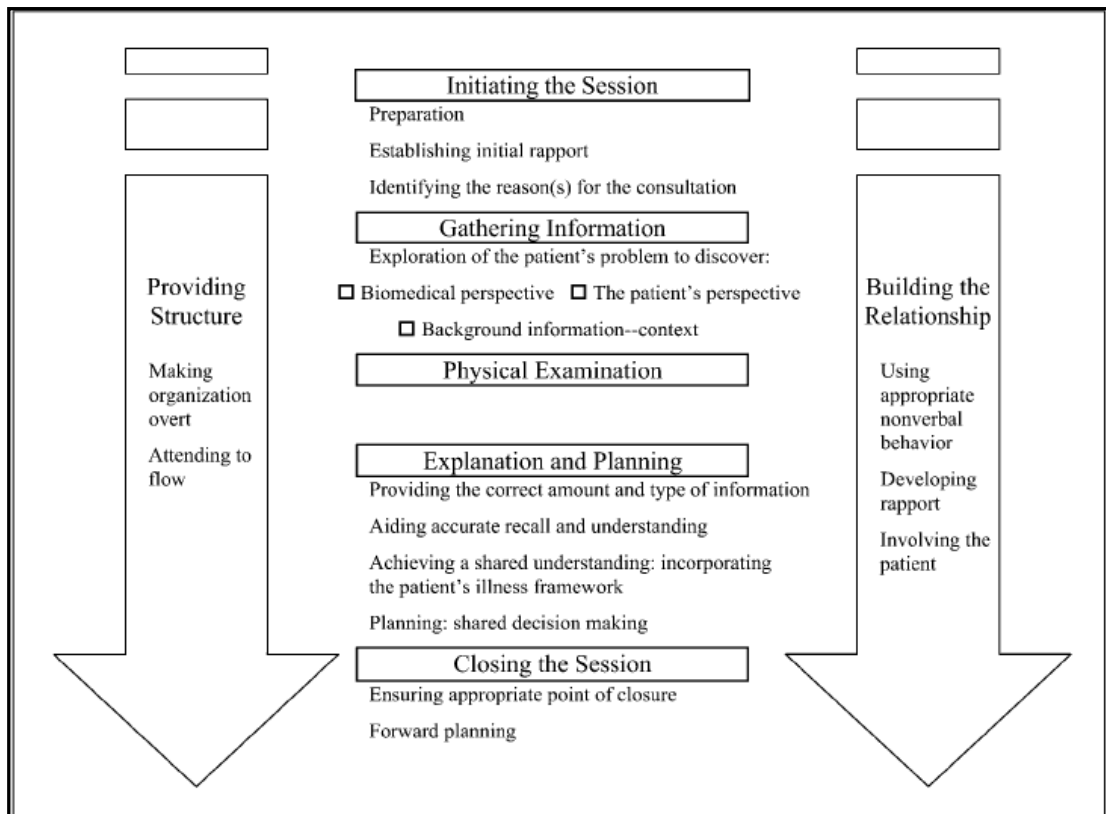
> behaviour, those sorts of things. So we talk a bit about those sorts of things, but we're fairly task-focused. You know, what are we doing today? Its information gathering or breaking bad news – and what are the skills needed for that? [Int. 06]

This model (Stott and Davis, 1979) reflects a more bio-medically focused and doctor-centred approach to the consultation whereby various hypotheses concerning the diagnosis are advanced, tested and discarded until a 'correct' diagnosis is arrived at. It may be criticised for an inadequate emphasis on patient perspectives and beliefs, which runs contrary to the prevailing patient-centred ethos. A tendency to downplay a theoretic basis for teaching in favour of a tasks and skills approach can also be seen in this example. Other models referred to by single respondents in Q. 10 included those from the field of psychology (e.g. stages of change; motivational interviewing and shared decision-making).

In line with previous discussions, the need for flexibility when using structured frameworks was highlighted by this respondent:

> Beginning, middle, end is generally a good model of the consultation. A degree of structure is helpful because patients culturally want to follow a journey. But if you get too stuck on that model you can miss important cues, and they [students] need the courage and confidence to go a bit off-piste, if something else happens that's important for the patient. So I'm not anti-structure but I think structure has a use with younger students in getting them into the swing of the direction they're going in but I still think they need to develop flexibility. [Int. 04]

This comment highlighting the use of judgment and the ability to deviate from 'protocol' resonates with Hilton and Slotnick's (2005) notion of *phronesis* or 'practical wisdom' (derived from Aristotole's Nicomachean Ethics – see Tredennick, 2004). This state is marked by the facility to apply situated judgment and flexibility, developed through extensive experience and reflection on experience. Whilst *phronesis* would not be attainable at undergraduate level, Hilton and Slotnick suggest that this phase, which they term proto-professionalism, may serve as a period of experimentation and consideration of reflective judgments. This accords with the above respondent's view, that undergraduate teaching should provide students the opportunity to consciously consider flexible approaches to communicating with patients.

Findings in this section demonstrate the use of the Calgary-Cambridge Guide as the predominant consultation framework used in clinical communication teaching. Despite acknowledging the importance of the 'perceptual elements' of the doctor – patient interaction, the skills-based focus of the guide limits its utility in attending to those elements and raises a central point of epistemological dissonance in subsuming a values-based approach within a skills paradigm. This resonates with wider concerns regarding the sufficiency of a skills approach to interpersonal areas of practice (Winch, 2010). The guide does, nonetheless, support a patient-centred style of communication through which broader areas of the doctor-patient relationship

may be addressed. This leads us on to findings related to the use of communication theory in the teaching of clinical communication.

Theoretic foundations:

In response to Q. 11, seventeen out of twenty survey respondents identified 'patient-centredness' as a theoretic framework which informed their curricula / teaching. As well as being widely accepted as a central component of modern health care practice (DoH, 2012, Foot et al., 2012), it forms a key recommendation of the UKCCC Teaching in Undergraduate Medical Education curriculum consensus statement (von Fragstein et al., 2008) as follows:

> The theoretical approach of patient-centredness has been demonstrated to be a paramount feature of high-quality care and should be a central component of any communication curriculum. (von Fragstein et al., 2008 p. 1103)

The recognition of its relevance to both communication teaching and the wider curriculum was articulated in this account:

> I think patient-centredness is one of those things that it partly belongs to clinical communication or communication skills but it partly is one of those overarching concepts that is not just the domain of clinical communication. So we use it in both versions, I suppose. We talk about it in terms of what does that mean in terms of a conversation that you have with a patient. And we also talk about it in terms of overall care, how one provides care to people. So it appears in the curriculum in both of those formats. [Int. 05]

And a further example of its centrality to current teaching was articulated thus:

> Patient-centredness is more of a concept. They're introduced to it but it forms the bedrock of absolutely everything we teach. It's written about in everything we write. It's about helping students to surrender their agenda, to a very large extent, and to understand what it's like. So it's putting the patient into a biosocial perspective. [Int. 01]

Respondents' accounts of patient-centredness varied in description and emphases of its features, with no particular versions, such as that offered by Mead and Bower

(2000) cited. This can be seen within the context of the vast literature which has emerged surrounding the notion of patient-centredness in healthcare, with differing perspectives as to what it entails (see Epstein and Street (2011) for a recent appraisal of the status of patient-centredness).

The tension between promoting a theoretic understanding of the concept of patient-centredness and of adopting a skills approach aimed at enacting it in practice was also raised:

> They [students] don't have a lot of teaching about patient-centredness … I'm more interested in teaching them about the skills, which would … I know would demonstrate patient-centredness … So I sort of see the skills as being the essential … If they then get it, that that's about being patient-centred, then that's a bonus. But it can't be the other way round, in my book … wanting to be patient-centred but not having any skills, you won't be patient-centred. [Int. 07]

This perspective echoes that of Kurtz et al. (1998) who also endorse a strongly skills-based approach on the basis that a focus on theoretic knowledge or attitudinal issues to doctor-patient relationships does not necessarily translate into effective or patient-centred communication. Whilst this is a valid point, a counterpoint can be made for the need to overtly contextualise skills within a theoretic or conceptual framework that encapsulates the moral nature of health care delivery and the human and professional values base that supports it. In this way, patient-centredness might be viewed as both a conceptual (or theoretic) model and as a value in itself concerning the nature of the doctor-patient relationship. While Kurtz et al. (1998) acknowledge the need for the 'perceptual' elements of the doctor-patient to be addressed alongside skills development, it is evident from the example above that the balance between these approaches may, in some curricula, be tipped in favour of skills.

Apart from patient-centredness, just one other theoretic approach was identified by a survey respondent (#22 - who was not interviewed), this being based on Jürgen Habermas' theory of communicative action and rationality (for example Habermas, 1984, Habermas, 2002). This respondent proposed communication to be a basic human need and noted *"the reflexive relationship between autonomy and*

125

communication which needs to be protected in health care" (Survey #22). The respondent had developed this premise and used it to provide a theoretic rationale and basis for a clinical communication curriculum (Gill, 2004)[5]. Others referred to pedagogic models used to help guide students' reflection on their clinical experiences, including Schon (1983), Gibbs (1988) and Kolb (1984) (these will be discussed further in Section 8.4.3).

In summary, the findings discussed in this section indicate that the two main sources which inform clinical communication curricula are the Calgary-Cambridge Guide and the concept of 'Patient-centredness'. The first of these is a consultation model rather than a theoretic framework, albeit the processes and skills it contains are supported by research evidence in terms of clinical outcomes and patient satisfaction studies. Patient-centredness, referred to as a theoretic base or conceptual model, while not drawn from communication theory *per se*, has clear relevance to the interactional aspect of the doctor-patient relationship. Although the concept of patient-centredness may be applied broadly to healthcare in terms of systems and processes (Foot et al., 2012), clinical communication is central to the human interface of its delivery. While patient-centredness was described in varying terms as a concept, respondents did refer to key principles in common which promote an ethos of respectfulness, egalitarianism and active engagement with patients. The potential for the application of other theoretic perspectives (such as Habermasian communicative theory) to enrich both clinical communication as a subject and the pedagogy which supports it, is a position which is garnering increasing support (Salmon and Young, 2009, Gill, 2004). This, along with the potential for patient-centredness as embodying and enabling a values-based approach to doctor-patient relations will be returned to in Chapter 9. In the next section I will discuss the findings related to teaching methods.

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[5] Interview respondent #22 gave permission to be identified by reference to this work.

7.4 Teaching methods

Findings related to how teaching is being delivered will contribute to the research aim of investigating the practices deployed in clinical communication contexts and which of these has most potential for addressing the complexity of the field. I have again drawn on selected data from the scoping survey to supplement interview data. I will begin in section 7.4.1 by discussing findings relating to formal teaching. I have classified this as teaching delivered primarily within the medical school (classrooms / skills laboratories) and delivered by dedicated communication tutors. In section 7.4.2, I will present findings related to practice-based teaching, both formal (i.e. organised / delivered by communication tutors) and informal (opportunistic / delivered by non-specialist teachers). The latter will include respondents' views on the role of the informal or hidden curriculum.

7.4.1 Formal classroom-based teaching

The predominant teaching method reported by all survey respondents (n. = 22) was experiential in nature, mainly involving simulated patients (SPs), with some additional role-play workshops in which students act as patients and work with actual patients in formal teaching sessions. The next most common method was seminars (20 out of 22 respondents) used for discussion and reflection, though their use was less frequent than experiential learning. This was followed by portfolio development and e-learning methods (15 and 16 reports respectively), with lectures and other directed learning featuring minimally. As stated, all survey and interview respondents reported the use of experiential learning with SPs as a core teaching method. This reflects widespread recognition of its efficacy above other more didactic methods in developing communication skills (Aspegren, 1999). It is of note that the discourse surrounding the use of experiential methods in this field is predominantly that of skills development, as exemplified here:

> We're just trying to make it, I suppose, just a relatively
> simple process of: you've done something … how do you
> think you got on, how do you need to improve, where do we
> go from here, kind of type stuff. [Int. 06]

However, other respondents clearly cited a role for experiential teaching beyond this remit, such as discussion of and reflection on attitudes and emotions. This is captured in the following account:

> There's a number of points within what we do that we invite students to reflect. Some of that is explicit within the communication. So, of course, workshops where they encounter the role-players and do simulations are deliberately creating opportunities, the facilitator's deliberately promoting questions that demand reflection of some sort, either as an audience member or as an individual. That's something that we can manage and I'm sure that that model is, well, I know that that model is used nation-wide and beyond. [Int.04]

This view was reiterated in this example:

> And I think building that reflection into the experiential sessions is by far the best way of doing it because I think then people do start to talk about things they've seen on the wards and how that's affected them and, you know, what they think about that. [Int. 03]

The role of experiential learning as means for exploring and validating the role of emotions when interacting with patients and providing a place to be 'introspective' and think about how emotions impact on actions was also cited [Int. 09 & 02]. The extent to which reflective activities are incorporated into experiential learning may be dependent on how workshops are organised and on institutional factors such as student numbers (with small groups being preferable); availability and experience of tutors and curricular time. An example of a highly developed experiential programme was provided by Int. 09 (from a smaller cohort medical school) where simulated consultations are recorded for participating students to use for reflection and development and are integrated with reflective writing assignments. This respondent also described the development of a learning environment conducive to experimentation and sharing among students, through consistency of group members and tutors, fostering an atmosphere in which trust could develop. However, not all respondents felt their curricula could support such a well-developed approach due to resource restraints:

> It feels to me like we would struggle … to have the time to
> do that sort of more detailed, "So, what are you thinking?"
> kind of type conversation with the students. And I think also,
> in a way, probably the quality of the tutors. I mean, that's a
> more sophisticated level of tutoring than simply saying to
> them, in effect, "Well," you know, "what were you trying to
> do? What skills were you using to…?" You know, having a
> conversation about the ethics side of it is, yeah, is higher-
> level stuff. [Int. 06]

The issue of having tutors who are skilled or comfortable enough to undertake more reflective facilitation is highly relevant as most medical schools rely on sessional tutors or clinicians to assist in teaching, who have varying degrees of experience and training.

While the opportunity provided by simulated scenarios to practice challenging communication situations such as breaking bad news was highlighted as a particular strength of this method [Int. 02 & 07], it was also noted to have its limitations:

> And there are other ways in which actually, well, I worry
> about simulation distorting learning as well, because its
> dynamics are quite different … So in a simulation setting
> you've got someone – generally actors – in that situation who
> are empowered, they are in a very powerful position relative
> to the, sort of, the position that the average patient might be
> in, or many patients might be in. And also the whole sense
> that it is a simulation. [Int. 07]

This concern regarding the 'gap' between use of simulation and authentic 'real' patients in clinical practice for communication training has been recognised in the literature (Yardley et al., 2013, Wear and Varley, 2008), along with the need to help students to process the dissonance which may arise in their learning experiences in relation to this. The gap between classroom and practice-based learning will be explored further in section 7.4.2 which follows. Findings in this section confirm the use of experiential learning with simulated patients as the predominant teaching and learning methodology for classroom-based teaching. The prominence given to the role of reflection in exploring affective and attitudinal aspects of communication within this process, challenges the dominant discourse of skills development associated with the method.

7.4.2 Practice-based learning – formal and informal

Aside from classroom-based learning, all medical students are expected to develop their communicative abilities in clinical practice. Longitudinally integrated curricula tend to provide more early years clinical exposure for students, whereas more traditional curricula with a distinct 'pre-clinical' phase (usually the first two years of the medical degree) tend to have more limited patient contact (Hopayian et al., 2007). In either case, the degree to which students are formally supervised and nurtured in relation to their clinical communication development in the practice area varies. Previous research (Egnew and Wilson, 2010, Malhotra et al., 2009) and my own IFS findings (O'Neill, 2010) indicate that supervision from senior medical staff focuses on biomedical aspects of learning (e.g. physical examination skills, diagnostic reasoning and management), or without explicit focus on how students communicate with patients in conducting and achieving these. Findings from the current study also highlight concern for a potential 'disconnect' between clinical communication learning in the simulated environment and that which students encounter in clinical practice, as captured in this account:

> We [clinical communication teachers] went out and we observed students on the wards, what we observed was that the clinical environment had a huge impact on them. And that although they were very clearly able to use the skills element of what we'd taught them, and were able to very clearly talk about how they'd learned it, and the methodology around that, what had been lost was empathy and patient-centredness. [Int. 01]

These observations correspond with previous research into the decline of empathy and patient-centredness during the undergraduate curriculum (Hojat et al., 2009, Coulehan and Williams, 2001). It is of note that students in this example were deemed to retain the skills element of what they were taught, but to have lost the human values aspect as mediated through a patient-centred approach. This serves to highlight the spectre of skills enactment disconnected from a conceptual basis or underpinning principles, despite formal teaching efforts to the contrary. For one respondent [Int. 01] the clinical environment was seen as 'essentially hostile' to how

students had been prepared through their communication teaching and she referred to a 'hidden agenda' which resonates with the notion of the hidden curriculum (Hafferty and Castellani, 2009). This view was voiced by a number of other respondents [Int. 05; 09; 10] and illustrated thus:

> I think it's more that they see some pretty crummy attitudes going on, on the wards, and behaviours which are not … I mean, for all sorts of reasons that I completely understand, of tiredness and exhaustion and fed-up-ness. So all sorts of reasons why people do show poor attitudes. [Int. 10]

The challenges students face on entering clinical practice, with the hidden curriculum '…pulling them in different directions' were also described [Int. 05] along with how faculty try to prepare students in terms of their role with patients and in developing 'professional boundaries'. The potential dissonance between formal teaching and that experienced in the practice milieu was further highlighted:

> That's the kind of conflict between what we teach them [students] and what they see in practice, which can be quite different. And there's that gap there. How do they reconcile, well, you need to be patient-centred, blah, blah, blah, with what they see on the wards? And how they deal with that. [Int. 09]

Efforts to address the classroom-practice gap by extending formal communication teaching into the practice area was described by Int. 01:

> So students, a pair of students, go out with one communication skills teacher and they clerk [i.e. elicit a medical history and examine] real patients and they get feedback in real time from one of us. Or a handpicked couple of others that you would allow to do that kind of very pioneering work. And it's extraordinary. Students love it.

This suggests that a shift of locus from simulation to authentic clinical practice is one means of addressing the previously identified 'gap' that students experience in clinical communication pedagogy. The potential for the use of 'work-placed teaching' such as that in the example above is currently being advocated (Brown, 2012) and builds on situated learning theory (Lave and Wenger, 1991) and reflective

practice (Schon, 1983) as a means of marrying academic and 'real world' perspectives.

Findings in this section have highlighted the pedagogical challenges of supporting students to transfer their formal learning in clinical communication into authentic clinical practice and to sustain and nurture the patient-centred elements of the subject in a potentially undermining environment. Beyond the scope of medical education, the wider NHS culture of healthcare has a significant role to play in this issue amid repeated attempts at creating a patient-focused and compassionate environment, particularly post-Francis report (Francis, 2013, DoH, 2012). The reported disconnect between classroom-based simulated clinical communication learning and students' practice-based learning experience is a source of on-going concern (Yardley et al., 2013, Wear and Varley, 2008). This suggests that the interplay between underpinning principles that promote a values-based and patient-centred approach and the tasks and skills elements of the subject are prone to separation at a time when their centrality to patient care is high on the health service agenda. This has pedagogical implications for extending formalised communication teaching beyond simulation and into the workplace to support a rounded learning experience where the development of skills remains firmly embedded within the broader domains of the subject.

7.4.3   *Pedagogic role of reflection and portfolios*

The role of reflection in clinical communication teaching and learning emerged as a strong theme in respondents' accounts. Twenty out of 22 survey responses indicated the use of seminars for discussion / reflection as part of their communication teaching and sixteen out of 19 confirmed the use of portfolios (as a means of collating reflective assignments). In addition, the role of reflection in experiential learning has been discussed in the previous section. Interview accounts suggest that reflection is utilised for two main purposes: firstly to enhance and expand experiential skills-based learning and secondly as a strand of professional development which includes communication. These will be discussed in further

detail below. The introduction of reflective practice into the field of health education (Schon, 1983) was cited in the following comment as instrumental in moving learning away from a transmission model of knowledge transfer to one which promotes a more self-directed, autonomous style of learning:

> At least with Schon and … the reflective practitioner, he moved it onto thinking that people actually could learn for themselves. So they could grab it by this reflective model. And I think that reflection works well for some people and we do formally teach it here, it's part of everything we do. [Int. 01]

This accords with an androgogical or adult-centred learning style (Knowles, 1990) and the stipulations for undergraduate medical education set out by the GMC (2009) that the foundations for 'lifelong learning' and continuous professional development are inculcated during this phase of medical training. The benefit of reflection as an embedded component of the wider curriculum, in order for it to 'make sense' to students in the context of communication learning, was commented on thus:

> Also, it depends on the rest of the context of the curriculum, because if you meet people just in one session and do something like that, you haven't built up a relationship and it's a bit of a drop in the ocean. And so it's like, well, what was that all about, you know. [Int. 03]

Reflection as a core component of the wider undergraduate curriculum was reported by a number of respondents (Int. 4; 7; 8; 9), sometimes to the extent of perceived reflection 'overload':

> I think the problem is, here, they're asked to reflect a lot in our curriculum. A lot. And I think they get thoroughly sickened of reflection. Because, you know, they only have to move and they're asked to reflect on the experience. [Int. 08]

While it is recommended that a climate of reflection needs to be established across the span of medical education to normalise its use (Sandars, 2009), the above account suggests a balanced approach needs to be struck in order to keep students 'on board' with this method. A number of examples were provided of how reflection was incorporated into communication curricula. In some instances reflective models

(such as Gibbs, 1988, Kolb, 1984) were provided as guidance for students [Int. 01, 09]. This type of guidance has been recommended to initiate students to the process and as a means of supporting more sophisticated reflection as they progress through programmes (Buckley et al., 2009). As discussed in the previous section, the use of reflection within experiential sessions was widely reported by respondents, such as in this example:

> Within the workshops … I think there's a massive
> opportunity for reflecting on what is happening but also
> reflecting on what do we do next. So there's always the two
> components. And the workshops with simulated patients are
> partly getting them to go through the process of thinking
> about what they're seeing and why they're seeing it and how
> they're seeing it. [Int. 09]

Aside from reflection as part of experiential teaching, other methods were discussed focusing on reflective writing; portfolio development and / or discussion. These are illustrated in the following accounts. Int. 07 outlined the use of reflective writing exercises and portfolios:

> In Year 2, there is a more formal kind of reflection process,
> the students are asked to write reflections on the cases that
> they need to record as part of their portfolio in logbooks.
> And I think about two or three of them … are sort of
> extended and there's a longer reflection on the
> communications side. And that covers what were their goals
> in talking to the patient, how they tried to address those goals
> and their reflections on … what went well about the
> [consultation]. [Int. 7]

Further reference to portfolios as a means of collating reflective activities and as evidence of engagement with learning (Buckley et al., 2009) was provided in this example:

> So there are certain things, for example in various clinical
> years, we're expecting students to do as part of the package
> of their learning, which will include … if there's a reflective
> piece that they're expected to do and they … they put things
> into their portfolio and their portfolio is looked at before
> they're permitted to go into the exam … They're not kind of
> formally marked … it's about, sort of, engagement with the
> course. [Int. 05]

The notion of engagement with learning and how portfolios might help with this, is reflected in the literature as outlined by Challis (2001):

> A portfolio offers the opportunity to bring together the personal and the shared … The narrative, or story, of medicine and the underpinning values and knowledge which form a crucial part of working effectively as a doctor, are interpreted and perceived by each individual within the context of that person's own personal narratives. (Challis, 2001 p. 438)

The extent to which this vision of portfolio usage is being realized, however, was shown to vary among the medical schools in this study. Students were reported to engage with reflection and to "take it seriously" in the following example, where portfolio development was reported to be embedded in the wider curriculum structure:

> At the start of first year they [students] get lectures about how important it is to do reflective writing, to understand it, not just for just now in helping you process the experiences you're having and therefore how to progress from them, but also for future years. You will be expected to do this and so you may as well learn now and we can give you feedback on it. [Int. 09]

But others [Int.07; 08; 10] reported a lack of engagement, dislike or manipulation of reflective writing by students, for example:

> But at the minute it's a written reflection and some of them engage with it and others just don't see the point of it at all and they just think they're writing it for the sake of, you know, it's just a means to an end … I'll write this essay … and it'll go in my portfolio. And I'll say the things they want me to say and I'll use the reflective framework and … that's it. [Int. 08]

A further issue was raised [Int. 04; 07; 10] that students may be reluctant to honestly share their experiences or views where these are being read by faculty members or that they may generally be less comfortable with reflective writing as a methodology:

> They're [students] also worried … because there are certain things that I think they would like to voice but they don't feel

it's a safe forum in which to voice those things. There's something about writing something down, isn't there, that makes it very formal? And … and then, a lot of the students don't have, perhaps, the writing skills to construct or represent the experience in the way that they want to represent it on paper. [Int. 07]

The use of reflective writing in medical education has been proposed as a means of assisting with professional development, enhancing patient care (through an increased appreciation of patients' perspectives) and enhanced practitioner well-being (by engaging with and sharing thoughts and emotions that arise from significant or challenging situations) (Shapiro et al., 2006). These elements fit well with a pedagogical approach to communication that attends to the 'personal' dimensions of student and patient and how these may impact on the professional encounter; however, the data here suggest there are genuine barriers to this methodology realising such potential. The benefits of accompanying, or even substituting written reflection with discussion, either with other students and / or tutors was discussed by several respondents [Int. 1; 3; 7; 8; 10], as in this example:

Part of this portfolio is that in the fourth year pairs of students have to reflect on a range of patients that they've been with. They meet with a tutor and we talk about it. That's the reflection that works. They love that … you can help them to dig down … you can help them to think, "So what's that about? So why do you think that happened? So what was your gut? What did you learn then? Are you going to do it like that again?" You know, all that stuff. [Int. 01]

The perceived benefits of this type of approach were further captured in this account:

I also feel that, to some extent…reflection is better done through discussion than through writing on one's own and then somebody reading that at a distance and giving you some comments on it. Because it's not a conversation. And I think, again, there's something about the conversation in learning and the development of ideas … something, you respond and we start to, kind of, evolve our thinking about it … [Int. 03]

Not all respondents viewed reflection as intrinsic to communication teaching, as illustrated in this comment:

Within clinical skills, obviously, you need to be getting them to reflect on their previous performance and then working out what their deficits are and going forwards. So I suppose there is some use of, if you like, reflection but I wouldn't be expecting to teach them, sort of, reflective … how to be a reflective learner within clinical skills. I sort of feel like that's a slightly separate vertical, kind of, theme that they need to be thinking about … we have a vertical theme of professionalism … which I think in a way it should be in that.[Int. 06]

This reflects a view of clinical communication as sitting firmly in the domain of clinical skills, which by extension, has led to the adoption of a more instrumentally orientated approach to reflection centred primarily on *skills* development. The development of reflective abilities in this instance is seen as 'separate' from the teaching of clinical communication i.e. lying within the professionalism strand. This position can be seen as congruent with the historical alignment of communication with other clinical skills (such as procedural skills or physical examination). As previously discussed, this approach was strategically adopted to facilitate its acceptance within the medical curriculum as a distinct subject. However, as both the subject and medical education are evolving, the case for integration across domains is being championed. This has been illustrated in previous respondent accounts where reflection is used as a teaching method within the subject of communication and as a strand of professional development within the overall medical curriculum.

The findings presented in this section provide some insights into the use of reflection as a teaching approach within clinical communication. The growing use of portfolios for professional development purposes within medical education – including at undergraduate level – has provided a platform for the inclusion of reflective assignments and accounts. This has been embraced by a number of curricula within this study sample. The benefits of reflection as a pedagogical approach can be seen in its capacity to extend the scope of the subject beyond behavioural skills acquisition, to include more in-depth consideration of the nature of the doctor-patient relationship and of students' personal and professional development and as such is highly congruent with a broader conceptualisation of clinical communication. How reflection is managed in curricula has significance for its impact on student

engagement with the process and the extent to which it enables them to develop a more in-depth and holistic approach to their clinical communication learning.

7.5 Discussion

A number of issues arising from the above findings have been discussed in the body of the chapter. I will therefore limit discussion in this section to the following key aspects: integration of communication teaching (with particular reference to professionalism), and how teaching related to personal and professional development may be enhanced. I will begin by highlighting the key issues which emerged relating to the integration of communication teaching with other subject areas. The value of integrated teaching, for example joint ethics / communication teaching or clinical skills and communication, was acknowledged by respondents. The benefits of such integration can be seen as 'joining the dots' of allied subject areas together (e.g. the need to communicate in an ethical way / the need for skilled communication to ethically gain consent). It also illustrates the centrality of communication to clinical practice, thereby minimising the unhelpful separating out of essentially integrated subject areas. The increasing formalisation of professionalism within the medical curriculum (Hilton and Southgate, 2007) provides an additional field for the integration of communication teaching. However, the adage 'be careful what you wish for' seems apt in capturing the newly emerging concern that increasing integration will result in the dilution (or loss) of a distinct subject identity for clinical communication. This may be seen as a retrograde step, returning clinical communication to a tacit, unarticulated form of know-how that might previously have been vaguely labelled as 'good bedside manner'. This highlights the current tension within the subject field – whether to retain a discrete identity, risking separation and reductionism or increase integration and risk possible dissolution.

As commented on above, the increasing profile of professionalism in the medical curriculum and its relationship to clinical communication is of particular note. It firstly raises the issue of what is meant by professionalism. While numerous definitions are available (for example RCP, 2005, Hilton and Slotnick, 2005), they commonly identify requirements to act in ways which meet agreed professional

standards such as those set out in 'Good Medical Practice' (GMC, 2013) and of
embodying a range of traits and qualities that may be characterised as both personal
and professional (e.g. honesty, self-awareness). The relevance of these factors to
clinical communication has been articulated in this and previous chapters and
reinforces the symbiotic relationship of the subject with professionalism. It further
suggests the need to soften the subject boundaries within medical education
curricula. In this way, curriculum and teaching practices can be developed which
foster a more integrated approach to learning.

Further consideration of the kinds of learning opportunities that are provided to
enable the development of the intrinsic qualities referred to above – associated with
values and development of moral traits or virtues – and identified as common to the
goals of professionalism and communication teaching, may also be required.
Experiential and scenario-based teaching already offer such a platform, provided
explicit reference is made to this aspect of learning, in addition to the skills and tasks
element. The use of reflection as a method suited to personal and professional
development garners mixed reviews by teachers and students. Its role and purpose,
i.e. as a means for developing habits of mind in terms of reflective learning may sit
at odds with its use for assessment purposes (which will be discussed in the next
chapter) and requires careful consideration. The potential of theoretic learning that
promotes the espousal of a values-based approach to clinical practice could also be
further emphasised as the bedrock from which instrumental learning is developed.
Finally, there appears to be a vital need to support students' learning and
development of communication from the simulated and formal teaching environment
to that of clinical practice, so that the values of patient-centredness which underpin it
are not undermined. This approach is already being implemented in some curricula
(e.g. Int. 01 & Int. 10), providing a model for how this may be achieved.

7.6   Conclusion

In this chapter, findings relating to the analytical category of teaching have been
presented. These included the structure and content of curricula, including the use of
theory and the methods used to deliver teaching. Key issues concerning the

integration of clinical communication with other aspects of learning – particularly professionalism - have been highlighted and ways of developing teaching to support the values-based 'person as professional' strand of learning have also been considered. In the next chapter, findings related to assessment of clinical communication will be discussed.

8 Pedagogic practice – Assessment

8.1 Introduction

In this chapter the findings relating to current assessment practices will be presented and discussed. They are organised under the following sub-themes: OSCES and their derivatives; other methods of assessment (including exam questions, formative experiential-based and practice-based assessment, reflection and portfolios). The final sub-theme comprises respondents' views on desired changes to assessment practice. The influence of assessment on learning is widely acknowledged (McLachlan, 2006, Newble and Jaeger, 1983, Cilliers et al., 2010) and the findings presented in this chapter aim to address the study objective of exploring respondents' views of clinical communication assessment methods and how these relate to identified teaching aims. A useful definition of assessment in medical education has been provided by Schuwirth and van der Vleuten (2014 p. 243) as 'any purported and formal action to obtain information about the competence and performance of a candidate', which may be summative (i.e. used for decision-making such as qualification or progress decisions) or formative (i.e. to inform students about their performance). Findings related to both types of assessment are discussed below, utilising data from the scoping survey and interviews.

The main methods of assessment reported by respondents along with their prevalence are as follows. Out of twenty-one survey responses, all confirmed the use of OSCEs (with some variations on this method), with eighteen using it as the main method of assessment. The use of OSCEs appeared to be spread evenly across all years of the medical degree programme. Four schools reported using OSCEs as the only method of assessing communication. Portfolios (which included reflective activities) were reported by five respondents as used for assessment purposes. Three respondents cited the use of recorded simulated interactions as the basis for formative reflective assessments. Three respondents reported the use of written exam questions; two of practice-based assessments and one of high fidelity clinical simulation. Again, while these findings are not exhaustive, they convey a sense of the prevalence of the

differing assessment methods currently employed. This range of methods largely accords with those reported by Laidlaw et al. (2014) in their comprehensive UK survey of clinical communication assessment methods (conducted in 2009), with the exception of simulation, suggesting this may be an emerging methodology. My own findings related to these categories are set out below along with discussion of their wider implications for pedagogic practice.

8.2 **OSCES and their derivatives.**

The use of OSCES in medical education is firmly established (Newble, 2004, Davis, 2003) as outlined in Section 2.3.3. The widespread use of this method among respondent medical schools confirms its status as a primary mode of formative and summative assessment in clinical communication. Two variations of the OSCE format were reported in the form of ISCEs (Integrated Structured Clinical Examinations) and OSLERs (Objective Structured Long Examination Record). The former tends to involve authentic patients in a clinical setting to examine clinical tasks while the latter offers longer clinical 'cases' than the more truncated OSCE stations. Otherwise they are similar to OSCES in aiming to capture students' abilities in differing areas of clinical practice (e.g. procedural skill; history-taking; clinical reasoning; communication skills) with criteria-based marking schemes. The key advantage of the OSCE (as discussed in 2.3.3) is its facility to administer a standardised test across cohorts of students with the use of clear criteria against which multiple examiners can 'objectively' assess students. However, the challenge of creating an exam which captures the complexity of clinical communication and which satisfies the 'objective' and 'structured' nature of OSCE marking criteria is captured by the following respondent:

> I think the balance between being holistic and integrated and pulling everything together in a way that has high validity compared to what they [students] were doing in practice … and marrying that with something that's transparent and has an appropriate mix of subjective and objective criteria and where students understand what's required of them, that's a really tricky balance and I think that's one of our key challenges in assessment. [Int. 04]

Historically OSCEs have comprised checklist criteria against which candidates are marked, generally in binary form whereby a skill is broken down into component parts that are either demonstrated satisfactorily or not. This method has been applied to test communication. Out of 21 survey respondents six reported the use of checklists alone as marking schedules, ten reported combining check-list criteria with global ratings or domain-based marking schemes and five reported the adoption of domains as their main marking scheme (the use of domains will be discussed more fully shortly). The continuing use of check-list criteria, which aim to satisfy notions of rigour and objectivity was recognised to have a detrimental effect on how students 'demonstrate' their communication during the exam, as voiced below:

> Because, actually, if that person relaxed a bit more and wasn't so bothered by checklists that we've designed … I think there's a tension between having things that you can observe, and try and assess, and constraining people to behaviour in particular ways that loses that whole essence of being yourself generally with good intentions and we've got very mechanistic about it. [Int. 03]

This view was echoed in the following observation:

> And then … you see all this really, really good communication in the teaching, and it's excellent. You know, members of our team go in and observe the OSCE and the students, suddenly under time pressure, start doing machine-gun-style communication because they know that they've got to lose three minutes somewhere. And if they lose three minutes by cutting out six questions, the clinician will say, "But you didn't ask about x. [Int. 04]

This suggests that the situation in which students find themselves, being required to demonstrate clinical acumen while retaining person-centred principles of communication within limited time constraints (e.g. 8 – 10 minutes to elicit a history and arrive at a provisional diagnosis, or to deliver sensitive news), places them in a significant bind. While a stated aim of teaching is to develop communication that is informed by and congruent with patient-centredness, it seems the foremost method of assessment may militate against this very premise, by reducing complex relational activities to formulaic time-bound interactions. An additional layer of paradox lies in

how students are curtailed in communicating in the way they are taught when undertaking OSCEs, but are also at times curtailed in clinical practice:

> I know for a fact that they behave differently in OSCEs than they do on the ward, because I see them, I've watched them. So they kind of learn for OSCEs but then don't apply it in the real clinical workplace because the consultants shout at them. There's a schism. [Int. 01]

The above findings reflect mixed perceptions among respondents concerning the role of OSCEs. On the one hand, they are seen as encouraging students to produce 'idealised' communication to pass the exam which they may be discouraged from using in authentic clinical practice. On the other hand, the OSCE is viewed as distorting the ordinarily (and possibly instinctive) patient-centred approach students adopt in order to manage exam tasks in very limited time-frames. These concerns can be seen as symptomatic of a wider pedagogic schism between how students are taught clinical communication and how it is assessed and the undermining role of the (not so hidden) informal curriculum (Hilton and Slotnick, 2005). The latter issue (along with potential strategies for lessening the teaching – practice gap) has been discussed in Section 7.5, but what is being done to address concerns about the distorting effects of check-list criteria on students' communication? As cited above, 10 survey respondents reported the combined use of check-list criteria with some form of global rating or domain-based rating to allow for a more holistic assessment of students' performance. Furthermore, the adoption of domains-based schedules (outlined in 2.3.3) by five respondents can be seen as an attempt to obviate reliance on 'tick-box' marking and to deter students from adopting a 'formulaic approach' [Int. 08]. This is reflected in the following comment:

> [Students] realise that what you're looking at is a whole domain, we're not looking at a particular thing and they realised that we're using our judgement far more, because I could never convince them that because they said to a patient, "I'm very sorry to hear that," that, you know, I still wouldn't tick the bloody marks … But in domains they kind of understand that a bit more, that sincerity around what you're doing. [Int. 01]

This also points to domains allowing greater judgement to be exercised by examiners

on the students' overall approach to communication, rather than assessing it in itemised units. Those who had adopted domains-based schemes commented that this was a recent development and a further two respondents indicated their schools were moving to adopt this method. This transition indicates an emerging shift away from checklists, a sense which was further conveyed in the interviews (e.g. marking schemes need to *'morph'* as students are following lists [Int. 03]; domains are *'the way to go'* [Int. 05]).The apparent dissatisfaction with applying a checklist approach to an area as complex as clinical communication, now giving rise to the adoption of domains, was articulated by one respondent as arising *"...partly because we're trying to shoehorn it into exams which were originally set up for other things"* [Int. 02]. This viewpoint resonates with the wider critique of the adoption of 'skills' and 'competence' frameworks (previously discussed in 3.2), originally designed for mass labour-force up-skilling into the professional and vocational education sphere (Winch, 2013). Winch describes this process as:

> Emphasising the visible behavioural and performance aspect of know-how at the expense of what might not be so immediately apparent, but which is nevertheless critical to the understanding of co-operation and autonomous action in the workplace. (Winch, 2013 p. 282)

He further proposed that conceptions of know-how born of this epistemology tend to blur the differential features of techniques, skills and transversal abilities (the latter referring to higher order abilities including communication). Such lack of clarity between these differing features may give rise to the unease surrounding the use of OSCEs for the assessment of clinical communication. For example, OSCEs in which criteria-based binary assessment processes are still being utilised may be seen as unsuitable for capturing higher order capabilities, but adequate for capturing skills. This becomes problematic, where success in OSCEs is conflated with indicating higher order capabilities and professional attributes which require additional means of evaluation and resonates with the 'shoe-horning' phenomenon referred to by the previous respondent. The increasing adoption of domains-based assessment and of additional methods of capturing students' communicative capabilities (discussed below) can also be seen as a shift towards re-balancing the currently prevalent behavioural and performative approach with a more values-based and person-centred

approach.

Increasing integration of communication with other subjects in the OSCE was also reported [Int. 4; 5; 10], such as in this example:

> We collaborate on the stations, so there isn't just an ethics station, which has no marks for communication skills, and equally there isn't a communication skills that has no marks for content or professionalism, so that students know that it's … that they're not just being marked in subjects. [Int. 05]

This suggests that assessment methods in some schools are matching the move towards integrated teaching discussed in 7.2.1 and also flagged the same ambivalence towards the merits and risks of integration. This was voiced by Int. 10 who suggested that if communication is spread across all OSCE stations, without more distinctly focused communication stations, students may perceive it is allocated only a small percentage of marks and will relegate its importance as part of their learning.

Despite the criticisms of OSCEs outlined above, chiefly centred on the reductive tendencies of check-list based criteria, the perceived benefits of the method for assessing clinical communication were also discussed. Among these, was the view that learning for the OSCE (albeit in a somewhat rote fashion), reinforced the use of specific communication skills:

> We know that students are very savvy about working to exams so … it's not rocket science to think that a communication skills station will require you to introduce yourself to the patient … Well … in my book, if that means that ninety-nine percent of the students introduce themselves well to patients in the OSCE and have got into that habit and then go and do it on the wards for real, I'm quite happy about them having learnt it, if you like, to pass the OSCE … if it's become an ingrained skill.[Int. 06]

The extent to which skills practiced for OSCEs are reproduced in practice or not is difficult to gauge, particularly in light of the examples provided by other respondents of the challenges of doing so. But this example raises a more fundamental issue, concerning how students' motivation for learning and perception of the subject is

shaped by such an approach. Are students (continuing with this example) introducing themselves to gain a mark in the exam or because they consider it a respectful act towards the patient and the first step in building a reciprocally-based relationship? For many students it may be seen as a means to both ends, with the key motivation being context-dependent. Nonetheless, it can be argued that if a student's motivation for remembering to introduce themselves is 'OSCE-driven' rather than 'patient-driven', that a disequilibrium has occurred between the skills element of the subject and its conceptual underpinning of patient-centredness. This reinforces the concern that behaviourally-derived assessment processes may encourage surface learning for an aspect of practice which warrants far greater consideration.

In summary, the main criticisms of OSCEs arising from these findings centre on the limitations of traditional checklist criteria and how this can drive student learning towards formulaic 'protocol' type communication. Such a formulaic approach is antithetical to the flexible and adaptive communicator previously identified as being a key attribute of the medical graduate (see 6.2.1.and 6.4). An attempt to counter this reductive tendency can be seen in the development of domains based marking schemes, although there are concerns that the boarder descriptors inherent to domains marking may result in a lack of clarity in identifying desired communicative behaviours for 'non-expert' examiners who find themselves assigned to assess communication stations (Int. 10). Despite these criticisms, respondents also highlighted the value of OSCES as an assessment method. This included driving or reinforcing learning (albeit to pass the exam) and ensuring students attend to the subject, given its role in summative clinical examinations. While the OSCE was primarily discussed in terms of skills assessment, it was also deemed to have some value in detecting students with attitudinal and insight problems, as highlighted by this respondent:

> And I have seen occasions where a student, who does lack insight, where there are some quite serious problems around attitude that are tied in with the insight, does behave in a way that is not comfortable because of that lack of insight and it flags two things at once … there are certain things that are hard to control and that leak a little. [Int. 04]

Fundamental to this issue, is the kind of inferences that can be drawn from this type of assessment. Lum points to the 'the ontological differentiation of inner knowledgeable states as against outward behaviours' (Lum, 2012 p. 4). By its nature assessment draws us to rely on outward behaviours because access to the candidate's inner mind (including notions of understanding, motivation, attitudes and so forth) is not possible for the assessor. The ontological dilemma which this gives rise to, is articulated in the following comment concerning reflection:

> Yeah, it depends if you're thinking of skills as being observable behaviours or not. It's very difficult to observe someone being self-reflective. [Int. 10]

Another respondent, while acknowledging the importance of making opportunity in the curriculum for students' consideration of the role of values for their clinical practice, including communication, cited problems in attempting to assess these elements:

> However, I suppose, although I'd like them to absorb some of this and to think about this, it can't be a pass or fail criterion. It can't be an element of what we assess because what we assess is: are you making an acceptable doctor from the patient's point of view? And that's very much about how you come across. [Int. 02]

This view coheres with the premise that students' internal values, beliefs and attitudes are not, by their nature, directly accessible for assessment purposes. Rather, as suggested by Int. 02, we have come to rely on inferences drawn from what is observable - in this case how the doctor is seen to interact with the patient and how the patient comes to view the doctor from such encounters. This illustrates the attraction of skills-based / criteria marked OSCEs in enabling such inferential judgments to be made against a comforting backdrop of a 'transparent' and 'objective' test. Yet inference, by its nature, is acknowledged as an inexact process, so that judgments made on this basis may suffer from 'inferential hazard' (Dearden, 1984). Despite this limitation and other concerns outlined above, the overall sense conveyed by respondents was that no better method than OSCEs has as yet been developed to practicably assess how students actually communicate across a range of pre-defined clinical scenarios. This acceptance however was not unequivocal, with

suggestions for improvements to OSCEs. These include a move away from prescriptive check-list to domain-based marking schedules, coupled with realistic time-frames for OSCE stations [e.g. Int. 01; 04] that more accurately reflect authentic clinical practice.

While OSCEs, particularly in the binary 'done or not done' mode can be categorised as a 'prescriptive mode' of assessment, an alternative 'expansive mode' of assessment is described by Davis and Winch (2015). Whilst prescriptive mode assessment can be seen to have a legitimate role in testing, particularly in high stakes situations such as medical education where clear 'fitness to practice' outcomes need to be unambiguously achieved, they argue that it can be seen as necessary but not sufficient in capturing a rounded view of capability. To achieve the latter, they propose an expansive mode of assessment, whereby as wide a range of information as possible, gained from differing sources (or means of assessment) are collated to arrive at a more complete picture of the candidate. The expansive method also allows for 'judgments of significance' (Davis and Winch, 2015 p. 123) to be made, whereby the assessor can take account of any signal of note (not just those prescribed on specific assessment criteria) that may form useful evaluative evidence. The other methods of assessment reported by respondents are discussed in the next section and are evaluated in light of their potential contributions to a more expansive view of assessment than that provided by OSCEs.

8.3   Other methods of assessment

In addition to OSCES, the other modes of assessment reported by respondents were: multiple choice examination questions (n. = 3); practice-based assessments (n. = 3); formative assessment as part of experiential learning (n. 1); assessment of reflective activities (no. = 7) and portfolios (no. = 5). Key findings relating to these areas are presented in this section.

8.3.1   *Examination questions*

Reference to the use of examination questions (framed as 'single best answer' / multiple-choice style) questions was limited to a few respondents. The rationale provided for their use was to check students' knowledge of theory or evidence that had been taught as part of the communication curriculum, as summed up in this comment:

> So I think putting stuff in the knowledge exam is only useful for making people realise that there's actually an evidence based part of it, and that's fair enough. [Int. 10]

Their limited use as a method may result from the perception that theoretic knowledge testing is of little value in predicting how students communicate in practice:

> I remember seeing some research kind of fairly early on in my career, which showed that what students would write down in a written exam about their communication bears absolutely no relationship, there's no correlation with actually how they would perform face-to-face with a person. I think if the outcome is a face-to-face conversation with a person, then you have to be there, create that and observe it and mark it as such. [Int. 05]

Research on the correlation between knowledge and performance assessment in clinical communication is relatively scant (e.g. van Dalen et al., 2002b, Humphris and Kaney, 2001) and largely supports the view expressed above. It is however worth considering that the teaching and assessment of theory or evidence, though not necessarily predictive of behaviour, may have a place in a rounded pedagogic approach to the subject, which accords it an academic foundation (theoretic or evidence-based) beyond behaviourism. However, the use of short written answer questions (or longer pieces which may sit within portfolios or special modules) is likely to be more suitable than the electronically marked MCQ style questions which now prevail.

8.3.2   *Practice / work based assessment*

The role of practice-based / work-based assessment (WBA) as outlined in 2.3.3 is often associated with completion of log-books or other records of skills attainment as students' progress through clinical areas. One of the difficulties associated with this method lies in the degree to which students' clinical communication is specifically observed and fed back on. Moving clinical communication tutors from the classroom / skills laboratory setting to facilitate teaching in the clinical setting was described by Int. 01 in Section 7.4.2. This in turn provided opportunity for formative assessment through feedback on students' interactions with patients in the authentic clinical environment:

> They [students] say it's so wonderful to get feedback and to
> get checked to make sure you're doing it in the right way,
> because nobody ever watches them clerk [i.e. take a medical
> history from a patient]. [Int. 01]

Another example of work-based assessment was described, in which part of students' final summative clinical assessment takes place in an authentic ward setting with actual patients [Int. 07], rather than in the simulated environment of the OSCE. In this case the assessment is designed to capture students' overall clinical competency with communication forming an element of the exam. This growing interest in practice-based assessment was echoed thus:

> And I know that there's all sorts of problems around
> subjectivity and standardisation but I'm increasingly warm
> towards the idea of capturing more in terms of workplace-
> based assessment. It would involve training a lot of people to
> do it well, but capturing more of what's going on explicitly
> outside. [Int. 05]

The resource intensive nature of WBA was endorsed by Int. 01 and Int. 07 from their experience of this method. For formative learning, the feedback provided by simulated patients was felt to be more instructive for students than that provided by authentic patients who were reported to err towards being 'nice' and supportive,

rather than identifying weaknesses and areas for development (Int. 07). It appears that these points, along with the issue of providing standardised and objectively assessed exams, continues to impede the wider scale adoption of WBA.

8.3.3 *Formative assessment as part of experiential learning*

Formative assessment was noted to take place as a matter of course within experiential teaching by a number of respondents [e.g. Int. 03; 06; 07; 10]. This resulted from the observation of students' interactions in clinical scenarios with SPs and the subsequent feedback provided by tutors, the SPs and peers. Its occurrence within experiential teaching was viewed as so embedded that it may be overlooked as a means of assessment (albeit largely informal):

> One of the things that we do, which people don't realise, I think, is that the very way we teach it is assessing people all the time, because we're doing direct observation, which hardly happens anywhere else. So, if you like, formative assessment doesn't have to be thought about, it's almost how we do it. [Int. 10]

The usefulness of this type of formative assessment for identifying students who need additional support was also identified:

> I think we pick up people who've got problems from the teaching sessions, which are formative, obviously, and it's about learning but we do pick up people who we think are going to have some difficulties, for whatever reason. Some of them you just can't hear what they're saying … And some of them are struggling with big cultural differences in how you relate to a patient and the expectation. [Int. 03]

In some instances students had the opportunity to have their simulated consultations recorded for further review and reflection as an additional learning opportunity. This measure can be seen to promote an andragogic approach to learning, appropriate to the development of reflective, professional practice. The use of reflection for assessment purposes will be further discussed in the next section.

8.3.4   Assessment via reflective activities and portfolios

The use of reflective activities, for both formative and summative assessment was reported by several respondents. This comprised a range of activities, mediated mainly through reflective writing exercises collated in portfolios. The potential of portfolios for assessing non-technical skills such as professionalism has been noted (Driessen and van Tartwijk, 2014), but respondent accounts expose a tension as to whether reflection (a key component of portfolios) should be used for assessment purposes or rather as a medium for formative professional development, as captured in this comment:

> I think it's about whether you regard reflection as something that you're using as a tool for learning, and that's often how it's used, when you are a professional, it's used as a tool of ongoing CPD [continuing professional development] and self-directed learning, or whether you regard it as something that needs to be produced to a particular standard and therefore is assessed. [Int. 05]

The following response also highlights the issue of whether reflection should be subject to assessment:

> Purists would say that you can't assess reflection. Pragmatists would say you can. I don't fall into either of those camps. I could argue that either way. We already have a portfolio here where people have to reflect on cases that they've seen, things that they were challenged by, poor practice that they've seen. And they bring them back in and they're marked. [Int. 01]

Such 'purist' and 'pragmatist' approaches were illustrated in other respondents' accounts, from formally and systematically assessed reflection, such as in this example describing the marking of electronic portfolio entries:

> It's like a matrix and you can click various boxes to see why you've thought this was satisfactory or unsatisfactory. [Int. 09]

To others, where reflective activities were viewed as a mark of student engagement rather than something to be assessed:

We don't use the reflective pieces; they're not part of …
they're not actually formally marked, as it would be kind of
slightly odd to mark them because I think that would change
the nature of what it is. [Int.05]

These mixed views regarding the use of reflective activities for assessment purposes
resonates with Ng et al's (2015) discussion of the issue. They describe how
prevailing epistemological positions and discourses in medicine, centred on the
privileging of scientific and evidence-based knowledge over experientially generated
knowledge, has separated reflection from its original theoretic bases. They propose
two relevant theoretic bases for reflection in medical education, namely reflection as
epistemology of practice and reflection as critical social enquiry. The first of these
envisages reflection as a means to generate practice-based knowledge in situations
of, for example, uncertainty or challenge or which entail value-conflict. The second
theoretic position concerns reflection as a means for critical social enquiry. This
involves a widening of the reflective lens from 'self-reflection' concerning what one
thinks or feels, to reflection on ones actions and interactions with wider societal and
healthcare systems. However, Ng et al. (2015) suggest that these theoretic bases of
reflection have been subverted by prevalent trends in medical education to the
following: i) utilitarian applications of reflection; ii) a focus on the self as the object
of reflection and iii) reflection and assessment. Whilst i) and ii) have been discussed
previously, point iii) will be addressed here. Ng et al. (2015) highlight some of the
difficulties of using reflection for assessment purposes. They cite Wear et al. (2012)
in cautioning that 'overly-regulated exercises in reflection might inadvertently serve
as tools for surveillance and regulation rather than as opportunities for revelation and
transformation' (Ng et al., 2015 p. 458). Indeed, the point that students would be
reluctant to record or submit what might be considered inappropriate or
unprofessional views was alluded to in this comment:

[Students] know that they can only reflect in a certain way.
So it's fine as long as it's not marked, if you see what I mean.
Assessed reflective writing, which we do, I think has inherent
problems. So, it's not the writing of it that's important, it's
the thinking about it that's important. [Int. 10]

Findings relating to the use of reflection illustrate differing perspectives among respondents. This included a positive stance on reflection being used for assessment purposes, with meaningful engagement by students, illustrated in this example:

> Actually the reflective writing, not just on communication, is actually taken quite seriously as well. So I think they do value it, actually, yeah. Certainly I know if you give feedback and it's not quite what they think, they will come back to you and say, "Oh, why did you do this? Why did I get that feedback?" So it's something that they do definitely engage with. [Int. 09]

Other examples however, suggested the use of reflection for assessment purposes had made students somewhat cynical towards the process (Int. 08; 10). This resulted in them considering it as a means to an end, rather than a process of intrinsic value. These views reflect wider concerns within medical education surrounding the use of reflection and portfolios and suggest a need to reappraise the ways in which the original theoretic bases of reflection are being transformed by competency and accountability discourses and practices. Such a reappraisal has direct implications for the use of reflection for both the teaching and assessment of clinical communication. I will now briefly present respondents' suggestions for changes they wish to make to clinical communication assessment practices.

8.4   Wished for changes to assessment practices

Sixteen out of 21 survey respondents answered affirmatively to the question (Q20) 'Would you like to make changes to the current system for assessing clinical communication in your institution?' A wide range of suggestions were made, resulting in no strong theme emerging from their comments, but the following areas were flagged by two or more respondents. A sense of dissatisfaction with an over-reliance on OSCEs as the main assessment method was reported and a wish to 'widen the focus [of assessment] from behavioural skills' [Survey #8]. Survey respondent #10 described the present method as 'simplistic, reductionist and lacking true person-centred values approach'. Improvements to OSCEs were sought with longer time for stations [Survey #11] and better developed domain marking [Survey

#4]. Others wanted more formative and observational assessment and a greater range of methods to be used including portfolios, integrated clinical simulations and greater overall integration of communication with clinical skills [Survey #1; 2; 6; 12]. These responses reinforce findings reported from the interview data above concerning the need to improve upon the ways OSCEs are designed in order to: a) minimize the reductionist tendencies they may foster and the associated detrimental effects on student communication and b) to establish an expansive mode of assessment that enables a more rounded picture of students' capabilities to emerge.

8.5   Discussion

Insights from the wider sphere of educational assessment concerning prescriptive and expansive modes of assessment (Davis and Winch, 2015) have provided an analytic lens through which to appraise current practice. It seems that some prescriptive mode assessment, particularly in the form of criteria-based OSCE style exams, will continue to be used for the purposes of communication *skills* assessment. A tension remains however, concerning the adoption of more expansive modes of communication assessment at undergraduate level. An expansive mode of assessment makes use of all available sources of information (e.g. practice-based, portfolio-based and any other available sources) to arrive at a rounded view or picture of the individual student's capabilities and attributes[6]. It also allows for judgments of 'significance' to play a crucial role, whereby for example, a serious attitudinal concern or other lapse of professionalism, red flags the need for further examination of the student's suitability. Whilst the findings suggest the majority of medical schools do use more than one mode to assess communication, a difficulty appears to persist within medical education as to the dependability or trustworthiness of judgments drawn from expansive mode types of assessment. This centres on a greater reliance on the judgment of the assessor, bringing with it the perceived vicissitudes of subjectivism. For example, the assessor's perspective may be sought

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[6] This type of "360º" appraisal has been adopted in the UK Foundation Programme spanning the first two years of the medical graduates' training (see United Kingdom Foundation Programme e-portfolio, 2014).

as to whether a student appears to have adequately developed a capacity for reflection or to have assimilated appropriate professional ideals or appear to care enough about their patients' needs and wishes. Such interpretive judgments sit uneasily alongside traditional approaches of objectivity and 'hard' measures of reliability and validity customary in medical education and are more difficult to justify in a climate of increasing governance and public accountability.

At present, it seems that clinical communication as a field of practice is attempting to widen its assessment methods to a more expansive mode through the use of portfolio-based reflective assessment and some practice-based appraisal, while maintaining prescriptive mode assessment through OSCEs. Whilst this can be seen as a means of achieving a balance of assessment processes, it seems that prescriptive indicators are still accorded greater significance and weighting when it comes to high stakes decision-making in qualifying and progress decisions. If we agree with Schuwirth and Van der Vleuten's (2011 p. 246) suggestion that 'the driving influence of assessment is a powerful tool to ensure students learn what, and *how*, teachers want them to learn' (my italics) and we accept clinical communication as a multi-faceted subject, comprised of knowledge; skills and values, then a persuasive case for coherence between expansive mode pedagogy and assessment can be made.

8.6   Conclusion

The findings presented in this chapter confirm a range of methods being used for assessment purposes and reflect a wider recognition that no single method will capture the complexity of any area of medical practice (Epstein and Hundert, 2002). The relevance of this for clinical communication is made all the more pertinent if its multifaceted nature, comprising the domains of knowledge, skills and values is fully acknowledged. This is captured by the following statement:

> Clinical communication is not just about displaying a certain
> number of communicative skills … It's also about one's
> attitude and one's thoughts and one's understanding. It's that
> whole package. And one's developing sense of your role as a
> professional and, well, what does that mean … And I think
> you can't just teach communication in one way and you can't

just assess it in one way but there are lots of things that you
do over the course of an entire curriculum. [Int. 05]

Indeed, a range of methods were reported including OSCEs; written exam questions; practice-based assessments; high-fidelity simulation and reflection - mainly in the form of written assignments collated in portfolios. Of these, OSCEs continue to dominate the assessment of clinical communication. It appears however that there is an increasing recognition among communication teachers of the detrimental effects that traditional check-list criteria mark schemes (a feature of CBET) may have on the ways students develop and demonstrate their learning. As a result efforts are being made to mitigate such reductionist tendencies through the development of domain based marking schedules, which encourage a less formulaic and atomised approach on students' part and allow greater flexibility of judgment by examiners of candidates' overall communicative capability. Despite the identified flaws of the OSCE, the majority of respondents continue to support its use as the most feasible way of capturing students' communication skills in a standardised test which meets accepted measures of validity and reliability.

The benefits and limitations of other methods described by respondents have been discussed. These include the limited use of examinations questions due to their lack of proven prediction for clinical practice, while the use of high fidelity simulation was noted as an emergent method, though currently used more widely for teaching than assessment purposes. Challenges persist concerning the variability inherent in work- place assessment in terms of real-time observations by clinicians and the resource implications of transferring communication faculty to the clinical environment. Lastly, the use of reflective activities for assessment was contentious, viewed positively by some respondents as a valid measure of students' engagement and capacity for insight and learning from experience, while others felt that assessing reflection distorts its very purpose, resulting in contrived (anti) reflective accounts. In the final and concluding chapter I will return to both the spirit and the substance of clinical communication by summarising and synthesising the study findings. I will also propose a framework to contribute to the enrichment of clinical communication pedagogy.

9   Conclusion: Towards an enrichment of clinical communication pedagogy.

9.1   Introduction

The overarching aim of this study was to explore how current pedagogical practice embodies the complexity of clinical communication as a subject in the undergraduate medical education curriculum. I approached the enquiry from a social constructionist perspective, employing a qualitative methodology. Interviewing a sample of lead tutors from different UK medical schools and administering a pre-interview scoping survey across all UK medical schools, provided first-hand insights from those responsible for the design and delivery of clinical communication curricula at undergraduate level. This enabled me to investigate the range of curriculum, pedagogical and assessment perspectives and practices deployed in clinical communication contexts and to explore which of these have the most potential for addressing the complexity of the field. The key study findings are outlined below and discussed in terms of their implications for practice and have been formulated into a schematic framework which may serve as a model to promote an enriched practice and discourse of clinical communication teaching. It is anticipated that the framework and additional recommendations for the further development of clinical communication teaching will make a distinct contribution to the evolving pedagogy of the subject field.

9.1.1   *The core emergent constructs of clinical communication*

Two distinct constructs have been identified relating to the nature and scope of clinical communication as a subject. The first, an instrumental construct, focuses on the accomplishment of clinical tasks through the acquisition of specific skills and strategies, reflecting the applied nature of communication in a medical setting. The second construct, labelled 'the person as professional', is premised on the view that the scope of the subject extends beyond the acquisition of skills to encompass a range of personal and professional attributes. This includes consideration of one's

beliefs; values; attitudes and emotions, as elements which influence the nature of clinical relationships and interactions. These latter elements are also seen as intrinsic to the development of students' sense of professionalism, highlighting the iterative relationship between professionalism and clinical communication. While this second, broader construct was expressed by a majority of respondents, it was not unanimous. Alternative perspectives maintained a more skills and task-focused view, with exploration of values or attitudes deemed largely beyond the scope of the subject. While a focus on the teaching of skills in order to appear patient-centred was justified in promoting a consistent, minimum standard of communicative behaviour ('the professional carapace'), the risk of a resulting inauthenticity or lack of genuine engagement with patients was also recognised.

Identified teaching aims centred on two key areas, which largely mirror the broad constructs identified above. The first aim centres on equipping students to manage a range of clinical communication tasks via the acquisition of skills and strategies. The second aim, categorized as developing communicative capability, involved higher order functioning, such as flexibility, an analytical perspective and the ability to judiciously apply learning to practice.

Key attributes of the graduating doctor centred on the vision of a well-rounded clinician, in the sense of being both clinically competent and patient-centred in their practice. A range of qualities both personal and professional were also identified as follows: being insightful of one's own beliefs and attitudes and their effect on practice; self-aware; reflective and able to learn from experiences; resourceful; confident; resilient; committed to do the best; honest; aware of own limitations; accountable and a role model of good practice for others. The way in which the two core constructs of 'instrumentalism' and 'the person as professional' intersect the three areas outlined above is presented in Table 6.

While the dual constructs a) instrumentalism and b) 'the person as professional' emerged as common to the three categories in the left hand column of Table 6, findings suggest a variation in the emphases accorded these constructs. This is most notable in terms of explicitly articulated teaching aims, which tend to focus more on

Table 6: Cross-cutting constructs of clinical communication:

	Construct	
Category	a) Instrumental	b) Person as professional
1) Nature & scope of subject	Accomplishment of clinical communication tasks and outcomes	Concerns role of values; beliefs; attitudes; emotions; professionalism
2) Aims of teaching	To equip students with skills and strategies to accomplish clinical tasks	To facilitate the development of the person as professional
3) Graduate attributes	Competent and capable	Patient-centred; possessed of a range of personal and professional attributes

instrumental learning outcomes. To redress the imbalance, we need to take account of both constructs in order not to 'short-circuit' teaching to the accomplishment of skills and tasks without consideration of the person as professional elements. The literature pertaining to the practice of medicine as a values-based activity may lend weight to this aim. Little (1995) has long been a proponent of developing empathic and compassionate doctors as key to the delivery of humane medical care and there is a notable surge of interest in this ideal at the present time, given further impetus post-Francis Report (2013). Indeed, all UK medical students beginning their training this year have been sent the following message from the Director of Education & Quality and Medical Director for Health Education England. Referring to the investment in training and education, she comments:

> This huge investment is not just about providing you with the skills to care for patients, but also about instilling the core values from the NHS Constitution, as well as the values and responsibilities in medical practice. Compassion, understanding, delivering high quality care and putting patients first are just a few of the attributes we expect you to bring into the NHS and remain with you during your career. (Reid, 2015)

This message provides a mandate of sorts for the promotion of construct b) within all aspects of medical education. Rider et al's (2014) 'The International Charter for Human Values in Healthcare: An inter-professional global collaboration to enhance values and communication in healthcare' is also helpful in delineating numerous

physician attributes and dispositions (e.g. self-awareness, empathy, respectfulness) as necessary for the delivery of compassionate and ethical patient-centred care under the rubric of human values. The Charter also emphasises the central role of clinical communication in enabling a values-based approach. As such, a plausible case can be made for attending to the 'development of the person as professional' as part of a values-based approach to clinical communication teaching and with which to inform and enhance the instrumental element of the subject.

9.1.2   Notable features of current communication pedagogy

Among the differing curricular features outlined in Chapter 7, the degree to which clinical communication is integrated with other subject areas emerged as particularly significant to current practice and is influenced by the structure and orientation of the medical curriculum in different universities. Bernsteinian perspectives of classification and framing provided an analytical lens through which to consider the symbolic strength of subject boundaries within the medical curriculum and their role in facilitating or hindering horizontal (across subject areas) and longitudinal (between clinical and pre-clinical) integration. This is exemplified by the suggestion that clinical communication and professionalism might appropriately be integrated for teaching. However, this gives rise to concurrent concerns regarding the loss of a distinct subject identity for clinical communication.

Findings pertaining to teaching methods were considered in terms of formal university-based teaching and that delivered in the practice setting. Of formal teaching, experiential learning using clinical scenarios and simulated patients is the most commonly utilized method, as supported by previous research recommendations (Aspegren, 1999). While the discourse surrounding the use of experiential methods in this field is predominantly focused on skills development, it is notable that respondents identify this teaching method as having a clear role to play in areas beyond that remit. This included the exploration of, and reflection on, areas such as attitudes and emotions and the ways in which they may impact the clinical encounter. Reports of formal communication teaching in the practice area were limited and can be seen to contribute to the 'disconnect' between clinical

communication learning in the simulated environment and that which students encounter in clinical practice, a feature noted in other recent research in the field (Malhotra et al., 2009, Yardley et al., 2013).

This suggests a continuing tension between the messages and practices promoted through formal clinical communication teaching and those students encounter in practice via the informal or hidden curriculum (Hafferty and Castellani, 2009). Of particular significance is the reported erosion (by Int. 01) of the patient-centred elements of communication, noted when tutors observe students in the practice area. This resonates with the literature concerning the decline of empathy during medical training – a key feature of patient-centred practice as discussed by Hojat et al. (2009) and Pedersen (2010). The latter author points to the lack of opportunity afforded in current medical curricula for the consideration of existential aspects of medical practice, which is viewed as perpetuating a separation of the biomedical from human experience and understanding. Findings from this study suggest that efforts are being made to foster the development of students' empathy and patient-centredness. However, a tension remains concerning the focus on surface displays of these dispositions in teaching and assessment practice which may serve to undermine students' motivation to foster a deeper sense of engagement with patients.

The role of reflection was also identified as a key theme in the category of teaching. It is seen as a means as to enhance and expand experiential skills-based learning and secondly as a strand of professional development, including clinical communication learning. Discussion surrounding how formalized the process of reflection should be within communication curricula resonates with a wider debate in medical education, such as that put forward by Ng et al. (2015). They point to the assimilation of reflection into the discourse of medical education as a 'learning tool', the outcome of which can be measured and evaluated, as a development which runs contra to the essence of reflection as a way of 'being and seeing' (Ng et al., 2015 p. 468). The implications of these findings for communication teaching, suggest the need to maximise opportunities in experiential learning to focus equally on fostering understanding of the patient's perspective as well as how to demonstrate it and to provide opportunities within the curriculum for students to share and reflect on

experiences from actual clinical practice, with a view to developing insights and 'habits of mind' which help them constructively process the challenges they encounter.

9.1.3   *Assessment that reflects the spirit of the teaching – an on-going quest*

Findings relating to the analytical category of assessment yielded the following insights. Prescriptive mode assessment in the form of OSCES (or derivatives thereof), continue to dominate the subject field, particularly for high stakes summative purposes. However, there is the sense of a growing concern regarding the potentially detrimental effects of this method (associated with a competency-based approach) in driving learning towards a superficial level. Attempts to respond to such criticisms have resulted in a softening of binary type marking criteria towards more global domain descriptors, aimed at decreasing a 'tick-box' or formulaic approach to communication and allowing examiners more nuanced judgments of students' communicative ability. There is limited reporting of formal assessment in clinical practice, where appraisal is more likely to focus on other clinical processes rather than communication per se. Issues of standardization, fairness, and the practicality of assessing large student numbers in practice areas continue to challenge its implementation. Other forms of assessment such as examination questions (written or MCQ) are deemed of limited value due to their lack of predictive value for how students' would communicate in practice. Findings also reveal ambivalence regarding the utility and appropriateness of reflection for assessment purposes. While it is viewed positively by some respondents as a valid measure of students' engagement and capacity for insight and learning from experience, others feel that formalising reflection in this way may serve to distort its purpose in promoting an open approach to the process among students, resulting in potentially contrived (anti) reflective accounts which are designed to meet assessment criteria. This resonates with Ng et al.'s (2015) perspective that the utilisation of reflection for assessment purposes in medical education has transformed it from its original theoretic foundations. These foundations centre on reflection as a means of developing an epistemology of practice and as a means of critical social enquiry.

So what can be gleaned from these insights? It seems that central to the quest of capturing a rounded picture of students' skills and understanding of clinical communication, is the need to develop assessment methods which (in the words of Int. 05) 'capture the spirit of the teaching'. By this I mean, methods which not only evaluate the necessary interactional skills element, but also how students understand and engage with the wider constructs of the subject, such as the nature of the doctor-patient relationship, how this fits with the purpose of medicine itself, how they - as a person – operate within these greater schemes, and so forth. While there is evidence of some shift from objective / quantifiable assessment methods to those which require a more subjective mode of evaluation, there is a continuing need to challenge and revise what are deemed acceptable markers of 'competence' in our subject field.

9.1.4 Harnessing the role of theory in clinical communication teaching

The final theme to emerge in relation to pedagogy, centred on how underpinning theory is utilised in teaching. Findings reveal that aside from consultation models and some psychology theories, patient-centredness is the main conceptual model used in teaching. It is also commonly referred to as underpinning the skills element of the subject. There are differing views among tutors as to how far notions of patient-centredness and associated components such as empathy, can or should be instilled as part of clinical communication teaching, or whether a skills-based approach, through which features of patient-centredness are enacted by students is a sufficient preparation for clinical practice. This raises a central question as to whether a lack of (or at least a lack of emphasis on) guiding theoretic foundations is problematic. Is it perhaps sufficient to apply a set of pre-defined communication skills (associated with evidence-based clinical outcomes), within a medical consultation framework, as a functional approach to communication teaching and practice? Pragmatically speaking, the answer may well be yes, however, I would argue that the lack of overt theoretic bases (and I will suggest what these might comprise shortly) is indeed problematic. It can be argued that a lack of theoretic basis renders the subject vulnerable to prevailing trends in educational practice, without firm bedrock from which to appraise their fittingness for the subject. I allude here to the adoption of competency frameworks, in which differing notions of what competency does or

should comprise, continue to be debated in the field of medical education (ten Cate and Billett, 2014). While a call for greater consideration of how dispositional aspects of students' development are appraised in terms of competency is gaining purchase, the influence of the behaviourist tradition in the development of competency markers remains apparent. This may in part account for the designation of clinical communication towards the 'skills' labelled entity it is now commonly assumed to be.

Further to this, a number of respondents in this study sought to articulate a view of the subject in relation to the nature of medical practice and those who deliver healthcare. This suggests a role for some form of theoretic guidance which helps to give form to this vision. Two particular theoretic approaches have emerged as having potential for this purpose, namely values-based medical practice and virtue theory from the field of ethics. Little (2002), as previously discussed, outlines the rationale for a values-based approach. Whilst acknowledging the ethical principles that underpin medical practice, such as beneficence; non-maleficence; justice and respect for autonomy, he argues that 'Principles do not simply emerge from no-where. They are based on values and beliefs' (Little, 2002 p. 320). On this basis, he advocates the ideal of values-based medicine, which he describes thus:

> Values-based medicine seeks to go beyond any reductionist model, because it asks that we consult our values when we face dilemmas and problems of service delivery. It does not seek to reduce medicine to one of its components. Our values underpin all those component parts, and each component becomes important as a means of expressing those values.
> (Little, 2002 p.320)

Here we can see how clinical communication can be viewed as one such component through which personal and professional values are enacted in medical practice (while not undermining the role of evidence-based communicative practice). Duggan et al. (2006) provide a cogent rationale for the application of virtue theory as a moral basis for patient-centredness (as discussed in 5.1.3), while Duncan et al. (2003) draw on virtue theory in their discussion of what makes a 'good' health care practitioner (discussed in section 2.5). They point out that having knowledge of the principles of patient-centredness and the possession of a set of communication skills, does not

necessarily translate into 'good' communication. They suggest that in order to develop the 'something extra' that makes for a holistic practitioner, opportunities for processing and reflecting on their personal lives and experiences and the interaction of these with their professional roles, need to be incorporated into healthcare education. In this way, we can see the potential for theoretic approaches of moral or ethical origins to lend solid foundations to the teaching and practice of clinical communication. This also supports the notion of patient-centredness - which may be considered as both a value and a conceptual model – as the medium through which the theoretic foundations are brought to bear in clinical practice.

9.2   A proposal for the enrichment of clinical communication pedagogy

The overall picture emerging from the study findings is a view of clinical communication that recognises its complexity as an intrinsically valuable element of humane medical practice and the means for achieving a range of clinical tasks. However, the emphasis placed on these elements varies in terms of how the nature of the subject is articulated and in the way teaching is carried out, at times privileging a skills-oriented view at the expense of a broader holistic subject view. In order to encourage and promote the latter, I have developed a schematic framework for the enrichment of clinical communication pedagogy. This is set out in Figure 3 below. While recognising that a key aim of teaching is to help equip students with a range of skills and strategies with which to accomplish clinical communication tasks (i.e. the instrumental goals of clinical communication), the framework illustrates the relationship of this element to the intrinsic worth of ethically informed and values based communicative practice. It does so by suggesting a breadth and depth of potential approaches to foster students' engagement with clinical communication for its intrinsic worth as a core component of humane medical practice. The framework is derived from a synthesis of the literature review, findings and discussion emerging from this study, and is offered as a 'prototype' to be developed and elaborated on within our field of practice.

The key points which the framework intends to convey are:

The iterative relationship between professionalism and clinical communication:
Whereby, values-based and ethically informed communication is both constitutive of and a necessary requirement for professional practice. The association between these elements was a marked feature of the study findings.

The instrumental and intrinsic worth of clinical communication:
The framework aims to illustrate the equal importance of the subject for the achievement of clinical tasks and outcomes and for the delivery of humane medical care, despite a dominant discourse in the subject field and literature relating to instrumental features of tasks, skills and outcomes.

The need for ethical and values-based theoretic perspectives:
The adoption of theoretic perspectives, which serve to overtly ground the subject in an ethical and values-based foundation, would provide bedrock from which the teaching and practice of the subject would emanate. Such grounding may be drawn upon to counter prevailing reductionist discourses and practices within the wider arena of medical education. Examples are provided, but other theoretic perspectives may be applied.

The role of conceptual models of the doctor-patient relationship in enacting values-based practice:
This refers to the role of models such as patient-centredness and relationship centred care in the delivery values-based practice. It is proposed that the ethical and values-based theoretic perspectives suggested in the framework can infuse and enliven the most commonly cited models of the doctor-patient relationship. This can be brought about through a meaningful engagement with factors (both personal and professional) that influence the interpersonal dynamics of clinical relationships and interactions. These conceptual frameworks of the doctor-patient relationship are themselves values-based in their commitment to clinical relationships based on mutuality and respect.

Figure 3: A framework for the enrichment of clinical communication pedagogy

Associated pedagogic approaches*:

Knowledge acquisition: of theoretic and values-based perspectives, as foundation for intrinsic value of comm. and as context for skills development

Experiential learning & simulation: for skills development plus consideration of role of emotions / attitudes / beliefs on interactional processes.

Reflection: In differing formats (discussion; written; other media) for development of person as professional; critical social enquiry and epistemology of practice.

[*indicative rather than exhaustive examples]

PROFESSIONALISM

CLINICAL COMMUNICATION

Intrinsic worth for humane practice   **Instrumental outcomes**

Tasks /skills

Evidence-based

Informed by a range of theoretic perspectives (including):

- **VALUES-BASED APPROACH - Professional and human values**

- **ETHICS (e.g. Virtue theory; deontology; consequentialism)**

- **COMMUNICATION THEORY (e.g. Habermasian theory);**

   PSYCHOLOGY (e.g. attachment theory); SOCIOLOGY (e.g.

   paradigms of doctor-patient relations; discourse analysis)

Consideration of the inter - relationship between:

Personal values; beliefs; attitudes; dispositions

The values that underpin the kind of doctor the student aspires to be

Normative professional values

Mediated into practice via conceptual models (such as):

- **Relationship-centred care**

- **Patient-centredness**

Cognisant of reciprocal influence of both parties: doctor *and* patient / or other

169

The need for a range of pedagogic approaches that enable learning in relation to all the elements illustrated in the framework:

This refers to the need for a range of teaching practices which facilitate a theoretically grounded and values-oriented approach to the development of skilled and humane communication. Indicative examples are given of how particular approaches may contribute to this.

Before setting out my final recommendations arising from this study, I will briefly outline in the next section how the design, undertaking and completion of this enquiry have contributed to my personal and professional development.

9.2.1 *The continuing journey – discovery and development*

At the start of this thesis I traced my personal and professional 'journey to the starting line' of embarking on the EdD (Section 1.2). As I now approach the completion of this venture, it seems fitting to revisit my journey and consider the personal impact of this experience and its significance for my future development. On a personal level I discovered that I possess an inner core of tenacity and resilience that enabled me to keep going through an intellectually challenging and tough programme, alongside my full-time role as lecturer in the medical school. Attending to these commitments and maintaining a home life seemed overwhelming at times – but with the support I was fortunate to receive from those around me – it has been achieved. This has underlined the great value of reciprocal supportive relationships both professionally and personally.

I discovered that doctoral level study, though demanding and taxing, has significantly advanced my self-identity as a scholar in relation to the subject area of clinical communication and as an educationalist. It has done so by providing me with the opportunity to take a metaphorical step back from day-to-day practice and create a space in which I could apply a critical lens, within a community of learning and enquiry. In terms of my development as an educationalist, the requirement of the doctorate programme for in-depth and critical engagement with a wide range of theoretic and

research literature enabled me to situate my particular niche of medical education within a much broader educational landscape. This gave me a much clearer appreciation of the ways in which educational theories are applied and transformed in the specialised area of medical education, enabling me to review and critique these from a much more informed position. As a result I am able to articulate more clearly the academic concepts and principles (e.g. the role of skills, competencies and reflection) that matter to my own practice as a teacher and to the development of the curriculum within my medical school.

The requirement of the EdD to engage with a wide range of literature, to research current pedagogic practice and to synthesise these elements through my writing, has afforded me a much deeper understanding of the subject area of clinical communication. A particularly salient aspect in this respect has been the realisation that the 'instinctive' or intuitive reasons for my personal and professional investment in the subject of clinical communication stemmed from my own values in relation to this area. This led me to the realisation that prior to embarking on this process my personal values-base had been something of an amorphous backdrop to my practice as a clinician and educator. The opportunity to interrogate the conceptual basis of clinician-patient relationships, the ethical foundations which underpin them and their relation to the notion of values-based practice, brought my own values into much clearer focus and enabled me to conceptually situate what had previously been an intuitive basis for my practice. This development has increased my confidence in proposing and contributing to the development of new approaches to the delivery of clinical communication teaching and is manifested in my role as a core member of a curriculum working group within the medical school. As part of a substantive review of the undergraduate medical curriculum, the group has designed and introduced a 'human values' strand, which will run longitudinally through the undergraduate curriculum. This strand operationalises the integration of associated subject areas including clinical communication, ethics, professionalism, clinical skills and medical humanities and reflects the theoretic literature concerning the negotiation of subject boundaries in curricula (drawing on Bernstein's (1971) work). Furthermore, the strand is informed by the literature

171

pertaining to values-based practice (Little, 2002; Rider et al., 2014; Fulford et al., 2012) and reflects the growing acknowledgement of the role of personal and professional values in the field of clinical communication and the development of professionalism. I have been able to draw directly on the findings of this study and the deeper understanding I have gained through my learning from the EdD to contribute to this work. I am also involved in the development of the electronic portfolio system which is to be a key feature of the revised curriculum. My input into this process has been enhanced by the insights gained from the fieldwork element of this study and from my knowledge of the wider literature pertaining to the purpose and role of portfolios as a repository for reflective elements of learning.

I will conclude these reflections by acknowledging how my experience of conducting this study has made me appreciate my capacity as a 'teacher researcher' as well as the benefits of integrating teaching and research. I have been inspired to draw on my knowledge and experience to ask questions that seek to expand current understanding and modes of practice. As my professional journey continues I hope to use this springboard to make further contributions to the field of clinical communication pedagogy.

9.2.2   *Concluding comments and recommendations*

I will finish here by setting out the key recommendations resulting from this study for the further enrichment of clinical communication pedagogy:

Firstly, that greater consideration be given to the adoption of theoretic foundations, within which models of the doctor-patient relationship can be situated and which overtly ground the tasks and skills element of the subject to a values and ethics base. This can also serve as a means to harness the various human relational factors that are recognised as central to ethical and compassionate healthcare through the provision of learning opportunities for developing such aspects as self-awareness; reflective practice;

empathy; flexibility and respect. The above framework offers a model for how this might work.

Secondly, that we continue to explore and research ways of incorporating reflection into curricula that support all elements of practice and professional formation. This may reside within communication teaching or within a wider related curriculum strand of professionalism. The use of portfolios provides a platform for collation and longitudinal development of reflective activities. However, the provision of feedback on written reflective work and the opportunity for group or individual discussion should be viewed as a necessary component of this approach. Care must also be taken that the potentiality of reflection as a means of 'being and seeing' is not subverted to a 'means – end' learning activity as part of the assessment demands of the medical education culture.

And finally, that an overt discourse of 'clinical communication' should emerge that reflects the breadth and complexity of the subject as detailed in this study and which marks an evolutionary shift from the discourse of communication skills. The need for doctors to be able to communicate skilfully is indisputable – in the same way they need to diagnose or carry out surgery skilfully. Therefore, the role of instrumental task / process / skills teaching remains central. While these elements are clearly identified in curricula, concurrent teaching that attends to additional elements such as values, attitudes and emotions, have been less visible and where it does occur has been largely subsumed under the rubric of communication skills teaching. It is now timely to redress this situation in order that clinical communication pedagogy reflects the growing emphasis on values-based, humane and compassionate care.

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11 APPENDICES

APPENDIX 1: Message posted on UKCCC blog to publicise study.

Re. doctoral research project: *'To what extent does current pedagogical practice realise the complexity of clinical communication in undergraduate medical education?'*

Dear clinical communication colleagues,

As part of my research
 for the above project, I will shortly be sending out a brief on-line survey to leads for clinical communication in all UK medical schools. I am particularly interested in exploring how our current clinical communication teaching and assessment practices are influenced by skills and competency approaches and what this means for the development of clinical communication as an educational discipline. The survey is an initial scoping exercise, to get an up to date picture of how we are delivering our curricula in relation to this and what areas we wish to further develop and focus on.

I am also seeking willing volunteers to interview, so that these areas can be discussed in more depth and to glean further insights into the findings of the survey.

I hope that the findings of the study will be of interest and hopefully of use to all of us involved in the teaching of clinical communication and I look forward to sharing them with you when it is done.

To this end, if you can make time to complete the survey and / or consider being interviewed, I would be most grateful!

With thanks in anticipation! Bernadette.

APPENDIX 2: Survey recruitment e-mail.

E-mail header: **Clinical Communication Teaching & Assessment Doctoral Research.**

Dear colleague,

Re. doctoral study: *To what extent does current pedagogical practice realise the complexity of clinical communication in undergraduate medical education?*

I am seeking the help of fellow lead clinical communication colleagues across UK medical schools for my doctoral research project. I am particularly interested in exploring how our current clinical communication teaching and assessment practices are influenced by skills and competency approaches and what this means for the development of clinical communication as an educational discipline.

In the first instance, I am hoping that as many of you as possible will complete this short survey, which should take no longer than 15 minutes. The target date for return of questionnaires is **FRIDAY 28 JUNE 2013**. You can complete the survey by clicking on the following link:

Secondly, I am hoping to interview a number of you about your curricula to gain more detailed insights into current approaches and influences in our field of practice. You are asked to indicate if I can contact you about this on the questionnaire.

If you are willing to be interviewed, but would rather not complete the questionnaire – that is fine. Please just reply to that effect to: bernadette.o'neill@kcl.ac.uk and I will contact you to arrange an interview at your convenience.

Ultimately – I hope that the completed study will be of some interest and value to all of us involved in the teaching of clinical communication and the findings will be circulated to all participants.

I am very aware of the high demands on your time and greatly appreciate any input you are able to offer to my research endeavour.

With thanks and best wishes,
Bernadette.

If you do not wish to have any further e-mail correspondence about this survey please click on the following link

APPENDIX 3: Survey information sheet

INFORMATION SHEET FOR SURVEY PARTICIPANTS

REC Reference Number: **REP(EM)/12/13-46**

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title study: To what extent does current pedagogical practice realise the complexity of clinical communication in undergraduate medical education?

NOTE: This information sheet refers only to the survey element of the study (a separate information sheet and consent form is provided for participants willing to consider being interviewed).

I would like to invite you to participate in this doctoral research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

This study is being undertaken as part of a doctoral research thesis focusing on undergraduate medical education and in particular the teaching and assessment of clinical communication. This element of the study comprises a small scale survey of lead faculty members across all UK medical schools with responsibility for the design / delivery of undergraduate clinical communication teaching. The aim of the survey is to gain an overview of curricula features relevant to the study and responses will help in the design of an interview guide for the next stage of the study.

It is with regard to the survey that I wish to invite you to complete a questionnaire, which focuses on areas of teaching and learning relevant to the study. It is anticipated that the focus of this

questionnaire will provide additional insights to those gleaned from previous enquiries and provides an opportunity to collate more recent curricula developments across the UK.

The survey should take no longer than 15 minutes to complete using an on-line survey tool. If a paper copy of the questionnaire is preferred, this can be supplied along with a return, stamped addressed envelope.

Submission of a partially completed questionnaire implies consent (by pressing the 'store', 'next' or 'continue' buttons) to participate, and for data entered up to this point to be included in the study. Submission of a completed questionnaire (by pressing the 'submit' or 'finish' buttons) implies consent to participate, and for all data collected to be used.

Participants who complete the survey, will be invited to take part in a follow-up interview with the researcher. If you indicate an interest in being interviewed, you will be sent a separate information sheet providing details of what is involved.

All information gathered from participants during the study will be anonymised, so that you will not be personally identifiable in the data and subsequent report. All the data collected will be treated as confidential, will be stored securely at King's college London and will be accessible only to myself and my research supervisor. All data will be used only for the purpose of my doctoral research and will be destroyed upon completion.

It is hoped that the findings of the study will be of interest to the wider community of clinical communication and medical educators and will contribute to the existing body of research in the field.

On completion of the study, a summary of the insights gained from the enquiry will be circulated to participants. It is anticipated that the study findings will be disseminated through publication in peer reviewed journals and / or presentation at medical education conferences.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw from the study at any time and without giving a reason. You may also withdraw any data/information you have already provided up until writing up of the research report i.e. 31/01/14.

If you have any questions or require more information about this study, please contact the researcher using the following contact details:

Bernadette O'Neill

Simulation and Interactive Learning Centre

Division of Medical Education, King's College London

R. 2.12 - Shepherd's House, Guys Campus

St Thomas' Street

London SE1 9RT

Tel: 0207 848 6354

e-mail: bernadette.o'neill@kcl.ac.uk

If this study has harmed you in any way, you can contact King's College London using the details below for further advice and information:

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APPENDIX 4 – The scoping survey questionaire

[Follows on next page]

Teaching and Assessment in Undergraduate Medical Education

INFORMATION SHEET FOR SURVEY PARTICIPANTS

REC Reference Number: (EM)12/13-46.

Title study: To what extent does current pedagogical practice realise the complexity of clinical communication in undergraduate medical education?

I would like to invite you to participate in this doctoral research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully. Ask me if there is anything that is not clear or if you would like more information.

The focus of this study is undergraduate medical education and in particular the teaching and assessment of clinical communication. I am particularly interested in exploring how our current clinical communication teaching and assessment practices are influenced by skills and competency approaches and what this means for the development of clinical communication as an educational discipline.

This element of the study comprises a small scale survey of lead faculty members across all UK medical schools, with responsibility for the design / delivery of undergraduate clinical communication teaching. The aim of the survey is to gain an overview of curricula features relevant to the study and responses will help in the design of an interview guide for the next stage of the study.

To this end, I invite you to complete the following questionnaire, which should take no longer than 15 minutes. It is anticipated that the survey will generate additional insights to those carried out previously and provides an opportunity to collate more recent curricula developments across the UK.

Submission of a partially completed questionnaire implies consent to participate, and for data entered up to this point to be included in the study. Submission of a completed questionnaire (by pressing the 'done' button) implies consent to participate, and for all data collected to be used.
The target date for return of questionnaires is FRIDAY 28 JUNE 2013.

Whilst completing the survey, you will be invited to take part in a follow-up interview with the researcher. If you agree to this, you will be sent a separate information sheet providing details of what is involved.

All information gathered from participants during the study will be anonymised, so that you will not be personally identifiable in the data and subsequent report. All data will be treated as confidential, stored securely at King's college London and will be accessible only to myself and my research supervisor. All data will be used only for the purpose of my doctoral research and will be destroyed upon completion.

I hope that the findings of the study will be of interest to the wider community of clinical communication and medical educators and will contribute to the existing body of research in the field. A summary of the study findings will be circulated to participants and members of the UK Council of Clinical Communication. It is anticipated that these will also be disseminated through publication in peer reviewed journals and / or presentation at conferences.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw from the study at any time and without giving a reason. You may also withdraw any data/information you have already provided up until writing up of the research report i.e. 31/01/14.

Teaching and Assessment in Undergraduate Medical Education

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Simulation and Interactive Learning Centre
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St Thomas' Street
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Tel: 0207 848 6354
e-mail: bernadette.o'neill@kcl.ac.uk

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Dr. Anwar Tlili (research supervisor)
Dept. of Education and Professional Studies
King's College London
Franklin-Wilkins Building
Waterloo Road
London SE1 9NN
Tel: 0207 848 3163
e-mail: anwar.tlili@kcl.ac.uk

Teaching and Assessment in Undergraduate Medical Education

SECTION 1: DEMOGRAPHIC DATA

1. Name of medical school?

2. Medical student cohort size per year?

3. Your designation / job title?

SECTION 2: CLINICAL COMMUNICATION TEACHING

Questions 4-8 refer to university/ skills laboratory based teaching, whilst questions 9 onwards refer more broadly to clinical communication teaching and assessment within your institution.

4. Approximately what percentage of your clinical communication curriculum comprises skills-based teaching*? (*defined as students developing specific behavioural and procedural skills required for clinical tasks, e.g. history-taking, exploring, explaining, breaking bad news).

5. What methods are used for experiential communication skills development in your medical school? (please select as appropriate and rank most frequently used methods - with 1 being most frequent, 2 next most frequent, etc. for all methods used).

	YES / NO	Rank most frequently used methods - with 1 being most frequent, 2 next most frequent, etc. for all methods used
Clinical scenarios with simulated patients (SPs)		
Clinical scenarios with role play between students (i.e. students taking on patient or other role)		
Practice scenarios with actual patients		
High or low fidelity simulation using manikins and SPs		
Other		

If 'Other' (please describe)

Teaching and Assessment in Undergraduate Medical Education

6. Which other (non-experiential) teaching methods do you use for clinical communication teaching and learning? (Please select as appropriate and rank most frequently used methods - with 1 being most frequent, 2 next most frequent, etc. for all methods used)

	YES / NO	Rank most frequently used methods - with 1 being most frequent, 2 next most frequent, etc. for all methods used
Seminars (e.g. reflective / discussion)		
Lectures		
E-learning resources		
Directed learning (e.g. reading / worksheets)		
Portfolio development related to clinical communication learning		
Other		

If 'Other' please describe

7. If you answered 'yes' to any of the options in question 6 - are these integrated with clinical communication skills teaching or delivered separately?

◯ Integrated ◯ Separately

Please give examples of any integrated activities and comment on any difficulties in achieving integration

Teaching and Assessment in Undergraduate Medical Education

8. Please select any subject areas from the list below that are linked with clinical communication teaching in your undergraduate medical curriculum and whether this is explicit (i.e. joint teaching sessions – explicit linkage by tutor/lecturer) or implicit (taught separately / linkage may be minimal or assumed, or tutor dependent). N/A = not taught within undergraduate medical curriculum:

	LINKED - YES / NO	LINKAGE EXPLICIT / IMPLICIT	N/A - NOT TAUGHT
Clinical skills – practical procedures (e.g. venepuncture, catheterisation)			
Clinical skills – physical examination			
Clinical specialities (e.g. paediatrics, obs. & gynae., A&E, General Practice)			
Medical ethics			
Psychology			
Sociology			
Interprofessional education			
Medical humanities			
Other			

Please add any comments you may have on the linkage / integration of clinical communication with other subject areas

9. Are any clinical communication related Student Selected Modules (SSCs) available to your students?

○ YES   ○ NO

If 'Yes' - please give the title / focus of SSCs

10. Which consultation models / frameworks are utilised in your clinical communication teaching?

☐ Calgary-Cambridge Guide

☐ The Three Function Approach

☐ Disease-Illness Model

☐ The Inner Consultation

Other (please specify)

Teaching and Assessment in Undergraduate Medical Education

11. Do any theoretic frameworks or perspectives (not included in Q.10) inform your clinical communication curriculum or teaching (e.g. 'Patient-centredness', 'Relationship-centredness')?

◯ YES   ◯ NO

If 'yes' please confirm which theoretic framework and comment briefly on why this choice

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12. To what extent do you agree that clinical communication teaching should address areas beyond behavioural communication skills acquisition (such as attitude formation, development of self-reflection, exploration of the effects of personal values)?

◯ Strongly disagree   ◯ Disagree   ◯ Neutral   ◯ Agree   ◯ Strongly agree

13. To what extent do you think your clinical communication curriculum currently addresses areas beyond behavioural communication skills acquisition?

◯ Minimally   ◯ Somewhat   ◯ Adequately   ◯ To a good extent   ◯ Fully

14. To what extent are the following areas addressed within the teaching of clinical communication in your institution?
Students':

	Minimally	Somewhat	Adequately	To a good extent	Fully
Attitudes	◯	◯	◯	◯	◯
Emotions	◯	◯	◯	◯	◯
Values	◯	◯	◯	◯	◯

SECTION 3: ASSESSMENT

15. To what extent do you feel your institution's clinical communication assessment procedures capture the following?
Students':

	Minimally	Somewhat	Adequately	To a good extent	Fully
Clinical knowledge	◯	◯	◯	◯	◯
Communication skills	◯	◯	◯	◯	◯
Attitudes	◯	◯	◯	◯	◯

16. Are OSCEs the main mode of assessing clinical communication in your undergraduate medical degree programme?

◯ YES   ◯ NO

17. In which year/s of the undergraduate medical degree programme are OSCEs used to assess students' clinical communication?

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5

18. Are your undergraduate clinical communication OSCEs stations marked predominantly against

◯ Domain-based criteria

◯ Check-list criteria

◯ Combination of above

Please add any comments (e.g. from your experience the benefits or drawbacks of either scheme)

19. Are methods other than OSCEs used to assess clinical communication in your institution?

◯ YES   ◯ NO

If 'Yes' - please outline what these are

20. Would you like to make changes to the current system for assessing clinical communication in your institution?

◯ YES   ◯ NO

If 'Yes' - please outline in what way/s and your reasons for this

21. Would you be happy to be interviewed as a follow up to this questionnaire? (this would be for approx. 45 minutes, at a time and place convenient for you).

◯ YES   ◯ NO

If 'yes' please confirm your contact e-mail address

MANY THANKS FOR YOUR TIME IN COMPLETING THIS SURVEY

INFORMATION SHEET FOR INTERVIEW PARTICIPANTS

REC Reference Number: **REP(EM)/12/13-46**

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title study: To what extent does current pedagogical practice realise the complexity of clinical communication in undergraduate medical education?

NOTE: This information sheet refers only to the interview part of the study.

I would like to invite you to participate in this doctoral research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

This study is being undertaken as part of a doctoral research thesis focusing on undergraduate medical education and in particular the teaching and assessment of clinical communication. This element of the study aims to shed light on how the current discourse of communication skills may be influencing the form and content of clinical communication curricula, and to explore the ways in which values-based approaches to clinical communication teaching are, or may be, incorporated into curricula.

So far, I have carried out a small scale survey across UK medical schools to gain an overview of curricula features relevant to the study. I now aim to carry out interviews with lead clinical communication teachers from different UK medical schools. In doing so, I hope to gain in-depth insights into the ways in which clinical communication teaching and assessment is being delivered in relation to the issues outlined above.

It is with regard to this that I am inviting you to participate in one in-depth interview (lasting approximately 45 - 50 minutes) at a location and time convenient to you. The researcher is happy

to carry out a telephone interview if that is preferred. In this case, consent will be sought by e-mail confirmation using the institutional e-mail addresses of the researcher and respondent.

Interviews will be audio recorded, subject to your permission and will be deleted once transcribed. You will be given the opportunity to review the transcript of your interview for accuracy and to add any further comments you may wish to make. All information gathered from participants during the study will be anonymised, so that you will not be personally identifiable in the data and subsequent report.

All data collected will be treated as confidential, will be stored securely at King's College London and will be accessible only to myself and my research supervisor. All recordings and data will be used only for the purpose of my doctoral research and will be destroyed upon completion.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw from the study at any time and without giving a reason. You may also withdraw any data/information you have already provided up until 31/01/14.

It is hoped that the findings of the study will be of interest to the wider community of clinical communication and medical educators and will contribute to the existing body of research in the field. On completion of the study, a summary of the insights gained from the enquiry will be circulated to participants. It is anticipated that the study findings will be disseminated through publication in peer reviewed journals and / or presentation at medical education conferences.

If you have any questions or require more information about this study, please contact the researcher using the following contact details:

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APPENDIX 6 – Interview consent form

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CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

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Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

KING'S College LONDON

Title of Study: To what extent does current pedagogical practice realise the complexity of clinical communication in undergraduate medical education?

King's College Research Ethics Committee Ref: REP(EM)/12/13-46

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please tick or initial

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to 31/01/14

- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the UK Data Protection Act 1998.

- I consent to my interview being audio recorded.

- I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications

☐

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed   Date

APPENDIX 7: Interview Guide

<u>**To what extent does current pedagogical practice realise the complexity of clinical communication in undergraduate medical education?**</u>

Preparation:
- Assign code to respondent's name.
- Note job role of respondent and number of medical students per year.
- Check any particular areas of interest raised in questionnaire to raise during interview.

Set up:
- Introductions
- Re-cap re. aim of interview
- Check willingness to proceed and gain written consent (including recording the interview).
- Ice-breaker - ask the respondent a little about themselves e.g. what they do, how they have come to do what they do.

1a) *Opening question -* **views on clinical communication as a subject***:*

> *1A) I'D LIKE TO START BY ASKING WHAT YOU THINK CLINICAL COMMUNICATION ENCOMPASSES AS A SUBJECT?*

Key areas for exploration in body of interview:

2) Integration of clinical communication with allied subjects and wider medical curriculum:

> *2A) COLLEAGUES HAVE REPORTED GREATER OR LESSER DEGREES OF INTEGRATION OF CLINICAL COMMUNICATION WITH OTHER AREAS OF LEARNING, COULD YOU TELL ME A BIT ABOUT YOUR VIEWS ON INTEGRATION?*

Possible prompts / follow up if needed:
- To what extent / how should it be pursued?
- *What do you consider to be the value of an integrated approach?*

3) **Enquire re. broader elements of clinical communication and relationship with comm. 'skills' teaching:**

3A) WHAT ARE YOUR VIEWSAS TO WHETHER CLINICAL COMMUNICATION TEACHING SHOULD ADDRESS AREAS SUCH AS DEVELOPMENT OF SELF-REFLECTION, EXPLORING THE EFFECTS OF PERSONAL VALUES AND BELIEFS?

Possible prompts / follow up if needed:

- *Where else in the curriculum would these aspects be considered?*
- *How do these elements 'sit' in relation to skills & task-based teaching?*

3B) WHAT DO WE HOPE TO ACHIEVE WITH STUDENTS BY ATTENDING TO THESE ASPECTS OF THEIR DEVELOPMENT?
WHAT KIND OF STUDENT ARE WE HOPING WILL EMERGE FROM OUR CLINICAL COMMUNICATION TEACHING?

- *How do we go about doing this?*

4) **Role of conceptual frameworks / models:**
   4A) CAN YOU TELL ME ABOUT YOUR VIEWS ON 'PATIENT' CENTREDNESS' AS A CONCEPTUAL FRAMEWORK IN THE CLINICAL COMMUNICATION CURRICULUM?

Possible prompts / follow up if needed:

- *If not used, explore reasons and if alternative model/s used?*

If used:

- *Explore how it's incorporated within teaching? (E.g. as an over-arching concept or in a more focused way?)*

5) **Reflection / portfolios:**
   5A) COULD YOU SHARE YOUR THOUGHTS ON THE ROLE OF REFLECTION IN RELATION TO CLINICAL COMMUNICATION TEACHING?

Possible prompts / follow up if needed:

- *How is it used in teaching (context / form)? How are students prepared for this (e.g. models of reflective practice / guidance?)*
- *Do you think there is a case for including some form of reflective work in the assessment process for clinical communication?*
- *How does this approach sit within a skills / competency framework?*

5B) *WHAT DO YOU THINK ABOUT THE USE OF PORTFOLIOS IN RELATION TO CLINICAL COMMUNICATION TEACHING AND LEARNING?*

Possible prompts / follow up if needed:

- *If used – how do students seem to engage with this approach?*
- *What do think students gain from portfolio development in relation to cc?*

6) **Views on assessment of clinical communication:**

6A) HOW DO YOU THINK STUDENTS' DEVELOPMENT IN CLINICAL COMMUNICATION CAN BEST BE CAPTURED?
6B) CAN YOU TELL ME ABOUT THE WAYS CLINICAL COMMUNICATION IS ASSESSED IN YOUR MEDICAL SCHOOL?
6C) ANY VIEWS ON THESE METHODS OF ASSESSMENT?

Possible prompts / follow up if needed:

- *What about OSCEs as a method of assessment for clinical communication?*
- *How do you think OSCEs effect student perceptions of clin. comm. / their approach to learning?*
- *Is it necessary / desirable to move beyond skills assessment at undergrad. level? Explore reasons for response?*

Closing:

- Is there anything else you would like to add to our discussion, especially regarding how to support and enhance the pedagogy and learning of clinical communication?

- Offer opportunity to review transcript if wanted. Outline how the study will proceed, when findings will become available and how I will let them know about this (if they want this).

Thank participant.

Appendix 8 – Data reduction table [related to Ch. 4, section 4.7 p. 72]

Codes from interviews	Sub-themes	Themes	Categories
Skills checklist; Behaviour as indicator of other things; what's covered; skills; aims; behaviours outcome of thinking; listening: behaviours linked to diversity;	[not in this category]	Comm. as skills and tasks	**Nature & scope of clinical communication**
range of tasks; breaking bad news; comm. with colleagues, helping pts with procedures; managing info. comm. through different mediums; consent; decision-making; educating patients; eliciting info.; giving info.; managing resources; listening & being supportive;		↑ Balance between skills / values ↓	
Behaviour as indicator of other things; EI & insight; interpersonal & relationship skills; team-working; time management & organisation; to shape thinking; developing self-awareness;		Comm as development of personal & professional self ↑↓	
Attitudes; Authenticity; Emotions; Empathy; Confidence; Values and beliefs; Insight; Resilience; Self-reflection; how to appear; putting on a face; understanding;		Authenticity / carapace	

Codes from interviews	Sub-themes	Themes	Categories
authenticity Other codes: Emergence of comm. as subject; Future of clin. comm.; Status of clin. comm. as subject; research			
strategies; ultimately help patients; manage situations; develop flexibility; developing judgment; cognitive schema; apply theory or knowledge; reflection on action; Other codes: make it less tough for stds; learning about the system;	a) Flexible approach b) Analytical perspective c) Application of learning	A) Learn to manage clinical situations B) Develop communicative capability	**Aims of clinical communication teaching**

Codes from interviews	Sub-themes	Themes	Categories
Type of doctor; Type of doctor you don't want; communicate effectively; able; shared-decision making; sensitive; 'walk alongside patient'	Competent; patient-centred	The well – rounded doctor	**Key graduate attributes**
professionalism; Insightful; reflective; confidence; learn from experience; self-aware; resilient; reality & challenges of doctoring; values; beliefs	Personal qualities; professional integrity	The person as professional: attributes and qualities	
Postgrad v. undergrad; reflection - relation to wider med curriculum; final yr content; yr 3 content; general content; Undergrad. comm. teaching - ABC! Medical school curriculum; Integration - challenges of; Link - health psychology; Link - professional development; Links - clinical skills; Links – ethics; IPE; better in later yrs.; early yrs about pt. experience	Curricular content	*A)Teaching*	**Pedagogy**
	Curricular structure	Classroom based – formal	
workplace-based learning, what happens in practice; hostile environment; role-models;		Practice-based learning – formal and informal	

Codes from interviews	Sub-themes	Themes	Categories
how to structure consultation; gather info.; clinical reasoning; explaining; shared decision-makinig; Responding to emotions; challenging situations; breaking bad news; communicate with particular patients - sensory impairment, post-stroke, end –of-life care); handovers; Promoting self-care/ motivational interviewing; obtain consent;content - based on experiences in practice.	Curricular content		
Biopsychosocial; Consultation models; Pt.- centrdness;	Models and theory		
creating the right environment; discussion; relation to wider med curriculum; reflection - std response & engagement; reflection & exploration of values - faculty view; reflection in curriculum; reflective writing*	Reflection and portfolios		
mixed methods; pitch to level of experience; Experiential; Simulated patients; Feedback; Reflection [codes as above] * Portfolios; research projects	Teaching methods		

Codes from interviews	Sub-themes	Themes	Categories
Other codes: Tutors – general; level of training re. reflection & exploration			
skills-based; formative; general; assessment of reflective writing; theory OSCE- impact on learning (Nodes); OSCE marking schemes; checklists; domains;		*B) Assessment*	**Pedagogy**