Chapter 7

Practical relevance

Extract 3. Interview 8

Well a lot of this stuff [clinical communication] we just think that was good or that wasn't good but actually defining what it is would be helpful ... perhaps we are doing it [teaching/evaluating communication] reasonably and we know those things but what is it that actually underpins that? (Medical educator/RACGP examiner)

Extract 8. Medical Educators' Workshop

It [discourse analysis] alerts us and highlights what we are actually doing and looking at ... it goes to a level of detail that we're aware is there but haven't had the vocabulary to describe ... being able to more precisely describe what is happening it gives us the vocabulary to do that ... I think that's really valuable (Medical educator).

These quotations book end the discourse analytical study that lies at the heart of this thesis. The first quotation, extracted from an interview conducted as research began, is a response to my question about how the proposed study might be helpful to practitioners. The second is drawn from a workshop for medical educators that took place towards the end of the discourse analytical phase and has been referred at various points throughout the thesis. At this workshop, participants were invited to consider my analysis of the discourse of a number of PBA consultations, to offer a practitioner's perspective on this analysis, and to discuss the relevance of such analysis to their work.

On the one hand, as the ethnographic phase of this study has shown, much professional knowledge about clinical communication in General Practice is 'discursively articulated'(Goodwin, 1994). It is made explicit in theories, guidelines, and skills sets that are set out in training texts. It is articulated by educators and trainers as they draw upon principles, models, and repertoires of exemplar phrases during training, and by examiners in their evaluations of communicative performance. Yet, as the experienced practitioners quoted above imply "competent practitioners usually know more than they can say"(Schön, 1983, p. viii). Much communicative knowledge remains tacit in the form of 'knowing in practice'(Schön, 1983). Whilst this tacit knowing flows from a long and intimate acquaintance with everyday practice, it is an "indwelling" in the

knower (Polanyi, 1969, p. 134) and may be difficult to describe and to define and, as a consequence, to retrieve and to share.

Nevertheless, knowledge that cannot be explicitly verbalised is open to reflection (Schön, 1983), and discourse analytical studies of professional practice offer insights that might inform such reflection (Sarangi & Candlin, to appear). As Eisner points out (1985, 1998), in order to see a situation or to appreciate an experience, we need to be able to name the different elements of that situation and to show how they relate one to another. For the medical educator quoted above, discourse analysis is of value as it offers educators, examiners, and registrars a language for describing what they observe as they reflect on practice and thus for seeing and appreciating what they do in its detail and complexity. It enables appreciation of the fine grained detail of doctor-patient interaction and this appreciation might inform the teaching and evaluation of clinical communication.

This chapter considers how the current practices of registrars, medical educators and trainers and, potentially examiners might benefit from the results of this thesis. It begins by revisiting the Australian General Practice Training program that was introduced in Chapter 1 to suggest how discourse analysis might complement current modes of teaching clinical communication. It considers precedents for incorporating the development of discourse analytical skills into professional development courses, and draws upon results from the current study to outline a model for integrating discourse analysis into the General Practice communication curriculum. Finally, a place for discourse analysis in examiner training is suggested.

7.1. Revisiting the clinical training site

Medical education, and General Practice education in particular, has long advocated a problem solving approach to the development of clinical skills, including communication (Gask, Usherwood, & Standart, 1992; Usherwood, 1993). Using this approach, learning is based around problem-solving experiences in the contexts of both naturally occurring and simulated consultations, and involves opportunities to collaboratively reflect on these experiences with mentors and peers.

The Australian General Practice Training program continues in this tradition. As previously described (See Chapter 1) this comprehensive program supports registrars in General Practice placements and prepares them for unsupervised practice. It combines on the job mentoring by experienced practitioners with classroom based learning that integrates communication into the development of clinical competence to manage the wide ranging situations that arise in practice. Ethnographic accounts and transcripts of teaching sessions have been drawn upon throughout this thesis as a resource to illuminate such teaching practices.

Both on the job and in the classroom, medical educators, trainers and registrars are constantly engaged in collaborative 'reflection-on-action'(Schön, 1983). In the workplace, following consultations that have sometimes been video-recorded, registrars and their mentors jointly reflect on the novice doctor's performance. By reflecting on why they acted as they did in specific situations, in the company of an accomplished practitioner, these registrars gradually build a repertoire of experiences that guide and inform future action through an on-going series of learning cycles.

At the more formal training site of the RTP classroom, the provision of information about communication theories, models and principles is combined with opportunities to participate in clinical role-plays designed to reflect real world clinical situations, to prepare registrars to communicate effectively in these situations, and to develop their capacity to 'reflect-in-action'(Schön, 1983). Through intervening strategically at critical moments in these role-plays, educators encourage registrars to reflect on their communication in the midst of practice, to apply pertinent theories and principles in context sensitive ways, and to test out new understandings with new moves as the interaction proceeds. In this way, novice doctors are to develop the capacity to 'think on their feet' as interaction unfolds and to respond strategically to the patient so as to advance the consultation. One of the objectives of this thesis is to ask how discourse analysis might assist this process and how it might contribute to such reflective, problem-based experiential learning.

7.2. Using discourse analytical themes to enhance reflection on practice

One strategy that educators frequently use to facilitate reflection in action in classroom settings involves intervening in role-plays to elicit exemplar phrases from the role-playing doctor and from observing participants which the doctor might then apply to the moment at hand. Often, wordings that are suggested by registrars are refined through discussions in which educators offer exemplars of their own.

However, exemplar phrases that are generated as responses to a particular moment in interaction in a specific 'site of engagement' (Scollon, 2001) may not of themselves be readily transferable to other situations. On the other hand, as suggested earlier in this thesis (See page 229), discourse 'analytical themes' that are derived empirically from analysis of naturally occurring transcribed interaction, may offer useful explanatory concepts that are able to absorb and incorporate exemplar phrases, but also have reach and applicability beyond a specific instance. In section 5.3.1, for example, the concept of "perspective display invitation " (Maynard, 1989, 1991b, 1992) was advanced as a means to encapsulate the course of action and exemplar wording that the educator had suggested to assist the registrar to move forward at a critical moment of conflict in a role-play involving patient-doctor dissent. The strategic introduction of such a relevant discourse analytical theme could have provided registrars with an empirically grounded communication strategy to draw upon when faced with similar communicative challenges in other contexts. Suggested phrases and specific wordings might assist registrars to respond effectively to a particular interactional moment, but discourse analytic themes have broader application and can be drawn upon to inform effective communicative action in a range of situations. In addition, such themes offer educators and registrars the possibility of a shared meta-language for discussing communication.

The following vignette from registrar training further underpins the value of pertinent empirically grounded discourse analytical themes as a means to add explanatory power to educators' feedback, and thus to enhance participant reflection. The vignette focuses on the theme of rapport that has emerged in this study as a co-constructed and collaborative interactional accomplishment. Two extracts from the training session are presented. The first extract is from the registrar's performance in a role-play involving a taciturn adolescent patient who has been sent to see the doctor by his mother. Analysed

in detail in section 3.2.6.2 of this thesis, the role play displays the actions taken to gradually build a viable therapeutic relationship with this initially reluctant patient, and, in particular, the interactional work whereby rapport is achieved. The second extract represents the medical educator's intervention in this role-play to focus attention on how rapport was accomplished.

Extract 1. Training role-play 1

99	R:	Mm and anything else at school you like um sport or [music or
100	P:	[Oh yeah I play a bit of sport I play a bit of music yeah
101	R:	Do you :
102	P:	Yeah
103	R:	What do you play
104	P:	Oh bass
105	R:	Excellent
106	P:	yeah
107	R:	Are you in a band
108	P:	Yeah oh well I'm with a few mates we jam on weekends and [stuff
109	R:	[cool=
110	P:	= Yeah it's really cool=
111	R:	=That's great yeah

A few turns later, the medical educator intervenes as follows:

Extract 4. Training role-play 1 (Educator's intervention)

131	Ed	((directs gaze to 'patient')) How are you feeling Bob
132	P:	Good good I think she's ok
133	Ed:	What about the band thing
134	Ed:	When she started talking about asking about the music. What was your reaction there
135	P:	Oh good cause that's something that I (love) yeah
136	Ed:	That was extremely obvious in your reaction you almost sort of jumped at the chance to say yeah I'm in the band and playing the bass so it's obvious it's something you're very passionate about
137	P:	mm
138	Ed:	and there was a real connection I saw at that point ((directs gaze to registrar)) ah did you say cool or something like that
139	P:	Yeah you did
140	All:	((laughter))
141	Ed:	And using the using your own language which we perceived as the patient's language

Clearly, this educator has noticed the impact on the patient of the registrar's appreciative assessments of his musical interests, including her use of language from a

young person's lexicon. Through eliciting the role-playing patient's feelings and responses (turns 131, 133, 134), he works to draw attention to the effects of these actions on the developing patient-doctor relationship. But role-played interaction is fleeting, and without the close looking that discourse analysis affords, the educator may be unable to see, in detail, just how rapport is collaboratively accomplished, and as a consequence may not be equipped to precisely describe this accomplishment.

Discourse analytical themes that have emerged as pertinent explanatory concepts in the current study can shed light on the co-construction of rapport in this role-play and in other contexts. For example, it is by way of an extended 'mutual affiliation sequence'(Clark et al., 2003) across turns 108-111 in the above extracted data that rapport can be seen to build and consolidate. At turn 109, speaking in the voice of a young person rather than as a doctor so as to construct an identity that is congruent with the patient's own, the registrar offers an appreciative assessment of the patient's weekend jamming sessions. This action obtains an affiliative second assessment from the patient that trades off and upgrades the registrar's appraisal (turn 110). As a final move in this sequence the registrar reciprocates with a further appraisal that amplifies that of the patient in a different form. Through this three-part sequence of assessment, affiliative second assessment and a confirming final assessment doctor and registrar provide evidence for each other that they are in alignment and getting along.

Rapport is a mutual accomplishment and does not exist simply in the doctor's contribution to talk. Exploring analytical themes such as 'mutual affiliation sequences'(Clark et al., 2003) that highlight how mutuality is developed through assessments that trade off and build on what has gone before, could assist registrars to see and to appreciate the mechanisms of rapport building. Further, concepts of identity construction and voice (See section 3.2.5.4) might help to explain how the registrar's lexical choices contributed to rapport building in this interaction and how such strategic choices that foreground a mutual, over a professional identity might be useful in other contexts.

7.3 Role-play – a discourse analytical perspective

As the above illustrations suggest, role-play is a well established and valued method for teaching clinical communication in the Australian General Practice Training program. It enables educators to design training sessions that focus on specific communication challenges, such as that offered by the reticent, reluctant adolescent patient, and that target particular communicative behaviours, such as the development of rapport or the accomplishment of empathy. It offers registrars the opportunity to try out communication strategies in a low risk environment, and to reflect in and on practice in the company of mentors and peers. Further, as the health and well being of the 'patient' is not at stake in such practice encounters, and bio-medical matters do not need to be rigorously pursued, it allows educators and registrars to attend more closely to communication and relationship (Hanna & Fins, 2006).

However, whilst role-plays in General Practice education derive from real world clinical scenarios and are designed to develop the capacity to deal with such situations in practice, simulations are "...essentially educational devices rather than exact representations of doctor-patient interactions"(De La Croix & Skelton, 2009, p. 695). As Stokoe points out (to appear), interaction is not actually 'simulate-able'. Within the role-play activity, doctor and 'patient' orient to different interactional contingencies than they would in a 'real' consultation where the patient is truly sick and vulnerable. For example, the 'patient', in keeping with the pedagogical purpose of the role-play, may orient to providing the registrar with opportunities to display particular abilities. Accordingly, he or she might steer the interaction in predetermined directions. In turn, the registrar, for whom what is at stake in this activity includes being judged by their teacher and peers, may orient towards display of desired behaviours rather than to the contingencies of a real world clinical encounter. Further, the role-play activities observed for this study, with the exception of those involving professional actors where the encounter is likely to unfold without interruption, represent a 'hybrid communicative form' (Roberts & Sarangi, 1999a; Seale, Butler, Hutchby, Kinnersley, & Rollnick, 2007). Registrars are constantly involved in extreme frame shifts as they switch back and forth between their clinical role as a doctor to interact with the 'patient' and their role as trainee as they listen and respond to educator's interventions. As De

La Croix and Skelton succinctly state (2009, p. 701), in simulated consultations "the game of teaching...overrides the game of medicine".

This is not to suggest that role-play may not have successful training effects. Studies have demonstrated empirically that communication strategies developed through role-play can be subsequently transferred into real clinical practice, and that such transfer occurs to varying degrees (Rollnick et al., 2002; Seale et al., 2007). Further, Seale and his colleagues argue that the interactional complexities of simulations, including discourse hybridity and the need for frame switching and cue sensitivity, may be of value in encouraging the 'linguistic multitasking' that is to be found in real clinical work (Seale et al., 2007, p. 179). Indeed, in the current study, the capacity of doctors to manage multiple frames, to accomplish frame shifts in pursuit of relational or medical goals, and to strategically and purposefully invoke a variety of voices and discourses, has emerged as a key indicator of communicative expertise. These capacities may well be enhanced through the interactional demands of training role-plays. Nevertheless, from a discourse analytical perspective, role-played and real world consultations represent distinct 'activity types'(Levinson, 1979). They differ in setting, purpose and structure, and in the roles that participants take up as they orient to different contingencies. It follows, then, that role-play as a teaching and learning modality could be usefully supplemented by opportunities provided to both educators and registrars to closely examine authentic patient-doctor interaction.

It might be argued that such opportunities already arise in training as registrars and their mentors jointly reflect on the registrar's performance in video-recorded real world consultations. But these interactions are not captured by way of transcription, making detailed close observation and analysis of interaction difficult if not impossible in real time. To the researcher's knowledge, the practice of reflection on real world practice is not yet informed by insights from discourse analysis to any considerable degree.

Through engaging with transcriptions of authentic patient-doctor interactions, and through learning about and applying discourse analytical techniques, registrars could deepen their understanding of clinical communication as it plays out in situ and sharpen their reflective and analytical skills. In light of this, it is suggested that the practice of discourse analysis might be usefully incorporated into the teaching curriculum and into

professional development activities for educators and trainers who implement this curriculum. Precedents exist in a range of related health care fields.

7.4. Integrating discourse analysis into the curriculum - precedents

Leahy and Walsh (2008) describe how discourse analysis is integrated into the clinical education of Speech-Language pathologists in Ireland at both pre-service level and in continuing professional development. As undergraduates, students are introduced to discourse analysis through course-work that engages them in examining their own and other's discourse styles and the impact of these styles on interaction. Students graduate with a firm grasp of the principal methods and applications of discourse analysis. During apprenticeship and in on-going professional development, problem-solving learning through case discussions and role-play is complemented by the analysis of transcribed clinical interaction that illustrates pertinent professional issues. For instance, extracts from transcribed therapy sessions might be analysed in order to examine how power differentials are manifest in interaction and the impact on the client's ability to display communicative expertise, or how rapport is built and maintained across a consultation. From the perspective of Leahy and Walsh, who are academics and practitioners in their field, the in-depth knowledge that emerges from joint novice-expert analysis of the discourse of authentic clinical interaction, outweighs that which can be gained by discussing issues in the abstract or by way of role-plays involving simulated clients as interactants (2008, p. 239).

In similar ways, discourse analysis has been integrated into clinical education programs for dieticians (Tapsell, 2000). In developing a communication curriculum for novice dieticians, Tapsell drew upon results of a study that analysed the discourse of consultations considered within the profession to represent exemplary practice. Focussing on the history taking phase of the consultation, transcriptions of recorded practice were used to illustrate a co-constructed, narrative interview structure that allowed a comprehensive account of the patient's dietary history to emerge. This approach to training represented a shift away from a skills approach to the teaching of history taking that had made use of fixed protocols and de-contextualised questions. It enabled appreciation of the interview as a dynamic collaboration in which questions are

integrated responsively and strategically into a co-constructed narrative. Tapsell's study included an evaluation phase in which the impact of this discourse based curriculum was examined. It was found that those students who had been exposed to desired patterns as represented in transcribed data, consequently co-constructed history taking in ways that befitted the effective narrative structure. Tapsell concludes that exposure to the 'conversational machinery'(Zimmerman, 1992) of the co-constructed interview by way of transcription 'speeds up' the learning process that is normally achieved gradually as students keep company with experienced practitioners.

According to General Practice educators and examiners participating in the current study, novice doctors also tend to adopt 'a hyper-questioning style' (Sarangi, 2007b) of history taking. Such a style, that adheres to a check-list like sequential question order risks precluding potentially relevant information from the discourse of the consultation.

> Extract 6. Interview 2
>
> It gets back to that hospital entrenched way of asking things... I mean most [novice] doctors just do it by rote. I mean they're trained in a hospital setting where they're taught well I'm the doctor and I'm the one to ask the questions to work out what's wrong with you ...When a patient presents with such and such well you've probably got about 20 questions to ask them. Now you've actually got to train yourself to shut up and not say anything and quite interestingly if you actually do that and not say anything and reflect, 18 of those questions will be answered for you ((slightly triumphant surprised laugh)). But not only will those questions be answered, you know not directly, I mean there should be more use of open ended questions than closed ended questions in the consultation anyway, they'll be answered in such a way that they have a flavour ... They're a lot more fluid the good communicators. They're more hypo-deductive. (Medical educator/PBA examiner)

In line with the curriculum approach developed by Tapsell (2000), results from the current study might be usefully incorporated into the clinical communication curriculum so as to fast track the capacity of General Practice registrars to engage in the fluid, dynamic and responsive consultation style that is considered to be indicative of experience and expertise.

Additional precedents for integrating discourse analysis into the clinical curriculum can be found in both nurse and undergraduate medical education. Working in the context of nurse education, S. Candlin (1995, 2007) has long advocated for educational programs at both pre-service and professional development levels that develop and enhance

communicative ability through the analysis of authentic discourse data. In her 1995 study for example, she draws upon results of her analysis of the discourse of both novice and expert nurses to develop a curriculum that uses transcriptions to highlight key aspects of communicative expertise in health assessment practice. In her later work (Candlin, 2007), she introduces nurses to discourse analytical theory as a foundation for problem-based learning through engagement with authentic scenarios that represent encounters across the lifecycle.

In the context of undergraduate medical education, as mentioned in the opening Chapter of this thesis, Roberts and her colleagues (2003) compared the discourse of 'good' and 'poor' performances in OSCE examination role-plays to identify key components of weak and strong communicators. Their findings were fed back into the communication curriculum and offered educators and students a new analytical language for examining practice. Whilst these researchers analysed simulated encounters, they suggest that the analytical method used could apply equally to the analysis of real world patient-health professional communication to inform on-going professional development.

Close to the aims of the present study, and to the research site, a recent innovative project has demonstrated the practical relevance of discourse analysis to the professional development of educators and trainers in the Australian General Practice Training program.[27] This project (introduced in Section 2.3.4.5) evolved in part out of the current study and was prompted by heightened interest in the practical application of discourse analysis amongst a group of participating medical educators. In a collaborative endeavour involving educators, trainers and discourse analysts, participants in the professional development activity developed their knowledge of discourse analytical themes and discourse analytical techniques as a means to reflect critically on their interactions with registrars. At monthly meetings across a period of almost a year, and using transcribed interactions from the current study and from related studies as illustration, educators were introduced to pertinent analytical themes including, face, frame, footing, contextualisation cues, voicing, and turn taking. These themes then informed collaborative reflection on video-recorded training encounters

[27] The project entitled 'Reflecting on teaching the Australian General Practice training program: Using discourse analysis to frame the interaction' was a collaboration between the RTP, WentWest Ltd, the Department of General Practice, Sydney University, and the Department of Linguistics, Macquarie University.

and teaching sessions. The primary goal of these workshops was to increase educators' appreciation of the impact of their communicative choices on registrars and to enhance the mentoring relationship. However, participants reported that the project had also expanded their awareness of how relevant clinical concepts, such as empathy, might be more fruitfully discussed with registrars (WentWest, 2009). Such an outcome indicates the potential for a similar program that integrates discourse analytical skills into registrar training as a means to enhance their communication with patients.

In the next section, a model for such a program will be outlined. In developing this model, the researcher was strongly influenced by a carefully considered system for working with authentic discourse data that was developed to introduce practising lawyers to discourse analytical techniques as a means of exploring and appraising their interactions with clients. Working in the legal context, Candlin, Maley, Crichton and Koster (1994) proposed a series of seminars each focussing on a communication issue that had arisen in their study of lawyer-client conferencing. Through engaging with transcripts that illustrated the issue at hand, participating lawyers deepened awareness of their practice, developed knowledge about the discursive resources available to them, critiqued these strategies in light of professional goals and concerns, and considered how new understandings might be translated into action to enhance real world lawyer-client conferencing.

The current study offers a rich resource of such authentic transcribed interaction, illustrating the accomplishment of salient professional themes and the realisation of professional theories and models of communication that might be similarly used in General Practice training.

7.5 Integrating discourse analysis into General Practice training - a proposed model

7.5.1 Focus and aims

This discourse analytical study has focussed attention on the complexity of clinical communication in specific challenging situations. Results of analysis have shown expert clinical communication to be:

- A resource of language, actions, ways with tools, behaviours, emotions, and attitudes that are drawn upon strategically to accomplish relational and clinical goals
- A multi-modal accomplishment in which gaze, gesture and body orientation function strategically and purposefully in concert with language or in place of language
- Dynamic and co-constructed as patient and doctor respond to each other to create the context for ensuing interaction
- Both locally managed, as doctors respond to the moment and to issues as they emerge, and strategic as they pursue broader clinical goals
- Creative, as doctors invoke a variety of voices, identities and discourses in purposeful ways
- Cumulative and changing; rapport for example, is built, challenged, threatened or enhanced as interaction unfolds across a whole encounter
- Consequential; effective empathy for example can open the way for previously hidden concerns to emerge.

By making use of transcriptions of authentic clinical interaction, the proposed program enables educators and registrars to jointly examine this complexity. It allows educators to move beyond the provision of abstract models and exemplar phrases that reduce and de-contextualise patient-doctor communication, by providing a way of making visible the actions that General Practitioners and patients actually perform in specific, challenging situations. Such a program has the following aims:

- To raise registrars' awareness to the strategic potential of the resources of language and other modes of meaning that are available to them in the consultation
- To enable registrars to evaluate the effectiveness of these strategies through examining transcriptions of authentic examples of patient-doctor interaction
- To enhance registrars' awareness of the co-constructed, purposeful, creative and consequential nature of clinical communication

- To develop the capacity of registrars to draw upon discourse analytical techniques and discourse analytical themes to reflect critically on their own and other's practice.

7.5.2. Content and process

In the proposed model, discourse analysis is to be integrated into existing training to complement experiential problem-solving learning that addresses existing curriculum topics and themes. For example, the topic of motivational interviewing might be illuminated by way of examination of extracts from Consultation 3 (Chapter 5) that shed light on how patient resistance and patient-doctor dissent are interactionally managed. The topic of adolescent health, and in particular the challenge of engaging reluctant patients and encouraging the development of patient autonomy, could be usefully informed by discussion of extracts from Consultation 4 (Chapter 6). Alternatively, educators might draw upon transcriptions to focus on particular communication themes, such as how empathy is accomplished in situ and how it functions to bring previously hidden patient concerns into the discourse of the consultation, or how rapport is interactionally enhanced, challenged and protected. Extracts from transcriptions might also be used to focus attention on how a particular communication strategy, such as silence, is used in context and to what effect.

Whichever focus is chosen, training would follow a procedure for working with transcriptions that is experiential and participatory and facilitates joint reflection on the transcribed interactions, with a view to behavioural change. Following Auerbach and Wallerstein (1984), Candlin and colleagues (1994, p. 49) suggest that such a procedure might usefully follow a pedagogically phased cycle of Awareness, Knowledge, Critique and Action as set out below.

Awareness: This phase involves consciousness-raising based on transcripts that are immediately recognisable by participants as authentic. By examining transcripts, first individually, and then collectively in small groups, and considering in Goffman's terms 'what it is that is going on' ([1974] 1986), participants can share what they know and enhance their awareness of the topic, issue, strategy or theme.

Knowledge: in this phase new knowledge is brought to bear on the task of describing, interpreting and explaining what it is that is going on in the transcribed interaction. Drawing upon analysis such as that described in this thesis, or on their personal knowledge of discourse analytical themes, as well as themes from the medical communication literature, educators introduce pertinent explanatory concepts to facilitate a more in depth analysis of the interaction.

Critique: Here in this phase registrars would be invited to consider why the doctor or patient in the exemplary consultation acted as they did and the impact of these actions on the interaction. Participants would assess why a particular strategy or action was chosen, evaluate the efficacy of the strategies used in this particular context, and consider what alternative strategies might have been selected and to what effect.

Action: Finally, participants consider how they plan to translate new insights into practical action. They move away from the learning activity with an expanded resource for reflecting on their own interactions with patients in role-played and real world consultations. The goal is 'reflexive practice' (Taylor & White, 2000) whereby registrars experiment by changing their own mode of interaction in order to assess its impact and efficacy.

As illustration of this training process, a sample session that makes use of results from this thesis will be outlined below. The session focuses on the theme of empathy. In order to highlight how discourse analysis might augment existing modes of teaching, a training vignette illustrating how empathic communication is currently taught will first be presented. This vignette is drawn from ethnographic observations of a clinical communication workshop for registrars at a participating RTP.

7.5.3. Teaching and learning the communication of empathy – an illustration from current practice

The workshop in question combined the provision of information with experiential problem-solving learning. Early in the session, by way of a power-point presentation, registrars were presented with a model for implementing the patient-centred clinical method. Strategies for eliciting patient's ideas and concerns were discussed, empathy as

the action of perceiving and communicating understanding of a patient's feelings was considered, and a repertoire of empathic statements for responding to patients' cues for emotional support was generated. Later, opportunities were provided to draw upon these principles and strategies through participation in a series of clinical role-plays.

The following extract is from a transcription of one such role-play designed with the theme of empathy in mind. The 'patient' had been briefed to begin the consultation with a display of anger at having been kept waiting for her appointment. It emerges that her anger masks fear that she may have diabetes, a fear that is compounded by a family history of amputation related to unmanaged diabetes, and the fact that the clinic had failed to get back to her following an earlier blood glucose test. By way of an apology, the registrar has succeeded in de-fusing the patient's anger. As we join the role-play, he has just consulted the computer records to locate the results of the patient's earlier glucose test.

Extract 1. Training Role-play 3

97	R:	I've checked your results what did the doctor say were you fasting at that time
98	P:	Yes
99	R:	Your blood sugar is a bit higher than normal
100	P:	Oh no re:ally > does that mean I'm diabetic ; will I have to take injections ; will that impact on my work ; <
101	R:	I can't tell you (..) it won't impact on your work I can tell you that but if you've got diabetes yes or no I can't tell you now
102	P:	Well would somebody get back to me this time ;
103	R:	Well what happens (.) you'll need to come back again I know it's very difficult for you you're a very busy person and time is very valuable for you

At turn 100 the 'patient' responds to her test results with a news receipt that suggests dismay. Successive questions, delivered with increased velocity are indicative of her underlying anxiety and constitute a cue that is designed to elicit the registrar's empathic response. But, whilst the registrar attends to the propositional content of the patient's questions (turn 101), and protects rapport by upholding her image as a busy person (turn 103), he does not offer an empathic response that displays understanding of the patient's fears. This prompts the educator to intervene as follows:

Extract 2. Training Role-Play 3 (educator intervention)

104	Ed:	Let's pause here a lot of material there so um the patient made a whole list of concerns and um ah worries there was about three or four just bang bang bang straight in a row and um I agree you dealt with that nicely
105	P:	((nods))
106	Ed:	But if we're to practice what we were talking about this morning what's some sort of empathic statement you can make after being told a:ll my worries
107	R:	((2.0))
108	Ed:	((directs gaze to observing participants)) Do you remember that part of the consultation (.) something we could say just to sort of make a connection
109	R:	Reassure her like
110	Ed:	Can we reassure her :
111	R:	Like she was worried about her job that it will affect her job
112	Ed:	Yeah something more general than that can we sort of =
113	R:	= We are not sure we are not sure that she has diabetes
114	Ed:	Yeah but again we don't know we're right at the front end of this consultation there's a lot of information we need to bring together before we can actually work out what needs to happen in the future but she's presenting with an enormous amount of concern and um and apprehension so (.) you need to practice an empathic statement
115	R:	I need to know about her personal life is she smoking and other =
116	Ed:	= yep we need we're going to get to all that but I just want a statement that will just make her know that she's being listened to
117	Prt:	I understand your concerns
118	Ed:	I understand your concerns
119	Prt:	Or you seem very concerned about these things I think maybe a statement to reflect back to her that you've heard what she's saying under all these questions
120	P:	((nods)) mm yeah
121	Ed:	So you've got many concerns (.) that's a lot of concerns yes you're very concerned (.) I can understand your concerns I mean you have to personalise it and make it work for you (.) empathic statements from a list don't work so well
122	Ed:	((directs gaze to observing participant)) What would you say Anne
123	Prt:	It depends on the patient but I'd probably say something like you've obviously got a lot of concerns we'll make sure we address all of these today
124	Ed:	Mm it's an empathic statement plus a sort of a way forward as well

Clearly role-play is a useful teaching and learning device that provides educators and registrars with the opportunity to jointly construct empathic responses in context sensitive ways. Empathy is perceived by this educator as an interactional accomplishment, and, across the sequence, he works with the registrars to construct an empathic statement that might display recognition of the patient's concerns at this particular moment. Further, he is wary of stock phrases that are inappropriate in a specific local interactional context and can run counter to the achievement of empathy. At turn 121 he enjoins the registrars to personalise their statements, "...empathic statements from a list don't work so well". But despite this concern to contextualise empathic responses and to avoid simple replications of pre-conceived phrases, the

teaching of empathy appears to be narrowly focussed on the doctor's contribution to the interaction.

This focus on the role of the doctor stands in contrast with results from the current study where empathy has been shown to be a complex, co-constructed, multimodal and cumulative process that goes beyond a responsive, verbal empathic statement on the doctor's part. Findings indicate that empathy involves on-going monitoring of a patient's changing emotional state and the perception of clues to that state that are frequently indirect and implicit in nature. These cues include visual and vocal perturbations such as shrugs, voice quavers or intake of breath that signal conversational discomfort (Extracts 8, 9, Consultation 1), laughter tokens that take a light hearted stance towards matters of concern (Extract 7, Consultation 2), and narrative expansions that offer a window on the patient's life-world to suggest what is on their mind (Extract 6, Consultation 2). The accomplishment of empathy involves empathic responses to these implicit cues that resonate accurately with the patient's feelings at a particular moment, and the patient's receipt of these responses as acknowledgement that they feel understood. Further, clinical empathy has been found to be purposeful and consequential, engendering trust and opening the way to a more effective therapeutic relationship (Consultation 4, Chapter 6) and bringing matters of clinical significance into the discourse (Consultation 1, Chapter 4).

Such interactional complexity suggests the value of complementing experiential problem solving learning through role-play, with opportunities for registrars and educators to engage with transcriptions of authentic action that capture the accomplishment of empathy in real world contexts.

7.5.4. Using discourse analysis to augment current teaching practice - an illustration.

Teaching/learning focus: Communicating Empathy

Phase 1: Awareness

Participants' ideas about the nature of empathy and its clinical importance are elicited. They reflect briefly on their experiences of consultations where empathy was invoked,

how they responded and the impact of this response. This discussion is consolidated with a definition of empathy that aligns with the findings from the current study to suggest that empathic communication is a collaborative interactional accomplishment that has consequences for the trajectory of the consultation.

Definition: Empathy is an interactional and sequential activity involving the doctor's accurate perception of the patient's feelings, the effective communication of that understanding back to the patient, and the patient's receipt of that understanding as acknowledgement that their feelings and situation have been accurately understood. Clinical empathy is effective and consequential, involving not only the ability to perceive and respond to the patient's feelings, but the ability to act on that understanding in a helpful and therapeutic way
(Frankel, 2009; Mercer & Reynolds, 2002; Suchman et al., 1997).

Example texts that illustrate empathy in action are then provided to participants as follows:

Example 1 (Extracts 8 & 9 Consultation 1)

The patient is a middle aged woman who has come to see her doctor seeking advice about a screening test for ovarian cancer. At this point in the consultation, the patient's concerns about cancer have been put to rest and the doctor moves to open up discussion of other issues.

104	D:	All right ((redirects gaze from computer screen to patient's face, reorients upper torso towards patient, placing hand on top of the slip of paper on desk)) so how are you apart from that ((withdraws hand from the slip)) that's one worry
105	P:	Um pretty good but : ((fall rise tone)) you know when I came last time I told you I had (.) you said I had you thought I had a panic attack :
106	D:	Yeah ((fall rise tone)) ((sits back from the desk, takes hands off paper records and places them on lap, focuses gaze on the patient))
107	P:	And I still sort of get that feeling (.)# inside :_h ((shrugs shoulders))
108	D:	((leans forward elbows on desk and hands cupping her face))
109	P:	[((shrugs shoulders again))]
110	D:	[It's a rotten thing °rotten°]
111	P:	.hh
112	D:	Tell me about the feeling
113	P:	(..) ((indicates chest)) Um # seem ok during the ## day
114	D:	Yeah
115	P:	But when I get into bed at night not relaxed # # it ° sort of goes chooooo ((gestures to indicate fluttering feeling over chest and abdomen)) ((slight shrug))
116	D:	What's your head doing in that time
117	P:	(.) That seems to be ok just sort of ((pats stomach and chest)) in here sort of thing ((shifts posture quickly in seat))
118	D:	So is your heart beating strangely ((enacts beating gesture across own heart))
119	P:	A little bit yeah

A few turns later:

124	D:	... just just tell me more [cause
125	P:	[((patient shrugs in bewilderment))
126	D:	((left hand stretches out towards the patient, palm open and fingers splayed)) You look worried like you're
127	P:	((left hand stretches out towards doctor palm open and fingers splayed))Um (..) I try not to think about it and I try not the tears when I talk the tears come um I don't know ((shakes head)) ##I don't (.) I just sort of get all ((gestures over stomach and chest)) and I thought when you get into bed you should be relaxed :
128	D:	° yeah°
129	P:	And um I just sort of hh (.) I don't know I sort of feel like everything's jumping around inside : It's all (.) and ((shrugs))# I don't know (.) I suppose ##I don't know and #I don't know if it's nerves or what it is (.) ### I don't know
130	D:	What are your nerves like at the moment
131	P:	((shrugs)) um (.) ## I'm fine most of the time and I think it's just um >when I was here last time I told you about< the dog [it's sort of been since then
132	D:	[°yeah°
133	P:	And I don't know if that's what it is (.) I think that's what's brought it on :
134	D:	°Yeah°
135	P:	((crying)) # ## and I'm trying to get over [it but I'm not :
136	D:	[o:h ((doctor reaches for tissues, takes two and hands them to the patient))
137	P:	((takes tissues, sniffs)) ## I'm sorry ((dries eyes with tissue))

Example 2 (Extract 8 Consultation 2)

This patient is a middle aged woman with previously diagnosed depression who visits the doctor for renewal of her prescriptions. Her husband has face cancer and has already undergone surgery on his nose. He is about to have a second operation.

89	P:	Yeah yeah um (.) and he's becoming a worry:
90	D:	((nods, directing gaze towards patient's face.))
91	P:	The nose was (.) horrendous absolutely horrendous (.) but we got through that (.) I hope they got it all this time they had three goes at it (.) in the end the flap's the way to go but o::hh [((shakes head)) no]
92	D:	[Yeah it's hard] (.) hard work for you cause well who did most of the looking after you or him
93	P:	((laughs)) I did (..) I did (.) but oh he came out of theatre and I just burst into tears when I seen him ((shakes head))
94	D:	But it's looking good now :
95	P:	Oh it's great=
96	D:	=yeah
97	P:	Couldn't believe (.) for what happened there (.) to what he is now (.) It's just (.)fantastic
98	D:	Good

As registrars examine these interactions and discuss them with their peers, they are likely to notice that in each case the doctors' empathic responses go beyond the stocks

of pre-conceptualised phrases that circulate in discussions and appear in training texts. They might see and appreciate that these responses are carefully designed to display sensitivity to the quality and intensity of the patient's experiences (turn 110, 126, Example 1), and understanding of the patient's life-world (turn 92, Example 2).Their awareness of empathy as a multi-modal accomplishment might also be enhanced as they appreciate the role of body orientation, gaze and gesture that function in concert with wording to intensify engagement with the patient (Turns 106-108, 126, Example 1). Their attention might also be drawn to the nature of the patient's cues for emotional support that are seldom explicit, frequently non verbal, and include head shakes (Example 2), and shrugs, voice quavers and intake of breath (Example 1).

Phase 2: Knowledge

As educator and registrars engage in joint discussion of these interactions, a shared analytical language is developed and new knowledge is generated. For example, the concept of 'emotional resonance'(Halpern, 1993) might be usefully introduced to capture the combination of cognitive understanding of the patient's experience of panic attack and emotional engagement that is displayed in the doctor's expert empathic response (Example 1, turn 110).

By describing these doctors' expert empathic responses as 'recipient designed'(Drew & Heritage, 1992), educators might draw registrars' attention to the context sensitive nature of effective empathic communication that stands in contrast to the pre-conceptualised trained response.

Further, during this phase educators could fruitfully broaden discussion beyond a focus on the doctors' empathic responses to consider empathy as a sequential, co-constructed and consequential accomplishment. With reference to example 1 for instance, they might direct attention to the empathic sequence that is instigated by the doctor's sensitively designed question (turn 124) and culminates in the patient's disclosure of the delicate and clinically significant matter of her tearfulness (turn 127).

124 D: ... just just tell me more [cause
125 P: [((patient shrugs in bewilderment))
126 D: ((left hand stretches out towards the patient, palm open and fingers splayed)) You look worried like you're
127 P: ((left hand stretches out towards doctor palm open and fingers splayed))Um (..) I try not to think about it and I try not the tears when I talk the tears come um I don't know ((shakes head)) ##I don't (.) I just sort of get all ((gestures over stomach and chest)) and I thought when you get into bed you should be relaxed :
128 D: ° yeah°

Here, close attention to the design of the doctor's question (turn 124), would refine registrars' knowledge of question design and its effects. Registrars would come to appreciate that such a formulation is not simply an open question that functions to elicit information or to invite elaboration. Rather, such a question type also has interpersonal effects. In choosing this form, the doctor conveys a personal as well as a professional interest in the patient and her symptoms, thereby evoking the subtle bewildered shrug (turn 125) that represents a clue to the patient's emotional state and a cue for emotional support.

As registrars take note of the doctor's empathic response (turn 126), appreciating how wording and gesture combine to intensify its effect, and, as they notice the affiliative, mirroring gesture that it evokes from the patient, their perception of empathy as a mutual accomplishment will be heightened. Further, as they consider the consequences of empathy, in encouraging the patient to disclose sensitive details of her symptoms, their appreciation of empathic communication as a clinical tool is likely to be sharpened.

Phase 3: Critique

During this phase, it is envisaged that registrars will examine the interactions more closely in order to critique the strategies that the doctors deploy. They would be asked to assess why particular strategies were chosen, to evaluate their effectiveness in the context of the interaction, and to consider what alternative actions might have been taken and to what effect.

For example, with regards to Example 1 they might be asked to consider the doctor's response to the patient's hedged, guarded allusion to her experience of panic attack (turn

105). Educators participating in this study have suggested that this doctor's action at this critical moment in the consultation contrasts with the likely response of a novice doctor, and is a marker of experience and expertise.

> Extract 9. Medical Educators' Workshop
>
> "I look at this and I see experience... 'cause we deal with registrars all the time. 'You said you thought I had a panic attack' A registrar would say 'well yeah' or 'we'll talk'. This doctor doesn't do anything other than leave an opening to go on...[she] concentrates on the feelings and this allows progression ... 'And I still get that sort of feeling' (turn 107). Again an opportunity where an inexperienced person I guess in my experience would rush in and say something and aga::in the doctor uses body language (.) doesn't fill the space (.) refuses to fill the space with noise (.) uses their body (.) does a number of things" (Medical educator)

In order to bring the expert practice of their experienced colleague into sharper focus, registrars would be encouraged to critique the doctor's actions by considering such questions as:

- Why did this doctor choose to respond as she did?
- What was the effect of her attentive silence?
- What if she had responded by sharing the reasoning behind her diagnosis of likely panic attack?
- What impact might this choice have had on the interaction?
- How might this choice have altered the trajectory of the consultation?

By interrogating the practices of their more experienced colleagues in this way, in the company of mentors and peers, it is envisaged that novice doctors would build knowledge about the mechanisms whereby effective empathy is accomplished, as well as confidence to try out new behaviours, including attentive silence, in their own practice.

Phase 4: Action

Here in this phase, registrars consider what they have learned about the accomplishment of empathy through their analysis of new transcribed interactions. They reflect on how this new knowledge will be brought to bear on their own practice as they try out new behaviours in both role-played and real world consultations and evaluate their impact and effect. They are also encouraged, with the consent and permission of patients, to

undertake the recording and transcription of critical moments from their own interactions with patients in the future as a means to reflect on their developing practice.

7.5.5. Incorporating discourse analysis into communication training – coda

In this final chapter of my thesis, I have argued for the integration of discourse analytical findings and discourse analytical techniques into clinical communication training. Results from this study have made visible the lived, in situ practices of experienced members of the professional community of General Practice as they interact with patients and accompanying parties in specific communicatively challenging encounters. These results constitute a resource that might be drawn upon as a means to enable novice doctors to closely examine the communicative practices of their experienced colleagues.

As Schön suggests (1983) professional expertise develops gradually and cumulatively as practitioners build up a repertoire of experiences, images, actions and examples that guide and inform reflection in action in subsequent situations. In this way, over time, practitioners develop a faculty of 'professional judgement' that can be relied upon to inform their choices in unforeseen situations.

Through engaging with transcriptions that represent real world practice, and learning to see, appreciate and critique what others do, registrars might augment the repertoire of communicative resources and discursive strategies available to them as they reflect in action and make communicative choices in the complex and challenging situations that make up clinical practice.

7.6 A place for discourse analysis in examiner training

The results of this study apply less immediately to the assessment of clinical communication and to the training of RACGP examiners. The thesis has not been concerned to explore the construct validity of assessment in General Practice. Whilst interviews with examiners and ethnographic observations of examiner training have

provided insight into examiner's perspectives, examination sites have not been examined in detail. OSCE role-plays that constitute a primary method for assessing the clinical capacity of registrars for unsupervised practice, including their communicative abilities, were not an object of study. Further, whilst discourse analysis focussed on

PBA consultations, and this analysis was carried out in light of examiners' ratings and comments, the purpose was to uncover discursive evidence for examiners' judgements as a means to describe the nature of communicative expertise, rather than to examine assessment practice.

Yet, the PBA data that was analysed for this study is the self-same data that examiners observe. This strongly suggests that insights and analyses derived from the thesis are of value and relevance not only to teaching and training but also to examining. Just as educators and registrars might benefit from the heightened appreciation of the complexity of patient doctor interaction that derives from fine grained analysis of transcribed data, so too examiners could profit from opportunities to engage closely with data that represents evidence for their judgements. Just as educators and registrars would gain from a shared analytical language for examining practice, so discourse analysis offers examiners a resource that might enrich their feedback to examination candidates on the parameter 'communication and rapport'.

Indeed, interim findings from the current study, distributed to project participants by way of discussion papers (See appendix 5) has generated considerable interest from examiners as well as from educators, as emailed feedback from the RACGP attests.

> Extract from Appendix 6 – Feedback on discussion papers
>
> "We believe your reports might be a useful resource for a college committee that is currently working on developing a Video module for pilot assessment pathway to Fellowship, so would like to ask if you would give your consent for the reports to be forwarded to the committee" (RACGP PBA administrator).

This display of interest resulted in a workshop for senior examiners at the RACGP in Melbourne at which examiners, in the company of the researcher and her supervisor, engaged with transcriptions of two PBA Consultations as a means to explore issues of professional concern. Whilst discussion at this workshop suggested the relevance of

results from this discourse analytical study to examiners, it also indicated the potential for a parallel study that might draw from and extend the data provided in this thesis, to focus more comprehensively on the assessment and evaluation of communication in General Practice. Data derived from such a study might offer a more comprehensive, grounded resource to inform examiner training.

At the afore-mentioned workshop, examiners focussed on results from the analysis of Consultations 1 and 2 (Chapter 4) in order to consider such issues as significant discrepancies in ratings between examiners on the parameter 'communication and rapport'. For example, as the examiners looked closely at the transcription of Consultation 2 in light of discourse analytical findings and in light of divergent assessments, they noted how the doctor's empathic formulations functioned selectively and consistently to direct the discourse away from the patient's emotional concerns. On the evidence of the transcript, they, like the medical educator cited in Chapter 4 (See p. 212), came to a consensus that the candidate's communication was indeed 'doubtful', as rated by the first examiner.

> Extract 1. Examiners' Workshop
>
> "I mean looking at the transcript he's doubtful ... he's doubtful on communication because he's deliberately shutting her off all the time ... he did not engage with her [the patient's] agenda and in many ways the other examiner is being overly kind" (Senior examiner).

But these examiners also considered the broader interactional context of background knowledge and understandings that might shape a doctor's decision about if when and how to pursue the patient's agenda, including the pressures of time constraints and the doctor's assessment of the clinical relevance of the patient's talk. This consideration prompted the examiners to share some concerns about the limitations of PBA assessment as it is currently practiced.

> Extract 2. Examiners' Workshop
>
> "What we lack is that internal dialogue that the doctor is having with himself...we need to look together at the video... that explanation is part of the expertise of the doctor" (RACGP examiner).

Recognising the impact of the brought-along context on interaction, and its role in interpreting what it is that is going on, these examiners suggested that, in such cases of discrepancy in judgement, the candidate's deliberations should be accessed and assessed by way of joint review of the videoed consultation in question.

As further illustration of the relevance of discourse analysis for examining, and of the potential value of a more focussed study of assessment, I will briefly refer to another issue raised by senior examiners at this workshop, that is, their concern with the validity of current rating scales.

Extract 3. Examiners' workshop

> "I think that the scales we actually use to assess are probably not measuring what we think they are measuring what we think they are intending to measure in the case of experienced doctors" (Senior RACGP examiner).

This comment was prompted by the examiner's appreciation of the performance of the experienced practitioner displayed in the transcription of PBA Consultation 1. Noticing how this doctor integrated history taking into responsive, co-constructed interaction, in a process that she described as 'weaving through', she contrasted this expert practice with that of novice doctors who, as also noted by the medical educator cited previously (See page 299), are likely to work through history taking questions in a step wise, sequential and doctor-centred fashion, that risks marginalising potentially significant information from the discourse.

It was a concern of this senior examiner that current rating scales, particularly on the parameter 'history taking' that makes use of such descriptors as 'focussed', 'relevant' and 'organised', might distort the lens through which examiners perceive a consultation and evaluate a candidate's communicative ability and clinical capacity. From her perspective, such descriptors tend to divert the attention of less experienced examiners away from an appreciation of the integrated and co-constructed history taking that has emerged in this thesis as an indicator of experience and expertise.

Extract 4. Examiners' workshop

> With the assessment of experienced doctors they are much more likely to weave through. They won't take a thorough history because they are working on (.) they've got

> different knowledge that they're using. Essentially what you're asking them to do is to unlearn (.) go back to when you were first starting out and do a history in that way because that's what our rating scales will actually mark you against and so they don't perform as well as the novice doctors do (Senior RACGP examiner).

This examiner goes on to comment that discourse analysis is of value as "... it breaks down what was occurring throughout the consultation ... it's actually showing the weaving that does take place". A training program that offers new examiners the opportunity to engage with such results would assist them to see and to appreciate the nature of such expert practice.

Further to this, a more comprehensive discourse analytical study, that examines a wider range of consultations to uncover evidence for relative degrees of communicative expertise, could offer senior assessors a resource of empirically derived data that they might draw upon as a resource for reviewing existing rating scales and for developing more accurate descriptors for assessing clinical communication.

Closing remarks

This thesis set out to examine the nature of expert communication as it is required for the General Practice of Medicine and as it is displayed in the discourse of specific, communicatively challenging clinical encounters. In bringing the thesis to a close, it is recognised that whilst communication is a crucial resource for the provision of health care in General Practice, medical care and clinical expertise cannot be reduced to matters of language and communication (Sarangi, 2004). Communication is always linked to action and, in the clinical context, that action is informed and driven by the doctor's medical knowledge and accumulated experience.

Nevertheless, discourse plays a crucial role in mediating such knowledge and experience and it is for this reason that communication and the patient-doctor relationship is given priority in the teaching, learning, and assessment of clinical expertise within the Royal Australian College of General Practitioners.

This study has made visible the actions that experienced members of the General Practice community actually perform in communicatively challenging clinical contexts. It has made tractable and available for discussion the strategic, discursive choices that these doctors make as they interact with patients and accompanying parties to pursue their relational and clinical goals. In this way it has provided a resource for reflection that is of practical relevance and value for registrars and educators and potentially for examiners as well.

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Appendices

Appendix 1: Sample information and consent form

Invitation to Participate in a Research Study
Information and Consent Form for Medical Educators

The Nature of Expert Communication as Required for the General Practice of Medicine

You are invited to take part in a research study of the nature of expert communication as required for the general practice of medicine. The study will use linguistic analysis to describe what makes for successful communication for clinical practice.

The study aims to use linguistic analysis to uncover the fine-grained detail of how broad categories of communicative expertise, such as "establishes and maintains rapport" or "responds to patient cues", are actually achieved in interaction within specific clinical situations. In so doing, it aims to enhance understanding of the nature of expert communication as required for General Practice and to make these new understandings available to medical educators and assessors, examination candidates, registrars and other participants in the study.

Who will conduct the study?
The study is being conducted by Catherine O'Grady, under the supervision of Professor Christopher N. Candlin and Dr Peter Roger, to meet the requirements for the degree of Doctor of Philosophy in Linguistics, Macquarie University. The study is being conducted with the endorsement and support of the Royal Australian College of General Practitioners. Researchers' details are:

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What does the study involve?
The study combines initial and on-going ethnographic research, involving interview and observation, with close analysis of recorded Practice Based Assessment encounters in light of examiners' assessment of candidates' communication skills. Segments of these consultations are transcribed using transcription conventions that capture both verbal and non-verbal signs. A detailed analysis of these transcriptions is then undertaken to uncover the linguistic evidence on which judgements of communication are based and so provide greater understanding of how expertise is achieved in interaction. Following linguistic analysis of the data, examiners, educators and other participants are invited to comment on the transcriptions so that the perspectives of both the medical profession and the discourse analyst are brought to bear on the final analysis of data.

What will you be asked to do?
If you decide to participate, you will be involved in the ethnographic research. Specifically you will be asked to consent to observation and/or video recording of clinical skills training that you conduct for registrars. Observation of training will allow the researcher to understand more about what educators look for in clinical performance as well as aspects of communication considered important in teaching and learning in specific clinical scenarios.

You may also be invited to participate in discussions of de-identified transcriptions of interactions from Practice Based Assessment consultations. The purpose of these discussions is to align the perspectives of experienced practitioner/ educators with those of the discourse analyst so as to achieve research outcomes that are relevant and practical.

How will the confidentiality of data be ensured?
Your contribution to this study will be kept private and confidential. Recordings of training will be viewed only by the researcher and her supervisors and used only for the purposes of the research. They will be kept in a locked cabinet that can be accessed only by the researcher. Once the researcher has viewed the recording, noting any comments or quotations that may inform the study, the recordings will be destroyed. Your comments and responses will be transcribed anonymously and any identifying features will be deleted.

It is anticipated that the results of this research will form the basis of a doctoral thesis. Research findings may also be made public through articles in linguistic or medical education journals and through presentations within faculties and at conferences. In all instances, data will be presented anonymously. Audio and video recordings will not be used and transcriptions, comments and quotations will carry no identifying features. Acknowledgements will be general in nature.

How will you receive feedback about the results of the research?
Feedback will be offered progressively to participants. A summary of research findings will be sent to all participants once analysis of the data is complete and significant findings are available.

During the research phase, short discussion papers will be distributed to all interested participants periodically.

Participation in this project is voluntary. The RACGP will not be seeking information about who is participating. No reason is needed if you decide not to participate and you are free to withdraw from the research at any time, without the need to give a reason and without consequence.

Who do you contact for further information or to participate?
If you would like clarification of any aspects of the study, please do not hesitate to contact Catherine O'Grady or the Supervisors of this project. Contact details are provided above.

Consent form

I, _____ have read and understood the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this research, knowing that I can withdraw from further participation at any time without consequence. I have been given a copy of this form to keep.

Participant's Name:
(block letters)
Participant's Signature:
Date:

Researcher's Name:
Researcher's Signature:
Date:

The ethical aspects of this study have been approved by the Macquarie University Ethics Committee (Human Research). If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Ethics Review Committee through its Secretary (9850 7854) email: ethics@vc.mq.edu.au Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Appendix 2: Final ethics approval letter

MACQUARIE
UNIVERSITY ~ SYDNEY

Ms Catherine O'Grady
8 Charles Street
Forest Lodge NSW 2037

22 May 2006

Dear Ms O'Grady

FINAL APPROVAL LETTER

Title of Project: The Nature of Expert Communication as Required for the General Practice of Medicine - a Discourse Analytical Study
Reference Number: HE24MAR2006-D04585

Thank you for your recent correspondence. Your responses have satisfactorily addressed the outstanding issues raised by the Committee. You may now proceed with your research.

Please note the following standard requirements of approval:

1. Approval will be for a period of twelve months. At the end of this period, if the project has been completed, abandoned, discontinued or not commenced for any reason, you are required to submit a Final Report on the project. If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. The Final Report is available at http://www.ro.mq.edu.au/ethics/human/forms.
2. However, at the end of the 12 month period if the project is still current you should instead submit an application for renewal of the approval if the project has run for less than five (5) years. This form is available at http://www.ro.mq.edu.au/ethics/human/forms If the project has run for more than five (5) years you cannot renew approval for the project. You will need to complete and submit a Final Report (see Point 1 above) and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).
3. Please remember the Committee must be notified of any alteration to the project.
4. You must notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that might affect continued ethical acceptability of the project.
5. At all times you are responsible for the ethical conduct of your research in accordance with the guidelines established by the University (http://www.ro.mq.edu.au/ethics/human)).
6. If you will be applying for or have applied for internal or external funding for the above project it is your responsibility to provide Macquarie University's Grants Officer with a copy of this letter as soon as possible. The Grants Officer will not inform external funding agencies that you have final approval for your project and funds will not be released until the Grants Officer has received a copy of this final approval letter.

Yours sincerely

P. Thom

P.P. **Associate Professor Richard Stevenson**
Acting Chair, Ethics Review Committee (Human Research)

Appendix 3: Guidelines for Interviews with Medical Educators and Examiners

Themes:

- what educators and examiners look for in communicative performance
- aspects of communication they consider important to teach/assess
- the types of clinical scenarios and situations that present particular communication challenges
- critical communication errors
- causes of communication difficulties
- the values and tenets that inform communication for General Practice

Possible questions:

As an educator/ examiner, what do you look for in communicative performance?

What aspects of communication do you consider it important to teach and/or assess?

Are there some aspects of communication you find it difficult to teach and/or assess?

What types of clinical scenarios are particularly dependent on communicative expertise?

Are some consultations particularly challenging for communicative ability?

How would you describe a successful communicator in each of these scenarios?

What are some of the critical communication errors that might occur in each of these scenarios?

Can poor communication fail a candidate?

Can you tell me about some difficult moments you have observed as an assessor or educator where communication was at play?

What do you see as the causes of such communication difficulties?

Do you think that the profession's view of what makes for successful communication has changed over the years? In what ways? What may have prompted these shifts?

Are there particular principles and values that shape what the profession now sees as effective clinical communication? Can you tell me about these? How are they realised in practice?

What are some major communication challenges that currently face doctors in General Practice?

How might this research be useful to educators, examiners and registrars?

Appendix 4: Sample selected logbook for Practice Based Assessment (Video recordings for assessment purposes).

No	DVD No/Consult No	Age (years)	M/F	Primary complaint	Other complaints	Duration of consultation (min)
1.	7	73	M	Diabetes/NIDDM/ compliance		13
2.	11	39	F	Cough/RTI		9
3.	17	F		Antenatal visit 38/40		10
4.	26	20 months	F	Vomiting/diarrhoea		7
5	33	59	F	Depression/asking about ovarian cancer screening		35
6	34	22	F	Contraceptive/pruritus ANI		18
7	36	66	M	Arthritis		9
8	37	9	M	Rash/ Impetigo Eczema		12
9	43	66	F	New patient to dr/Parkinson's	Abdominal pain/constipation	20
10	45	49	M	Chest pain recently	Post AMI with delayed presentation	20
11	49	27	F	Generalised anxiety/discussion re chronic CBT		12
12	55	21	F	Early pregnancy bleeding @ 6/40		15
13	69	60	F	Hypertension/Leg swelling/anaphylaxis to ace's		17
14	70	33	M	Morbid obesity/on weight loss program	Renal impairment	13
15	83	36	F	Spina bifida check up/post admission	With cellulitis and oedema	18

Appendix 5: Discussion paper 2 distributed to project participants

The Nature of Expert Communication for the General Practice of Medicine – a Discourse Analytical Study
Discussion Paper 2: Focus on Empathy and Rapport

Introduction and background

The purpose of this discussion paper is to provide feedback to Medical Educators, Examiners, Fellowship candidates and other interested parties on the progress of the on-going research project, "The Nature of Expert Communication for the General Practice of Medicine – a Discourse Analytical Study".

State of play with the project

The project is now in an extensive discourse analysis phase, involving transcription and fine-grained analysis of a wide range of Practice Based Assessment consultations in light of examiners' judgements of communication skills. Ultimately, our aim is to uncover those patterns of interaction upon which perceptions about successful communication are based, to describe what constitutes relative degrees of communicative expertise in the eyes and ears of experienced practitioner-examiners [28], and to make this analysis available to the profession of General Practice in a useful form.

The role of ethnography

The project seeks to describe, interpret and offer explanations of clinical interaction in meaningful, practical and relevant ways, and for this to be achieved the discourse analyst needs to draw upon insider knowledge. Ethnographic research has preceded and now informs analysis of the discourse data. It has included observations of briefing sessions and workshops for examiners, of registrar training sessions and trial examinations, including educator feedback on communication skills, as well as intensive interviews with educators and examiners. This, together with a review of texts that inform clinical education[29], has allowed us considerable insight into those beliefs, values and principles that shape what counts as appropriate and effective doctor-patient communication for General Practice, such as patient-centredness, a bio-psycho-social approach, acceptance and non-judgementalism, and informed and shared decision making. To be accepted by the profession as accomplished communicators, doctors need to display commitment to these principles, to varying degrees for varying contexts, through their interactions with patients.

Ethnography has also highlighted those categories of language use through which educators and examiners routinely observe and classify the communicative performance of registrars and Fellowship candidates These categories, prescribed in examiner rating forms, announced in examiners' reports, and deduced from the comments of educators and examiners in wide ranging discussions, include the display by the candidate of an appropriate mix of open and closed questions, the ability to perceive and respond to subtle verbal and non verbal cues, sharing of clinical thinking, lucid explanations that avoid jargon, responsive listening and the achievement of empathy and rapport.

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[28] During the course of this project, the research focus shifted away from relative degrees of expertise to communicative expertise as it is displayed through a small number of case studies representing crucial communicative sites.

[29] Kurtz, S. et al. 1998. *Teaching and learning communication skills in medicine*. Oxford: Radcliff Medical Press

Neighbour, R. 2005. *The Inner Consultation. How to develop an effective and intuitive consulting style.* Oxford: Radcliffe

Stewart, M. et al 2003. *Transforming the clinical method.* Oxford: Radcliff Medical Press

Focus on empathy and rapport

For this paper, we will draw upon a Practice Based Assessment consultation, rated by medical examiners as excellent on communication skills, as a site for exploring how the categories empathy and rapport might be usefully augmented by discourse analysis. Our research stance is consultative and reflexive and our purpose is to invite comment and to gain the perspective of practitioners on our analysis of the data.

A challenging site for communication

The consultation chosen for analysis illustrates a case type that many doctors in our study believe to be particularly significant in the evaluation and teaching of communication skills, that is a consultation where underlying psychological and emotional issues are not evident in the initial reason for presentation. One challenge for practitioners is to activate and display rapport and empathy so as to create a climate wherein deeper issues can emerge to be addressed.

> The difficult ones are ones that have some sort of psychological problems going on. I mean the patient may not straight away come out with that, so you've got to try to elicit some of those things... (Educator/examiner)

> Dealing with emotions is always difficult....structuring a consultation to find out what the patient wants in the first place; hidden agendas, they're the difficult ones. (Educator)

> The emotionally laden ones are always more difficult (Examiner)

Crucial sites and critical moments

Such consultations, identified by practitioners as potentially problematic and likely to be highly charged, represent 'crucial sites'[30] where the "abilities, positions, identities and face of participants are on the line" They are likely to throw up 'critical moments'[31] that is moments within the process of the consultation which are particularly significant for the doctor or patient or both, and which, as a consequence, present challenges to both participants' communication skills. These may be moments wherein the consultation could turn so that a therapeutic relationship breaks down or crucial clinical information is lost. An example might be the moment when a patient offers some barely perceptible clue to the depth of their sadness or thoughts of self-harm. At such moments, challenges to the communication skills of doctors are at a premium. And, as in any co-constructed interacted event, such challenges are likely to impact, perhaps to differing degrees, on the patient as well.

The case in focus and examiners' comments

The patient in this case is a 58-year-old woman who begins the consultation with a request for advice about screening for ovarian cancer. She has had a single panic attack in the past and the doctor is aware of this. As the consultation unfolds, the likelihood of more pervasive anxiety and serious depression arises.

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[30] Candlin, C.N 1987(a) Explaining moments of conflict in discourse. In R.Steele & T. Threadgold (eds) *Language Topics: Essays in Honour of Michael Halliday*. Amsterdam: John Benjamins. (413-429)

[31] Candlin, C.N. 1987(b) General Editor's Preface. In B.L. Gunnarsson, P. Linell & B. Nordberg (eds) *The Construction of Professional Discourse*. London: Longman (x-xiv)

Examiners rated this candidate as 'excellent' and 'good' on communication skills and their evaluative comments attest that the doctor is considered to be an accomplished and effective communicator:

> "Obviously caring GP with good communication skills. Rapport with patient excellent"
> "Very thorough and caring, very good manner, no jargon used, excellent nature and friendliness, very good empathy with patient".

Such comments distil examiners' responses to the moment-to-moment interaction through which categories such as empathy and rapport are actually enacted. But these responses have not typically been precisely linked to particular instances in the interaction and so, as a consequence, the immediate context within which language choices and behaviours have meaning and impact tends to be washed away. One way of making such expert judgements tractable for feedback to candidates and applicable in clinical communication skills training would be to highlight particular inter-actional strategies that appear to be used by successful candidates and which in turn are in harmony with those categories drawn upon by their examiners.

Strategies of rapport

As an example, we might link the category 'rapport' with various strategies through which this doctor aligns with her patient, thus reducing social distance and realising solidarity. Such strategies include the co-construction of talk such as the collaborative completion of turns, face-work in the sense of deferring to patient's positions, micro strategies of engagement including modes of questioning and the appropriate use of a personal voice that foregrounds the doctor's personal over professional or institutional identity

Strategies of empathy

The category 'empathy', involving as it does perception and appreciation of the patient's condition, position, emotions and attitudes and the appropriate communication of that understanding, can itself be linked to 'reflecting', a strategy that is explicitly taught by many educators in our study. Discourse analysis may serve to inform us more about how this strategy, expertly executed, functions to uncover hidden emotions and how this may in consequence shift the consultation to a new footing such as that of more open discussion about symptoms.

It's important to note that the data underpinning such analyses may be more than wording alone. Indeed the full range of semiotic modes including gesture, gaze and body orientation may co-occur or, on occasion, stand in place of actual wording to strategically deepen engagement at critical moments

Achieving rapport

A note on face and face work

In our encounters with others, we tend to act out what is called '**a line**'.[32] Through this line we express our view of what is going on as well as an evaluation of ourselves and the other participants in an encounter. In a consultation, a patient may act out the line of someone who can cope or someone who is in control of their alcohol use and could stop whenever they wished. A doctor may take the line of someone who is non-judgemental or sensitive, or task oriented and efficient.

Our line is the sort of person we want to be seen to be and the term **'face'** may be defined as "the positive social value a person effectively claims for himself by the line others assume he

[32] Goffman,E. 1969. Where the action is. Three essays. London: Allen Lane The Penguin Press

has taken during a particular contact".[33] So face is not something we have. It is not lodged in our body. Rather it is located in the flow of events. It is sustained or enhanced or disconfirmed or lost in our interactions with others. Feelings are attached to face. If an encounter sustains our face, then we are unlikely to experience any feelings about the matter but if our self-image or face appears to be threatened or disconfirmed we will feel bad.

Maintenance of face appears to be a condition of rapport, and during the ordinary course of a consultation doctor and patient are likely to act to sustain the image each projects. But at times, particularly in situations involving sensitive issues or high emotion, incidents may occur that threaten face. A patient may act defensively to protect their face and as a result rapport is in danger of fracturing. The corrective work that goes into restoring equilibrium at such moments is called **face work**.[34]

Face and face work in action

(See appendix for transcription symbols)

Despite, or perhaps because of her underlying emotional difficulties, the patient in this case strives to represent and defend a version of herself as a reasonable person who does not seek tests or worry without cause. The positive image that she claims for herself by taking this line constitutes her **'face'**. At various points throughout the consultation the doctor acts to sustain the patient's view of the kind of person she wants to be.

How does the doctor achieve this? We argue that one subtle way she does so is through **'collaborative completion' of the patient's turns** (Lerner: 1996).

Extract 1.

36	D:	So::: Just having a look back. You have seen Doctor B about your bowels over the years :
37	P:	Yeah and when I had my last colonoscopy he said he didn't need to see me unless I had
38	D	yeah
39	P	unless I saw (.) blood (.) So you know as I said I don't want to be alarmed (.) I don't want to have to [have things done if [I don't need it
40	D	[no [you don't need it (.) Right

Note that at line 40 the doctor produces an almost identical utterance in chorus with the patient, "you don't need it". She is attuned to the patient's view of herself as someone who doesn't seek tests unnecessarily. She displays this through anticipating what the patient is about to say and collaborating with her to complete her turn by a sympathetic overlapping of her talk. In this way she aligns with, and ratifies the way the patient wants to be seen. Such supportive, collaborative alignment appears to be one signifier of the crucial strategy of rapport.

Corrective face work

In a number of extended turns the doctor then goes on to share the clinical reasoning that would lead her to discount ovarian cancer as a cause for this patient's symptoms.
The doctor concludes this sequence with a reassuring coda " So the ovarian cancer (.) your level of worry about it should should ease : OK :" and then moves to shift topic: "Now let's just have a look at"

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[33] Goffman, E. 1969. On face work: an analysis of ritual elements in social interaction. In Where the action is. Three essays. London: Allen Lane The Penguin Press

[34] Goffman, E. 1969. On face work: an analysis of ritual elements in social interaction. In Where the action is. Three essays. London: Allen Lane The Penguin Press

Extract 2

		.....So the ovarian cancer (.) your level of worry about it should should ease : OK : Now let's just have [a look at
46	P	[I'm not really worried about [it
47	D	[no but it's something as women : (.)
48	P	Yes :

But at line 46 we note that the patient interrupts to reject the implication that she is 'a worrier': "I'm not really worried about it". Face is at stake and, as a consequence, rapport is uncertain as the patient perceives that her version of herself as someone who does not worry unnecessarily is disturbed. The doctor moves swiftly to mitigate this potentially face-threatening incident with face-work. We note that in using the 'in-group identity marker' 'as women'... she aligns with the patient as a co-worrier, implying that for women, including herself, to worry about ovarian cancer is reasonable. At line 48 the patient picks up the inference and adamantly agrees. Her line as a reasonable patient is sustained. Rapport is maintained and indeed strengthened and the consultation can proceed.

Strategic use of a personal voice

Sarangi and Roberts[35] have observed that doctors, through their talk, manage at least three overlapping identities: professional, institutional and personal. Professional identity involves drawing upon professional knowledge to talk with a patient in the voice of a doctor. Institutional identity involves talking as a member of the institution of medicine as happens for example when the doctor uses the institutional 'we' to refer to the rules that regulate practice: "We wouldn't normally recommend that women have a CT scan for no reason" or "We're just not authorised to prescribe that particular drug". Personal identity involves talking with the patient in ways that highlight that both doctor and patient belong to the same world of human experience.

All three identities and all three voices may co-occur within a consultation. Communicative expertise may lie, in part, in the ability to determine, at any given moment in the flow of the interaction, which identity is appropriate and effective to foreground and which voice to invoke. As Candlin and Candlin[36] point out, expert health practitioners employ " a variety of voices polyphonically" and perhaps unconsciously "as the context and the expert's shifting roles warrant". (2002: 126)

In extract 2 for example we saw how the doctor momentarily shifts to the voice of personal identity. She aligns with the patient by speaking as a woman rather than as a member of a professional category, namely as a doctor, and highlights their common world of personal experience. She does so, probably unconsciously, to manage a potentially critical moment.

'Firmly standing on two feet whilst jumping up and down on another'(Goffman)

On other occasions throughout the consultation, this doctor invokes a personal voice to put the interaction onto a new footing of small talk. It is notable that she brackets these strips of small talk within the wider frame of the clinical business at hand. In extract 3 for example we see how she helps the patient to relax by engaging her in small talk during physical examination.

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[35] Sarangi,S.and Roberts,C. 1999. The dynamics of interactional and institutional orders. In S.Sarangi and C.Roberts (Eds.) Talk, Work and Institutional Order (pp.1-57). Berlin: Mouton de Gruyter.

[36] Candlin,C. and Candlin.S. 2002. Discourse, expertise and management of risk. *Journal of Research on Language & Social Interaction*, 35(2), 115-137

Extract 3

292	D	I'll pop you up on the bed ((walks towards bed)) and I'll just have a feel of your tummy
293	P	((patient blows nose and moves to bed))
294	D	So how was your holiday
295	P	It was good (.) it was good ((physical examination off screen))
296	D	How long were you in H for
297	P	hh fifty four years
298	D	Ahh (...) it's a long time isn't it
299	P	Yep
300	D	So is that
301	P	It's sore down here ((physical examination continues off screen))

In extract 4, towards the end of the consultation, small talk functions to maintain engagement with the patient as information is entered into the computer. The doctor again injects a personal voice into the consultation, this time adopting the voice of a mother.

Extract 4

319	D	Not bad for a one handed typist ((enters information))
320	P	hh hh
321	D	The kids are at me to get a dog for Christmas
322	P	A dog
323	D	Mm ((continues to enter information))
324	P	Oh I've been ringing up a couple of breeders
325	D	((continues to enter information))
326	P	There's one lot I can go and have a look at and another lot due on the 5th of December
327	D	((looks at patient)) Oooh ((gets up to retrieve print out)) So that'll make you feel better
328	P	Yeah it will

What is of interest is how apparently innocuous and conversational talk can be heard as having significance professionally. Far from being of no particular consequence, such small talk can carry deeply significant meaning, especially in the context of voicing. This is not just small talk. In highlighting their common membership of the world of ordinary everyday experience, the doctor strategically closes the social distance inherent in the doctor- patient relationship to strengthen solidarity and rapport.

We might conclude by noting how this is achieved while the medical and administrative work of the clinic continues. In Goffman's phrase this doctor, 'while firmly standing on two feet [is able to] jump up and down on another".[37] (1981:155)

Achieving empathy

Empathy is defined in the medical communication literature as " the accurate understanding of the patient's feelings by the clinician and the effective communication of that understanding back to the patient so that the patient feels understood" (Suchman 1997: 678).[38]

[37] Goffman, E. 1981. Forms of Talk. Oxford: Basil Blackwell

[38] Suchman,A. et al. 1997. A model of empathic communication in the medical interview. *JAMA* 277(8) 678-682

Examiners and educators in our study frequently refer to 'reflecting' as a particular communication strategy by which empathy may be achieved.

It might be thought that achieving empathy would be only a matter of modelling and memorising a number of stock phrases held to have empathic value. But such a conclusion would be problematic. Ethnographic study reveals that repetition of such stock phrases can backfire. As one medical educator reported,

"One of the things I teach is 'That must be hard for you'[Referring to a registrar in training] 'If you use the phrase 'that must be hard for you' one more time I'm going to strangle you. You need to be more adaptable. It can't just be by numbers'.

So it is within the context of particular interaction that language has meaning and appropriacy and a learned and rehearsed response can in fact communicate the exact opposite of empathy. Use of language that does not accurately reflect the patient's emotion and attitude at the moment of interaction can be received by the patient as a sign of lack of engagement and attention and consequently as failure by the doctor to fully grasp and fully to understand their true position.

Turning to this particular case, discourse analysis directs us to understand the degree to which empathy is interactionally achieved. We note in particular how the doctor uses language that matches the intensity of the patient's experience. And, as we indicated earlier, a range of semiotic means, including gaze, body orientation and gesture, function in concert with language to intensify engagement at critical moments. We also note how the consultation clearly illustrates that empathy is not simply about perceiving, appreciating and expressing understanding. Particularly in cases such as this, empathy has work to do. The linguistic strategy of reformulation enables us to reinterpret reflecting as a process by which the doctor transforms the patient's downgraded assessment of her experience, playing it back in a manner that puts the consultation on a new footing, and thereby creates a frame for franker discussion of the patient's symptoms.

By line 78, concern about ovarian cancer has been put to rest and the doctor moves to open up discussion about other issues.

Extract 5

78	D	All right. ((turns head back to patient, placing hand on top of the slip of paper on the desk)) so how are you apart from that. ((withdraws hand from the slip)) that's one worry
79	P	Pretty good but : (fall rise tone) You know when I came last time I told you I had (.) you said you thought I had a panic attack :
80	D	Yeah : (fall rise tone) ((rolls chair away from desk, places hands on lap, head and torso align, focuses gaze on the patient))
81	P	And I still sort of get that feeling (.)# inside : h ((shrugs shoulders))
82	D	[((leans forward towards the patient, both elbows on desk, hands cupping her face))
83	P	[((patient shrugs shoulders again))
84	D	It's a rotten thing. Rotten
86	P	hh
87	D	Tell me about the feeling
88	P	(..) ((indicates chest)) Um # seem OK during the ## day but when I get into bed at night not relaxed # # it ° sort of goes chooooo ((gestures to indicate fluttering feeling over chest and abdomen)) ((slight shrug))
89	D	What's your head doing in that time
90	P	That seems to be OK just sort of ((pats stomach and chest)) in here sort of thing ((shifts quickly in seat))

91 D So is your heart beating strangely
92 P A little bit yeah

This sequence of talk illustrates well what we said earlier about critical moments in a consultation. At line 79, the patient raises the topic of panic attack guardedly. At line 81 she offers her symptoms vaguely, tentatively, hedging their certainty with the particle 'sort of'. Apologetic shrugs, pauses and intake of breath appear to underline her conversational discomfort with the topic. The doctor acts to acknowledge this discomfort by heightening her engagement, re-orienting her body towards the patient and intensifying her gaze.

Note that as the patient shrugs apologetically once more (line 83), the doctor transforms the patient's downgraded assessment of her experience with an utterance that mirrors the degree of intensity the patient feels. 'It's a rotten thing. Rotten'. With a small intake of breath the patient acknowledges this assessment. It is this expert reformulation by the doctor that appears in our view to diffuse the patient's embarrassment and discomfort. Her experience is now out in the open as a matter that can be interpersonally but professionally discussed.

Note also the consequent shift to franker discussion. The doctor's open invitation to talk at line 87 'Tell me about the feeling?' ushers in a series of more focussed diagnostic questions and responses through which the true character and intensity of the patient's symptoms begins to emerge.

Gaze and body alignment

We have referred earlier to the way rapport and empathy can be realised by not just wording but by a range of modalities. Analysis of 'gaze' and 'body orientation' helps to illustrate just how this and other accomplished candidates create frame-works of engagement with their patient at critical moments in the interaction.

Gaze and body orientation are interrelated (Mehrabian:1967)[39] The body can be seen as an organisation of segments each of which can be oriented in different directions. (Kendon :1990)[40] It is the lower segments of the body, the legs and torso that are relatively more stable and so more strongly communicate participants' frames of dominant orientation with the action going on and with each other.

In this, and in almost all consultations in our corpus, doctors are engaged with both the patient in person and the patient 'inscribed' in computer records and files. (Robinson:1998)[41] In many, the doctor's engagement with records is accompanied by dominant body orientation towards the computer. Doctors may turn their gaze towards the patient periodically, but legs and torso squarely front the desk. This communicates the doctor's dominant engagement in the impersonal, non-collaborative action of dealing with records.

However, this doctor, rated highly on empathy and rapport, frequently enters records with her right hand whilst legs and torso continue to align with those of the patient. Often, this body orientation is maintained as she reads records as well. Her body alignment consistently communicates that she is in interpersonal contact with the patient and poised for mutual talk.

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[39] Mehrabian,A. 1967. Orientation behaviours and nonverbal attitude communication. *Journal of Communication,* 17(4), 324-332

[40] Kendon, A. 1990. Behavioural foundations for the process of frame-attunement in face-to-face interaction. In *Conducting Interaction: Patterns of behaviour in focused encounters* (pp239-262). Cambridge, UK: Cambridge University Press.

[41] Robinson,J. 1998. Getting down to business: talk, gaze and body orientation during openings of doctor-patient consultations. *Journal of the Society for Human Communication Research.* 25(1), 97-123

Notice how at critical moments, she moves strategically to intensify her engagement with the patient. For example, at line 80 she signals readiness for full collaboration, rolling her chair back from the desk, realigning head and torso and focussing her gaze. This engagement is intensified further from line 81 as she leans forward, cupped hands framing her gaze. It is these semiotic actions that herald and accompany her crucial empathic reformulation of the patient's experience, intensifying its impact and enabling the patient to present relevant information for the purpose of the consultation.

Sharing of clinical thinking.

It appears that in evaluating the clinical communication skills of candidates, examiners and educators are responding not just to the presence or absence of certain signifiers of rapport and empathy but also to patterns across the consultation as a whole. It may well be that their assessment of this doctor has much to do with the manner in which she aligns with the patient and closes the social distance between them through including her in the clinical reasoning process.

Throughout this consultation, the patient draws upon lay reasoning to account for her symptoms and to discount psychological causes. Strategically, the doctor acknowledges this reasoning, puts unwarranted concerns into perspective through including the patient in the clinical reasoning process, and so clears the way for sensitive emotional and psychological issues to emerge.

Extract 6 illustrates this recurring pattern. The patient has been talking of the death of the family dog. At line 139 she concludes by attributing her low mood to this loss. " And I gather that's what it probably is". Note that this line of reasoning is considered by the doctor in a long pause, and acknowledged at line 141: "Its probably a lot of it". But marked stress on 'a lot' implies that there are other causes as well and the patient acknowledges this.

The doctor then turns to the issue of heart palpitations which the patient considers may have a physical cause. A Holter monitor will investigate the possibility of underlying heart problems that the doctor considers unlikely. In a long turn at line 145 the procedure and clinical reasoning behind it is shared collaboratively with the patient to reassure and allay her concerns. This done, the way is open for exploration of the patient's sadness. The patient's barely perceptible nod at line 148 indicates a deepening readiness to engage with this exploration.

Extract 6

139	P	And I gather that's what it probably is
140		(0.4)
141	D:	It's probably a lot of it
142	P:	mm
143	D	((doctor takes gaze off the patient and gestures towards the computer)) That last ECG looks fine but if you're not having the symptoms at the time (0.2) then I can't comment on what your heart rates doing …..
144	P	The last what looked fine (.) sorry :
145	D	Your ECG. We can do a Holter monitor(.) so that stays on you over night so when those jumpy horrible feelings are there actually looking at the electrical activity of your heart (.) and looking at your symptoms and saying well it's either your heart jumping around (.) or it's not (.) and that will set your mind at ease (.) about that
146	P	mm
147	D	((leans forward focusing gaze on patient, head and torso aligned)) but the other issue is dealing with your level of (.) sadness I think ° at the moment
148	P	((patient nods almost imperceptibly))

Into the future

In this paper we have focussed on the examiner/educator categories of empathy and rapport and have analysed the discourse of a challenging consultation involving a doctor rated as 'excellent' on communication skills by her examiners. Through this close analysis, we have endeavoured to add to an understanding of how empathy and rapport are actually achieved in interaction and how, expertly executed, strategies of empathy and rapport function to move the consultation towards the desired clinical outcome.

In future papers, we have in mind to compare our analysis of the performance of a range of candidates in similar Practice Based Assessment consultations so as to describe relative degrees of communicative expertise.

Question design

Another area that may warrant focus for future papers is question design. There is much in the medical communication literature about the important role of open questions in history-taking to elicit the patient's full story and to gain insight into the patient's life world[42], and examiners and educators in our study routinely refer to the category 'appropriate use of open and closed questions' when teaching and appraising communicative performance.

But recent discourse analytical research suggests that the way doctors design questions, including the wording, ordering and placement of questions by the doctor, may also contribute to the construction of a particular kind of relationship with the patient. The following example from Boyd and Heritage (2006:167)[43] illustrates how question design contributes to the formation of an empathic relationship by displaying the doctor's sensitivity to the patient's circumstances.

The doctor is taking the social history of an over-weight, hypertensive patient who has gained eleven pounds and works at least 60 hours a week in a restaurant. The doctor knows this.

D	Tk Do you exercise at all?
	(2.5)
P	N::o, uh huh huh huh (.hh //.hh huh //huh (.hh huh huh)
D	// hm // $not your thing
	//ah:
P	//.hh $Would you believe me if I sai(h)d y(h)e(h)s

Given the patient's life world, a bald, checklist type question such as "Do you exercise?" would risk being heard as ill-fitted and insensitive. But this doctor's question is designed with the particular patient and their situation in mind. By adding the item 'at all' the doctor changes the polarity of the question. It is natural to respond negatively to a question designed in this way. Negation is the expected response. In choosing this form, the doctor displays his expectation that the patient is likely to tell him that she doesn't exercise, and his insight into life circumstances that would make exercise difficult.

Question design is an area that might be beneficially explored through our on going analysis of the discourse of Practice Based Assessment consultations

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[42] Beckman,H. and Frankel,R. 1984. The effect of physician behaviour on the collection of data. *Annals of Internal Medicine* 101:692-6
Roter, D. and Hall,J. 1992. *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits.* Westport: Auburn House

[43] Boyd,E. and Heritage,J. 2006. Taking the history: questioning during comprehensive history taking. In Heritage,J. and Maynard,D. (Eds.), *Communication in Medical Care. Interaction between primary care physicians and patients*. Cambridge: CUP.

We welcome comment on this paper. In particular, we would value the perspective of educators, examiners, registrars and examination candidates on the analysis we have presented, advice about how such analyses might have practical application to their work as well as suggestions for future directions.

Catherine O'Grady & Professor Christopher N. Candlin
Department of Linguistics
Macquarie University, Sydney. October 2007.

Appendix 6: Extracts from emailed participant feedback on Discussion Paper 2.

Extract 1

It was a very useful read for me. The linguistic slant gets one thinking outside our usual box, constructed by traditional medical education theory. Haven't got any strong feelings or suggestions to improve. I think it would be interesting to present this at a workshop for some valuable discussion - what does the RACGP plan to do with it???
(Medical educator/PBA examiner)

Extract 2

I have read the paper and found it interesting to see each aspect of communication 'teased out'. I will pass the paper on to others (Senior Medical educator)

Extract 3

Your discussion paper made for very interesting reading. I think it beautifully describes the various aspects of good communication. Some trainees would benefit enormously from seeing that sort of detailed analysis (Medical educator)

Extract 4

Here are some random comments and they may not relate to the paper always, but also to the ideas and concepts discussed in the paper

Page 7 - the theory and concept of " line" and "face" are very foreign to practitioners. There seems to be an implication that the benefits of therapeutic relationship are just a value claimed by an individual and assumed to exist by the patient. If this were the only basis for human contact, we should all go home. Personally I think true rapport goes a lot deeper than the non-challenging of mutual psychological assumptions. It's conceivable in fact that the allowing of non-defence of " face in the presence of insight may be a truer basis for rapport! But that's a rather large topic – certainly a lot of suffering arises from habitual misinterpretation of experience as being "personal" or referring to a "self".

I do enjoy reading the analysis – the consultation is a very private and hidden thing and the best consultations are really lost to study as they are so personal and immediate to the doctor and the patient. As you say, the very small details in the conversation mean a lot more than people think. You are interpreting behavioural actions in studying communication technique, but of course the insights of the consultation - the volitions and perceptions - remain private to the doctor and the patient (Medical educator/registrar trainer).

Extract 5

We believe your reports might be a useful resource for a college committee that is currently working on developing a Video module for pilot assessment pathway to Fellowship, so would like to ask if you would give your consent for the reports to be forwarded to the committee (RACGP administrator)

Extract 6

- I think that the case you chose illustrated the discussion points very well.

- I agree that the changes in voice and changes in body positioning are, most likely unconscious things....making it harder in the end to TEACH these skills, yet not to examine them (if they CAN be taught)

Re practical application – personally these observations are very interesting and I think would add to registrar training (in addition to the stock standard teaching you have commented on - reflective listening, body language, seating position). All doctors know that patients often have a hidden agenda (the trick is how to get to that separate agenda – if in fact you wish to as a doctor (ie in 6 minute medicine I don't believe this would be possible)). However, do doctors know that THEY often have unconscious tacks in language style, body language etc- and that these things often do assist with empathy and rapport? I think that further understanding about the interactions that go on between doctor and patient is always useful – I just don't know exactly how it would practically be implemented. Having read this myself I think I might reflect more on what I did or said in future successful or unsuccessful consultations (Medical examiner).