**Current Research Project**

# THE NATURE OF EXPERT COMMUNICATION AS REQUIRED FOR GENERAL PRACTICE – A DISCOURSE ANALYTICAL STUDY.

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[NOTE: This project is directed in part at the PhD degree in the Linguistics Department of Catherine O'Grady supervised by Professor Candlin, and is undertaken with the full support of the Royal Australian College of General Practitioners. Responses to its subject-matter and methodology are welcome and should be directed to ccandlin@optusnet.com.au
A recent conference paper on the progress of the project and issues arising was presented at the 2007 COMET (Communication, Medicine & Ethics Conference) held in Lugano, Switzerland, June 2007. Updates on the project can be obtained on request]

## Background and rationale

Communicative expertise lies at the core of clinical practice. This is highlighted by the fact that communication skills and the doctor-patient relationship is one of five domains of General Practice assessed in the clinical component of the RACGP College Examination. Further, it is through a series of Objective Structured Clinical Examination style encounters, representing aspects of typical general practice consultations, that such expertise in professional communication is assessed.

It appears that there is a considerable degree of consensus amongst examiners in the global assessment of candidates' communication skills. Experienced, accomplished practitioner-examiners largely agree on the 'outstanding' or 'good' or 'borderline fail' performance, and communication skills checklists provide some evidence for this global assessment. However, such checklists make use of broad categories and so cannot provide explanatory detail of what constitutes, in more specific terms, expert or poor communication for clinical practice.

As the College Handbook sets out, the assessment of communication skills for clinical practice relies on professional judgement of such specific traits.

> "We can fairly easily measure how much history candidates obtain or how many physical finding they elicit, but it is a matter of judgement how well they pick up subtle cues, how at ease they are, and how lucid their explanations are. We have no scales, ruler or counter that will do that for us".[1]

Accordingly, there appears to be a need for a more fine-grained analysis which would allow for more precise indices of successful communication to be defined. Discourse analysis research includes such close, in depth analysis on the basis of recorded interactions. Such analysis can uncover some of the evidence on which judgements are based and can provide a greater understanding of how broad categories of expertise, such as the ability to establish and maintain rapport, to provide lucid explanations and to respond to linguistically subtle cues, are actually achieved in interaction.

[1] Royal Australian College of General Practitioners. The college examination. A handbook for candidates and examiners. 2005:47

The King's Fund in the UK for example, recently commissioned a study by Celia Roberts of King's College London and Professor Srikant Sarangi of the Health Communication Research Centre of Cardiff University, which explored how the results of such research might be relevant to the evaluation and assessment of the clinical communication skills of medical students. In this study, discourse analysis was used to shed light on what makes for good and poor communication in an OSCE.[2] Subsequently, summative assessment was able to inform education as new insights, detailed understandings and descriptions of aspects of competent and less competent communication were available for professional development and training programs.

In a similar way, analysis of the fine-grained details of interaction can also be made available to examiners in a manner which would allow for more authenticated judgements of relative expertise for General Practice. Furthermore, as these judgements are made by experienced and accomplished practitioners, such discourse analytical research can uncover much about the nature of expert communication as perceived by the profession.

Such research will be of value to assessment and training at the RACGP. In particular, it is hoped that it would:

- Inform examiner training so that feedback to candidates could be richer and more descriptive
- Support clinical communication skills training, enabling educators to draw from new insights into the details of successful and less successful communication
- Increase understanding of any special difficulties experienced by doctors trained overseas whose first language is not English.

It is the understanding of the proposer that, as a group, these doctors fare less well on the College examination than the general population of candidates. Whilst doctors trained overseas would not be singled out as subjects for research, close analysis of the interactions of all doctors in a sample would throw up any differences in the nature of their interactions that might affect judgements of their individual performance. Findings would then inform feedback, education and the candidates' development towards greater expertise.

**Research aims**

To enhance understanding of the nature of expert communication as required for General Practice and to make these new understandings available to educators and assessors.

Research is designed to explore these specific questions:

- How is expert communication, within particular communicatively challenging clinical contexts, perceived by experienced practitioner-educators and examiners?
- How can close analysis of such communication enable us to establish the basis for degrees of expertise among those presenting for College examinations?
- How can insights gained from the analysis of such communication enable us to contribute to the enhancement of assessment and teaching practices for College candidates including those trained overseas whose first language is not English?

[2] Roberts,C., Wass,V., Jones,R.,Sarangi,S., Gillett,A. (2003)A discourse analysis study of 'good' and 'poor' communication in an OSCE: a proposed new framework for teaching students. *Medical Education* 37:192-201

**Proposed methodology**

To address these questions, the proposed research methodology combines an initial period of ethnographic research with discourse analysis of recorded examination encounters and subsequent discussion with examiners and educators.

**Ethnographic research** involves study of the 'communicative ecology'[3] of a setting or a research site through observation and interviewing of key participants. Such an ecology includes those values, ideologies and principles that shape expectations about appropriate behaviours and ways of communicating in clinical encounters, and may affect interpretation and assessment of what transpires during such interactions. It is important to explore and understand this broader institutional communicative context before recording and interpreting discourse data.

**Discourse analysis** involves the recording, transcription and in depth analysis of the features of specific interactions. Such fine grained analysis, using sensitive transcription conventions, enables the analyst to identify and describe how broad descriptors of success such as 'responds to patient cues' or 'maintains rapport' are achieved.

In moment to moment interaction, we cannot express in words all that we mean and all that listeners need to attune their talk in response. Subtle signals such as intonation, stress or rhythm, cue the listener to infer what is intended and these cues are usually produced and interpreted unconsciously. In depth discourse analysis is needed to reveal those subtle aspects of the process by which candidates and patient/examiner interpret and respond to each other during a consultation.

Further, as previous research has shown[4], discourse analysis can describe how successful candidates stage a consultation in response to the interactional context produced by the patient/examiner.

## Administration and Data Collection

The Ethnographic research phase involves:

1. Audio recordings of interviews with medical educators who teach clinical skills in Pre-Examination courses. Interviews would be semi-structured, using open-ended questions to explore such themes as:
   - what educators look for in communicative performance
   - aspects of communication they consider important to teach
   - the types of clinical scenarios that present particular communication challenges
   - critical communication errors.

2. Observation of Pre-Examination courses.

   These themes are being further explored through observing the classroom performances of candidates in light of educators' comments and feedback, and taking note of those aspects of communication that are the focus of teaching.

[3] Gumperz,J. On interactional sociolinguistic method. In Sarangi S, Roberts C.,eds. Talk, Work and Institutional Order. Berlin: Mouton de Gruyter 1999; 453-71

[4] Roberts,C., Wass,V., Jones,R., Sarangi,S., Gillett,A. (2003) A discourse analysis study of 'good' and 'poor' communication in an OSCE: a proposed new framework for teaching students. *Medical Education* 37:192-201

3. Observation of examiner training sessions and pre-examination briefings.

   This would provide further insight into what is valued in communicative performance, the principles that constrain what counts as successful communication in a range of clinical settings, as well as the types of clinical scenarios that are likely to be problematic.

   Detailed field notes are being used to record data during these observations.

4. Discussions with examiners following transcription and analysis of sampled examination data.

   These discussions will bring the perspectives of both the profession and the discourse analyst to bear on the final analyses of data.

The Discourse Analysis research phase involves:

1. Recording of data.

   In light of ethnographic findings and consultation with College examiners, two clinical examination stations would be identified for audio-video recording in each of the bi-annual College examinations. Stations that particularly challenge candidates' communication skills would be selected.

   Sequential audio-visual recordings are to be made of the performances of all consenting candidates taking these stations.

   In addition, video recorded data of Practice-Based Assessments (PBA's) from selected candidates' consultations have been provided by the RACGP with doctors' consent. These are being analysed and appraised partly in relation to the assessments made by examiners of these authentic performances recorded on site by candidates.

2. Selection of data for transcription and analysis.

   All audio video-recorded consultations would be viewed and notes made to identify salient patterns of communication in the data that relate to examiners' broad assessment categories.

   These viewing notes would be used to select a sample of consultations for transcription. The sample would include balanced numbers of candidates judged by examiners as 'outstanding', 'good' or 'fail' on communication skills.

   Transcriptions would capture all verbal and non-verbal signs that are perceived as communicatively significant, including those features that listeners rely on to infer intention and speakers rely on to respond appropriately.

3. Analysis of data

   Analysis of the transcribed discourse would be informed by analytic concepts from past and on-going linguistic/discourse analytical research, including the increasing body of linguistic

research into interaction in health care settings. This body of work includes studies of the nature of expertise in clinical communication[5] as well as studies of the assessment of such communication.[6]

Such analysis across the data would shed light on those features of communication style and patterns of interaction that characterise the performance of candidates at different levels of ability and expertise.

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[5] Candlin, C.N.and Candlin, S. Discourse, Expertise, and the Management of Risk in Health Care Settings. [Special issue of:] *Research on Language and Social Interaction* 2002;35 (2)
[6] Sarangi S. and Roberts C. (2000) Oral examinations-equal opportunity, ethnicity, and fairness in the MRCGP. British Medical Journal 320: 370-374