Surgeon Communication in Outpatient Consultations – What seems to be the problem?

A thematic discourse analysis

Megan E. Riley

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The School of Psychology

The University of Adelaide

Faculty of Health and Medical Sciences

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Abstract

There is widespread acceptance in the literature and in practice that 'good communication skills' are integral to treatment outcomes and patient satisfaction. However, it is also acknowledged that many medical students and practising clinicians are skeptical of communication skills training. The majority of this research focuses on interaction between patients and primary care providers and less is known about the nature of surgeon-specific communication. The present study involves an exploration of surgeons' accounts of communication in outpatient consultations. Participants were 12 surgeons from two large public hospitals in South Australia. Semi-structured interviews were transcribed and analysed using thematic discourse analysis. Surgeons were asked to talk about their experience of communicating with patients in outpatient consultations with reference to what helps, what hinders and whether there is a role for training. Five interpretative repertoires were generated. Two repertoires, *It's not us who are the bad communicators* and *Time is the enemy,* locate communication difficulties as an unavoidable consequence of the social and organisational context. Three repertoires, *Communication as generic skill set, Communication changes with experience* and *Communication as fixed trait*, construct a case against communication education in its current form. Clear implications for future training are explored.

Declaration

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Megan E Riley

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CHAPTER 1

1.1: Status of health communication research

Health communication is a thriving area of scholarly investigation. The growth of the field has been accompanied by the development of scholarly institutions dedicated to health communication (e.g. *Journal of Health Communication* and *Journal of Communication in Healthcare*) and the recently established ANU Institute for Communication in Health Care (2018). The status afforded this body of knowledge is reflected in the way communication has become embedded in government policies (*Australian Charter of Healthcare Rights*, 2019; *National Safety and Quality Health Service (NSQHS) Standards*, 2019) and a range of healthcare strategies, checklists and tools (such as Introduction, Situation, Background, Assessment, Recommendations (ISBAR) for patient handovers or Subjective, Objective, Assessment and Plan (SOAP) for clinical rounds). Communication has also become a prominent feature of medical, nursing and health curricula, worldwide, both in terms of undergraduate medical education and continuing professional development (Sarangi, 2004). In Australia, for example, communication is now regarded as a required 'competence' for doctors and surgeons (Medical Board of Australia, 2017; Royal Australian College of Surgeons, n.d.).

On the one hand, it is easy to see why contemporary accounts situate communication as an essential aspect of medical practice, as much a part of a physician's toolkit as their knowledge of anatomy and physiology. From eliciting patients' concerns and formulating diagnoses, to clinical handover and performing as part of a team in the operating room, a significant amount of medicine is accomplished through interaction (Heritage & Maynard, 2006a; White et al., 2013). Routinely cited benefits of 'effective communication' include decreased litigation (Levinson, Roter, Mullooly, Dull, & Frankel, 1997), improved patient

satisfaction (Bredart, Bouleuc, & Dolbeault, 2005; Wanzer, Booth-Butterfield, & Gruber, 2004); improved patient recall, understanding and adherence to treatment (Stewart, 1995; Zolnierek & Dimatteo, 2009); and better health outcomes (Street, Makoul, Arora, & Epstein, 2009; Williams, Haskard, & DiMatteo, 2007).

On the other hand, it is easy to forget that learning how to elicit a patient history, discussing treatment options or breaking bad news, would once have seemed unwarranted, perhaps even beyond the scope of education (Marshall & Bleakley, 2008). It is also widely acknowledged many medical students and professionals remain suspicious of the notion that communication is a transmissible 'skill', believing it to be more of an ability that may or may not be enhanced through clinical experience (Rees, Sheard, & McPherson, 2002; Turner, Payne, & O'Brien, 2011).

Although the status of communication in the medical consultation is not in question, its nature and characteristics are the subject of ongoing debate – particularly when it comes to the concept of 'patient-centredness' (Ishikawa, Hashimoto, & Kiuchi, 2013), and defining what makes a 'successful' consultation (Jones, 2015; Zill et al., 2014). It is particularly interesting to consider the question of whose interests are best served by 'effective communication'. What may be effective communication for physicians does not necessarily correspond with patient plans, perceptions or preferences (Brown, Crawford, & Carter, 2006).

1.2: Dominant paradigms in health communication research

The field of health communication research is characterised by 'methodological pluralism' (Neumann, Kreps, & Visser, 2011). From this diversity Heritage and Maynard

(2006a) identify three broad research traditions which have helped shape our current understanding of physician-patient communication. Each of these traditions – interaction process analysis, critical discourse analysis and conversation analysis – employ different methodologies and each conceptualises communication in different ways.

The use of interaction process analysis in medicine commenced with studies on doctor-patient interaction in a paediatric emergency room (Korsch, Freemon, & Negrete, 1971; Korsch, Gozzi, & Francis, 1968). This research demonstrated that mothers were often reluctant to ask questions or to express their primary concerns. Patients who were least satisfied with information received were the least cooperative with recommended treatments. This research suggested that systematic study of physician-patient interaction was possible and beneficial. These studies used Robert Bales' interaction process analysis. This quantitative approach was developed as an approach for studying interaction in small groups (Bales, 1951). It conceptualises communication as a set of discrete behaviours or acts. Although the method had benefits (including the ability to code interaction), it was not adapted specifically to doctor-patient communication.

Coding schemes have been refined and adjusted to suit physician-patient interactions. From the 1980s, Roter and colleagues developed an interaction analysis system (RIAS) designed to exhaustively classify the events of a medical visit (Roter & Larson, 2002). Roter's method significantly opened up the doctor-patient relationship and accommodated a wider range of medical interactions and communications. Subsequent studies highlight the benefits of taking into account the patient's view of the illness and have revealed significant differences between how males and females interact in the medical visit. (Roter & Hall, 2004; Stewart, 1995). However, critics argue the Roter system fails to sufficiently take into

account content, context and meaning in medical communication. They suggest that the RIAS categories concentrate on an overview of medical encounters but ignore how the parties influence and adjust to each other's behaviour (Heritage & Maynard, 2006a).

Studies which focus on the microanalysis of medical discourse rely on ethnographic and interpretive methodology to analyse the complexities of the medical visit (Heritage & Maynard, 2006a). This approach tends to highlight the asymmetrical nature of power in the medical consultation and the way physicians regularly suppress patient concerns. For example, Elliot Mishler's *The Discourse of Medicine* (1984) revealed that physicians and patients often pursue different and conflicting agendas during the visit. In pursuing a medical agenda ('the voice of medicine'), doctors frequently suppress patients' concerns and anxieties ('the voice of the lifeworld'). The mechanism of this suppression in history-taking is the structure of questions and responses whereby the physician controls initiation of topics, their development and degree of patient response. Through this process physicians often confine communication to a narrowly focused medical agenda.

Most recently, conversation analysis (CA) has provided a fine-grained analysis of the medical encounter taking into account the perspectives of both physician and patient (Heritage & Maynard, 2006b). The consultation is presented as a series of activities unfolding sequentially, with doctor and patient facing a succession of dilemmas and conflicts. Of particular analytic emphasis is the conduct of both physician and patient in co-constructing the interaction. While the majority of CA research in the field of health communication has concentrated on primary care interviews, some recent studies have focussed on aspects of the surgeon-patient interaction such as interactional sequences involved in closing consultations (White, 2012). Analysis of the overall structure of surgeon-patient consultations have found

some differences with GP-patient consultations (White et al., 2013), in particular the role of the referral letter in reaching agreement about the reason for the appointment (White et al., 2014).

Sociological accounts of changes in health care occurring over the same period of time follow a similar trajectory. Patients go from being represented as passive recipients of medical expertise and authority to active consumers of medical services. Physicians, meanwhile, are no longer characterised as autonomous professionals but positioned as highly regulated service providers (Cushing, 2016; Heritage & Maynard, 2006a; Iedema, 2012). At the same time, the biomedical model of health care, with its focus on disease and diagnosis, has been challenged by the biopsychosocial model that places patients and their psychological and social concerns centre-stage (Brown, Kidd, Noble, & Papageorgiou, 2015; Heritage & Maynard, 2006a).

New normative standards for the physician-patient interaction have emerged as a result of these changes. With regard to the physician, communication has come to be regarded as a 'skill' that can be acquired alongside technical abilities. In line with flattening of the power hierarchy, patients are assumed to want an equal role in decision making and thus should demonstrate an equal share of the interaction. The physician, meanwhile, is expected to take into consideration the patient's feelings and to display empathy. However, the physician's biomedical agenda still dominates the majority of consultations (Gwyn, 2001; Pilnick & Dingwall, 2011). This is usually interpreted as evidence for educational or motivational shortfalls among medical practitioners, that requires correction via better skills training, or appeals to professional integrity (Pilnick & Dingwall, 2011).

1.3: Differences between primary care and the surgical context

The majority of health communication research focuses on interaction between patients and primary care providers (i.e. GP consultations) and less is known about the nature of surgeon-specific communication. Existing literature suggests surgeons perform well with regard to patient education, but it is argued that there are demonstrated deficiencies in areas such as assessing patient understanding, discussing uncertainties in patient care, acknowledging emotional cues, and addressing psychosocial aspects of patient care (Levinson, Hudak, & Tricco, 2013). However, some of these apparent 'shortcomings' may be due to assumptions arising from a reliance on GP-patient communication research rather than actual deficiencies in surgeon communication.

Interactions between surgeons and patients can be distinguished from GP consultations in a number of ways. Surgeons are expected to educate patients about complex medical issues and procedures, explore treatment options, describe post-operative rehabilitation requirements, and address patient questions, fears and emotions – as well as discuss risks and elicit 'informed consent' for operations (Orri, Farges, Clavien, Barkun, & Revah-Lévy, 2014). The invasive and potentially life-threatening nature of surgery shapes the relationship between surgeon and patient in way that is fundamentally different from primary care interactions. Decisions must be made between different types of surgery, or whether to undergo a procedure at all. Surgical interventions are usually permanent, and surgical complications may be more enduring than side-effects from medications (de Mik, Stubenrouch, Balm, & Ubbink, 2018). Patients who undergo surgery ultimately relinquish all control and are placed in a position of unparalleled vulnerability, unlike the patient of a GP who at all times remains responsible for maintaining their own adherence to a treatment regimen (Axelrod & Goold, 2000).

1.4: Different perspectives on surgeon-patient communication

When surgeon-patient communication is measured by the same criteria as GP-patient consultations, surgeons are usually found to be lacking. For example, the dominant model for what constitutes 'good' doctor-patient interaction is framed in terms of 'patient-centred care' and 'shared decision making' (Brown et al., 2015; Dwamena et al., 2012). These descriptions construct an environment in which patients are presumed to want, and doctors expected to encourage, equal input in terms of decision making about diagnosis and treatment. When compared against these benchmarks, use of shared decision making in surgical practice has been described as infrequent (de Mik et al., 2018) or characterised as 'basic' (Etchells et al., 2011) and this is deemed a deficiency. However, contrary to the assumption that patients want to be included in decision-making, when it comes to surgical procedures some research suggests patients prefer surgeons to 'manage' information rather than 'deliver' it (Mendick, Young, Holcombe, & Salmon, 2011, 2013). In other words, patients trust surgeons to make important decisions and select which information to present and which to withhold.

The difference in the conclusions drawn by these studies might be explained to some extent by the different methodologies employed by researchers. When surgeon communication is analysed using quantitative measures (like questionnaire studies or the 'code and count' method of Interaction Process Analysis) it is generally found to be lacking. In these studies what constitutes 'good' or 'effective' communication is predetermined by theoretical assumptions. In the examples given above (de Mik et al., 2018; Etchells et al., 2011), 'shared-decision making' is unequivocally accepted as best practice and alternative approaches are automatically deemed inferior. A more exploratory qualitative approach (such

as that used by Mendick et al) allows the particular nature of the surgical context to be taken into account rather than measuring the interaction against some generic 'ideal'.

In a similar way, the biopsychosocial model of health care makes a number of assumptions regarding patient-physician interaction which may not be entirely applicable in the surgical context. This model puts patients and their psychological and social concerns centre-stage (Brown et al., 2015; Heritage & Maynard, 2006a). In line with this approach, physicians are expected to take into consideration patients' feelings and to display empathy based on the assumption that this is an appropriate response to patient displays of emotion. Studies using Interaction Process Analysis suggest this kind of interaction between patients and breast cancer surgeons is the exception rather than the norm (Hack et al., 2010) and further communication training for oncologists is recommended. However, qualitative research comprising audio-recorded consultations and semi-structured interviews suggests patients are comforted by surgeons' displays of competence, rather than empathy (Young et al., 2013).

Likewise, it has been suggested relationships arise automatically from a patient's trust in their surgeon's clinical expertise and authority, rather than being built over time, as with a GP (Beesley, Goodfellow, Holcombe, & Salmon, 2016). These findings suggest concerns about the hierarchical nature of the doctor-patient relationship may be misplaced in the context of the surgical outpatient consultation. The ongoing power asymmetry identified in doctor-patient relationships (Heritage & Maynard, 2006a; Korsch et al., 1968; Mishler, 1984; Pilnick & Dingwall, 2011) is perhaps in some ways crucial to the patient-surgeon relationship.

1.5: From Classroom to Consulting Room

Despite the fact that the evidence base consists of contradictory findings regarding what makes for 'good communication' between surgeon and patient, there is current emphasis on communication training. Communication is one of the nine essential competencies for being a surgeon in Australia and all surgeons regardless of age and experience are expected to participate in ongoing professional development (Royal Australian College of Surgeons, n.d.).

Communication skills training (CST) is widely accepted as a valid practice, and numerous frameworks for 'good communication' have been advanced in a variety of medical settings. However, it is also acknowledged that many medical students and practising clinicians are skeptical of communication teaching in its current form. For example, when course facilitators were interviewed as part of an evaluation they described senior doctors and consultants as 'defensive', 'disruptive' and 'cynical' about the benefits of compulsory training (Bibila & Rabiee, 2014; Turner et al., 2011) although the reasons for this resistance have not been fully explored. Beliefs that communication competence is an innate ability that naturally improves with age and clinical experience are commonly expressed by medical professionals and students (Denniston, Molloy, Ting, Lin, & Rees, 2019; Fadlon, Pessach, & Toker, 2004; Mendick, Young, Holcombe, & Salmon, 2015; Turner et al., 2011). The formal teaching of communication often involves role-play or dialogue with simulated patients and skills are broken down into checklists for the purposes of summative assessment. This approach is widely disliked for being 'artificial' (Mendick et al., 2011, 2015; van den Eertwegh, van Dalen, van Dulmen, van der Vleuten, & Scherpbier, 2014). By contrast, receiving personalised feedback after watching oneself perform in real situations has been identified as a powerful motivator for learning (van den Eertwegh et al., 2014).

Doubts also remain about the outcomes of training. The efficacy of communication programs, particularly over the long term, is yet to be determined (Fellowes, Wilkinson, & Moore, 2004). Current evidence is reported to be flawed by methodological problems and unconvincing effect sizes (Grady, Carey, Bryant, Sanson-Fisher, & Hobden, 2017; King & Hoppe, 2013; Mead & Bower, 2002). Particular issues which need to be taken into consideration are determining 1) the nature of 'effective' patient-physician communication; 2) how this should be measured; 3) how patient preferences should be taken into consideration (Grady et al., 2017). However, a feature of these critiques is the self-perpetuating nature of the research cycle in spite of the lack of evidence. For example, King and Hoppe (2013, p.385) asserted a 'compelling case' for 'communication skills and behaviours', despite recognised methodological shortcomings and inconsistencies in the studies under review. Likewise, Mead and Bower (2002, p.60) stated that the evidence for patient-centred communication was 'ambiguous', citing poor-quality methodology and inconsistent patterns of association, yet still concluded the answer involved more, and 'better' research.

1.6: The present study – what seems to be the problem?

The GP-patient consultation has been the focus of attention in health communication literature, but comparatively little is known about the surgical context (White et al., 2013). Scholarly emphasis on theories, models and statistical evidence has tended to produce idealised accounts of how doctor-patient communication should proceed (Tracy, 2008). It is no wonder then, that the reality of what occurs in the consulting room is often perceived to fall short (Cox & Li, 2019). Communication skills training (CST) and numerous frameworks for 'good communication' have been advanced to address these perceived shortfalls but after

several decades of efforts aimed at reform, 'problems' in physician-patient communication are still reported to exist (Heritage & Maynard, 2006a; Pilnick & Dingwall, 2011).

Mainstream approaches to health communication take a predominantly realist perspective, searching for an objectively measurable reality that researchers can measure or discover. What is missing from these accounts is an appreciation of the way knowledge is socially and culturally situated and 'meaning' co-constructed in the local context. From a relativist perspective there is no independent means of determining the 'true' nature of surgeon-patient interaction. Rather, there are a variety of ways in which outpatient consultations or communication training can be described and understood.

Instead of comparing surgeon communication to some theoretical ideal, or assuming that communication training is a necessary panacea, this report aims to describe and analyse how surgeons routinely discuss the nature of communication in outpatient consultations and consider what the implications of these formulations might be. It will allow surgeons to provide their own answers to the question – *what seems to be the problem?*

CHAPTER 2

Method

2.1: Design overview and analytic approach

Twelve surgeons from two large public hospitals in metropolitan South Australia were invited to talk to the researcher about their experience of communicating with patients in outpatient consultations, with reference to what helps, what hinders and whether there is a role for training. Interviews were transcribed and analysed using a 'synthetic approach' to discourse analysis (Wetherell, 1998), drawing on both discursive psychology (Potter, 2012; Potter & Wetherell, 1987) and post-structuralist Foucauldian discourse analytic traditions (Hepburn, 2003). From this perspective, language does not present a neutral reflection of the world or transparent window into speakers' beliefs and motivations. Rather, talk and interaction are understood in context, at both the local level (e.g., interaction between specific participants in a particular setting), and the wider historical and social contexts or discourses that shape language and social practices (Wetherell & Potter, 1992).

The use of interviews as a means of gathering qualitative data has been criticised (Potter & Hepburn, 2005; Silverman, 2007). However, interviews are deemed an appropriate data source here because the research question concerned how surgeons constructed communication with patients. Specifically, the aim was to explore issues such as, for example, how the nature of 'problem communication' was established, or how surgeons justified not wanting to engage in Communication Skills Training. In this study, interview transcripts are viewed as providing evidence of the different and sometimes contradictory ways a particular phenomenon can be approached (Talja, 1999). These routine and systematic ways of talking about a topic are termed 'interpretative repertoires' (Gilbert & Mulkay, 1984; Potter & Mulkay, 1985). The analytic point of interest is not the veracity of participants'

claims, but the processes whereby claims are framed as factual or real (Wetherell & Potter, 1992).

Preliminary readings of the data focussed on identifying inconsistencies and internal contradictions in participants' answers. Particular attention was paid to the way speakers constructed their accounts as factual through the use of particular rhetorical devices (Augoustinos, Walker, & Donaghue, 2014). Subsequent readings paid close attention to repeatedly occurring descriptions, explanations or arguments across the talk of different participants. Finally, interpretative repertoires were identified on the basis of the particular assumptions and 'statements' which typified particular ways of talking about a topic (Braun & Clarke, 2006; Potter & Wetherell, 1987).

2.2: Participants and recruitment

A purposive sample of surgeons and surgical fellows was recruited from two large metropolitan public hospitals in South Australia. Although there is no ideal sample size for qualitative research (Braun & Clarke, 2006) the aim is to generate insight into the topic of interest (Patton, 2002). To this end, it was hoped to recruit 12-15 participants as such a sample size is common in interview studies in the social sciences.

Contact was established with the head of a surgical unit at a major public hospital who has a particular interest in communication in medical settings. Information about the study was circulated to surgical unit heads via email. The researcher attended unit meetings to outline the project and recruit participants. Twelve participants were recruited. The diverse range of specialty areas and levels of seniority of participants recruited for this study reflects the

diversity of practitioners that patients are likely to encounter in the context of an outpatient consultation in a public hospital.

The relatively small number of participants increases the risk that they will be identified and so, in order to protect confidentiality, demographic information is presented for the group as a whole. Ten male and two female surgeons were interviewed. Six were consultants, two were general surgeons, two surgical fellows, one surgical registrar, and one was a trainee. Specialties represented were upper gastro-intestinal, colorectal, urology, breast and endocrine. The number of years' experience as a surgeon ranged from three to twenty-eight years.

2.3: Data Collection

Interviews took place at a time and location of participants' choosing, typically at their workplace. Participants were interviewed individually and face-to-face for approximately 30 minutes each. Interviews involved open-ended, semi-structured questions that were adapted or elaborated according to the demands of individual local contexts. The researcher developed an Interview Guide (Appendix A) in line with the recommendations of Braun and Clarke (2013). Questions were used to promote a two-way dialogue in order to explore key topics and themes (Patton, 2002). In summary, participants were asked to talk about their experience of communicating with patients in outpatient consultations with reference to what helps, what hinders and whether there is a role for training.

Interviews were audio-recorded and transcribed for analysis. The transcription notation method adopted is a simplified version of that described by Jefferson (2004), as developed by Braun and Clarke (2013, p. 165-166). This notation has the advantage of containing some of the important details of interaction, while being easier to transcribe and

more accessible for readers (Goodman, 2017). Materials were de-identified to protect participants' anonymity, and any information that might serve to identify individuals was removed during transcription.

2.4: Ethical considerations

This study was approved by an ethics committee and governance review panel at Central Adelaide Local Health Network (CAHLN HREC [redacted]). Participants were fully informed of the purpose of the study via a verbal briefing and Participant Information Sheet (Appendix B). Participants signed a Consent Form (Appendix C) before commencing the interview. All data were de-identified by allocating participants a pseudonym upon commencement. Data were stored securely on password-protected devices.

CHAPTER 3

Analysis and Discussion

Participants were asked to talk about their experience of communication in outpatient consultations with particular reference to what helps, what hinders and whether or not there is a role for training. In line with well-established principles of social psychology, it is taken for granted that in describing their experiences and observations, participants are simultaneously engaged in an act of self-presentation. Participants' responses were typically nuanced and constructed with an eye to appearing reasonable and open-minded, particularly with regard to communication training and involvement of the patient in decision making.

Two interpretative repertoires were identified with regard to barriers and facilitators to communication: *It's not us who are the bad communicators* and *Time is the enemy*. Three interpretative repertoires were also generated with regard to communication training: *Communication as generic skill set*, *Communication changes with experience*, *Communication as a fixed trait*.

3.1: Barriers and facilitators to communication

Participants offered a limited range of explanations for barriers and facilitators to communication – notably language and cultural barriers, time pressures and 'angry patients'. However, when analytic attention was broadened to examine the organisation of participants' responses more generally (rather than simply focussing on answers to direct questions about what helps or hinders) two broader patterns were generated: *It's not us who are the bad communicators* and *Time is the enemy*.

The first repertoire draws on the idea of 'social and emotional capital' (Brown et al., 2006). Social and emotional capital relates to assumptions about differential access to

knowledge, culture, language and emotional resources between surgeon and patient. Throughout the dataset, surgeons are presented as being rich in social and emotional capital while patients are shown to be lacking. This justifies the surgeon as being the one who legitimately takes control of the interaction and facilitates communication. By contrast, patients are either described as passive and compliant or angry and resistant. It is rare to find them positioned as 'partners' who are capable of taking an equal role in the interaction. Difficulties in communication are attributed to patient characteristics such as not speaking English, being overly emotional or lacking the ability to comprehend. Participants drew on the second repertoire as a means of justifying any perceived shortfalls in their communication practices as being due to organisational constraints on time rather than personal failings.

Significantly, no participant cited 'lack of training' as a cause of communication failure or 'more training' as a method of amelioration. Explanations proffered generally concerned issues with communication that could be considered beyond the scope of training. (e.g. surgeons cannot be held accountable for the insufficient time allocated for appointments, the inadequate skills of translators, or patients who are angry, anxious or ill-informed). These accounts foreground the broader institutional and interactional context of the outpatient consultation, formulating communication difficulties as outside the surgeon's control or remit.

3.1.1: 'It's not us who are the bad communicators' [Transcript 10]

This repertoire identifies the way participants characteristically present themselves as controlling the interaction and thereby facilitating communication. This is justified by surgeons' superior access to medical knowledge and resources in relation to patients whose dependence on surgeon expertise is taken for granted. The outpatient consultation is routinely

constructed as a meeting between 'surgeon' and 'patient' (expert and lay person) not as between two people. Transcript 4 and Transcript 9 are notable exceptions in their use of the category 'person' to describe the other participant in the interaction. The consultation is largely formulated as a surgeon-led process and this has the effect of reinforcing the difference in status between expert and lay person. For example:

> KW: it's about telling them why we're recommending surgery, what the other options are if they don't have surgery, telling them about all the risks and benefits of surgery and then getting that consent signed [Transcript 2]

> ZH: to fulfil the patient's expectations regarding their diagnosis, to explain it to them, to give them an idea of what it encompasses for them and then to gauge what their expectation's about in regards to how you're going to treat that and what they're going to have [Transcript 3]

In these constructions, surgeons 'tell', 'fulfil', 'explain', 'gauge', 'inform', 'elicit'. This may not seem unusual given that surgeons are talking about what they do in their daily work, however, one effect is to construct the consultation as a context where the surgeon is active and the patient is passive. Alternative descriptions which formulate the process in more *collaborative* terms reveal that other formulations are possible, if infrequent:

> DX: I guess it's to exchange information and to make decisions [Transcript 12]

This account presents the surgeon and patient on an equal footing as compared with the majority of accounts which render the surgeon as being dominant. The 'exchange' of

information portrays the patient as an equal contributor to the interaction. However, in most accounts, participants present themselves as being in charge and therefore also responsible for facilitating communication. Their role is to 'educate' and 'inform' the patient, taking care to 'read' patients, look for 'cues' or 'gauge' patient expectations and reactions:

> AC: Yeah I mean if you're consenting someone for a procedure you have to really, in my mind because I follow that, I gauge the conversation based on the way the patient speaks, using language that they understand and you tailor, each consultation is slightly different because it's tailored to that patient

In the extract above, AC describes 'tailoring' communication to the apparent needs of the patient 'using language that they understand'. This notion of the surgeon fashioning bespoke consultations for every patient draws on a consumer model of patient-centred communication in which the physician is a service provider whose interactional goal is patient satisfaction (Ishikawa et al., 2013). However, to meet this theoretical ideal the patient is expected to adopt a more active role, setting the agenda and taking sole responsibility for decision making. Instead, when viewed from a social capital perspective, this description draws on an assumption the surgeon has access to a broad range of 'language styles' in comparison to the patient who is limited to just one. Again, the surgeon is presented as 'rich' in resources while the patient is lacking.

The literature which focuses on shared decision making as the goal of interaction takes a utilitarian perspective on communication (Ishikawa et al., 2013). From this angle the consultation is a meeting between two experts. The physician uses their expertise to provide 'facts' about treatment options, benefits and risks while the patient uses their expertise to

provide values and preferences with which to evaluate the facts provided by the physician. This viewpoint assumes the physician can and should provide medical facts in value-neutral form and the patient has the emotional and intellectual resources required to make a rational choice.

In Extract One, below, KW's account of obtaining informed consent contrasts sharply with the assumptions embedded in the utilitarian ideal. Far from being a meeting between two experts, patients are depicted as passively accepting surgeons' recommendations (lines 1, 3-4, 8-9):

Extract One – taken from Transcript 2

KW: Most people are happy to go ahead and informed consent is actually really difficult, you learn a lot about it in medical school but when you've been practising a few years you kind of realise that most patients will do what you recommend and (.) and there've been a lot of studies looking at informed consent and asking patients after surgery what were the things discussed in your consent process which have been very well documented, and they can't remember any of them, so (.) we do it as best we can but we have to also be aware that many patients, and it varies, just rely on us to make a recommendation and it's all about how you phrase things to a patient as to whether or not they're likely to go ahead and it is, it's a difficult process which ((pause)) I think it's done imperfectly even when we try our hardest

Int: Mm can you talk a bit more you said about how you phrase things is important (.) can you just explain that a little bit more?

KW: Yeah, so I mean it can be something as simple as saying you've got a one percent chance of faecal incontinence after this procedure versus there's a ninety nine percent chance you'll be fine and that's kind of an obvious concrete example of how it is but there's (.) it's the way you (.) er (.) portray the severity and the frequency of complications to patients has a big impact on how they would how they respond even though you're kind of giving them the same information

In this account, patients are not only presented as biddable but also liable to forget what has been discussed ('they can't remember any of them', lines 6-7). Rather than providing objective facts, KW describes how it is possible to convey statistics on the likely outcome of a procedure (lines 14-16) in such a way that the patient is more 'likely to go ahead' (line 10). Counter-intuitively, patient passivity and compliance is presented as making the consent process 'really difficult' (lines 1-2) despite the best efforts of the surgeon ('even when we try our hardest', line 11). Research that finds the shared decision making process to be rudimentary in the surgical context, such as Etchells et al., (2011), generally calls for the development of techniques to better train and evaluate surgeons. Accounts that present patients as unwilling or unable to participate in decision making may be used to justify surgeons' unwillingness to engage in training of this kind.

Consistent with the notion that surgeons are 'in control' of the consultation, participants also claim responsibility for establishing the relationship with the patient by means of developing 'trust' and 'rapport'. The act of 'listening' is frequently characterised as a means of ensuring the patient is 'receptive' to the surgeons' suggestions rather than as a

means of obtaining information from the patient or encouraging the patient's active participation as an equal partner who may also instigate topics:

> KW: if you've listened to them they're receptive to that, if you haven't they're not receptive to that because (.) you've, they've already pegged you as someone who won't who doesn't really care [Transcript 2]

> AC: if you sit down and listen to what they have to say (…) it's just the whole consultation goes more easily, you've developed a rapport that helps with long term care [Transcript 6]

If the patient is not in the 'right frame of mind' (i.e. receptive) they may not be able to take information on board and make appropriate decisions for themselves – 'appropriate' being in alignment with the surgeon's suggestions. Patients in this state may be described as being 'shell shocked' due to the emotions provoked by their diagnosis. Emotions such as 'anxiety', 'embarrassment' or 'anger' disrupt the channel of communication and may scupper the surgeon's efforts to communicate. In these cases, patients are offered the chance to 'go away and think about it' – in other words, time to come around to the surgeon's way of thinking or weigh up options if appropriate.

Extract Two demonstrates a good example of the way 'unreceptive' patients are typically represented. Rather than being portrayed as passive and compliant, this patient is exercising their right to autonomy, seeking a procedure that the surgeon deems inappropriate ('I want this fixed', line 10):

Extract Two – taken from Transcript 9

PG: Er (.) off- usually I would say that (.) offer for them to get a second opinion (.) like y'know I don't think (.) I've had that experience with someone that got very angry at me who had a hernia (.) well he didn't (.) so his GP had done an ultrasound that showed a hernia and often lots of ultrasounds will show what looks like a hernia but if you can't feel anything and so I have just decided that if I can't feel a hernia clinically then it's not significant enough for me to offer an operation and the associated risk for that and that's not what everyone does (.) but erm (.) so and he came in and he said 'well my ultrasound says I've got a hernia' I said 'but I can't feel anything and so it's not significant', 'but I want, I want this fixed' and I said 'look I'm sorry, I'm not y'know happy to but y'know let's get you to see someone else and see what they think' and then I ended up I don't know what happened but I think that (.) that's one of the things that people tell you is that y'know you learn, when you go through training you learn how to operate (.) and then you learn when not (.) when's appropriate not to operate and sometimes it's harder to say (.) no

PG uses an extreme case formulation ('very angry', line 3) to present the patient's anger as excessive and therefore misplaced. By contrast, the surgeon's position is presented as reasonable and warranted on account of their superior claims to medical knowledge ('often lots of ultrasounds will show what looks like a hernia', lines 4-5) and understanding of the 'associated risk' (line 7). PG's observation 'sometimes it's harder to say no' (line 15) draws attention to one of the perhaps under-valued roles of surgeons. As gatekeepers to the operating room they have an ethical obligation to prevent patients from undergoing unnecessary or potentially harmful interventions (Wall, 2015).

Emphasis on Psychological terminology - Participants draw on an individualistic notion of 'communication' as the transmission of a message between two minds.

3.1.2: 'Time is the enemy' [Transcript 11]

Participants expressed a number of concerns and considerations over the issue of time. While lack of time is a common concern in health care consultations (Law, Bunning, Byng, Farrelly, & Heyman, 2005) this matter may be considered especially important in the surgical context because of the complexity of procedures, the potentially life-altering consequences of surgical intervention and the emotional impact of receiving an unfavourable prognosis.

The range of 'common sense' ideas regarding how time impacts on communication is evident in the following two extracts:

Extract Three – taken from Transcript 10

Int: Okay (.) erm is there anything that would make outpatient consultations easier for you, communication-wise?

VF: ((laughing)) Probably the (.) erm it's the sense of time pressure that's always there and (.) y'know I (.) sort of get used to it but it's always (.) in the back of your mind (.) you know you have one patient who y'know if you start late it puts you behind the eight ball, if you have a difficult (.) if you have a challenging issue that takes a bit longer to manage with the patient, that puts you behind time (.) and so that's probably the one aspect that I think is really difficult to manage but does impact on the way you

(.) erm you communicate, so I've learned (.) or I've noticed if I'm stressed or if I'm time pressured I tend to be less communicative and I ask a lot more direct questions

Int: Right

VF: Probably (.) er very economical then on my empathetic statements and all that (.) I just 'Yeah, okay, fine this is what we're gonna do' and probably then ask less questions that allow the patients to express any specific concerns they have (.) so there's no doubt it does have a negative impact on the way I communicate (.) and I suspect that goes for a lot of (.) consultants

Extract Four – taken from Transcript 11

Int: So finally, is there anything else that you think I should know about what it's like to be a surgeon who has to communicate with patients?

JT: No I think you've sort of (.) I mean (.) the (.) I think time is the pressure, if we could actually sit and sit down and said 'right this is your patient for the morning' (.) y'know I'd bore them to tears so but it's not that, you <u>can't</u> do that, so it's about efficient and effective communication isn't it, I mean it's sort of really about trying to (.) get across (.) time is the enemy, like in everything, so (.) you've just got to get across the key points in the time allotted and not sort of (.) my concern is (.) sometimes the ability to be able to y'know talk and shoot the breeze (.) what quite often comes back to me is that one liner that you've thrown out there as just a sort of a throwaway line can be the one thing they grab onto (.) and that's (.) you can do all that hard work for fifteen minutes and you can make y'know some sort of verbiage that comes out just as they're walking out the day (.) it'll be the one thing they can grab on to so (.) patients in that situation can be very brittle, very brittle, and some are

more brittle than others, and you've really got to be careful and when you're under pressure (.) if you make an unconsidered comment well you can unravel it all so (.) but time is the problem (.) you're trying to get across as much information as possible, enormous amount of information and be respectful and be emotionally intelligent and get the patient some time to answer questions and give them the impression that you're actually on their side and we're gonna sort it out together (.) so it's a lot to cover in (.) sometimes twelve minutes ((laughing)) a bit more than that, but you know what I mean

The limitation on time available for consultations was repeatedly described as a 'pressure' (Extract Three, line 3; Extract Four, line 3) that negatively impacts on surgeons' ability to communicate. In addition to the time allocated per patient, there is also a further burden of having to keep to an inflexible schedule. In Extract Three, VF alludes to the knock-on effects of starting an appointment late (line 5-6). This is also described by JT in another section of Transcript 11:

JT: […] got a <u>huge</u> list of patients (.) the patient list just blows out beyond the scope of what you can really get through in the time allotted and it's not really fair to anyone

It is interesting to note how these accounts are constructed to foreground the surgeons' lack of accountability for running over time. For example, 'it puts you behind the eight ball' (Extract Three, line 5-6); 'the patient list just blows out … it's not really fair to anyone' (Transcript 11, above); or ER's explanation for how to deal with a patient who has been kept waiting:

ER: […] you have to say ‘well I’m terribly sorry but (.) unfortunately things have arisen that I have no control of and that’s why’ [Transcript 4]

These explanations shift the focus onto ‘time’ rather than ‘communication’ as the problematic issue. ‘Time pressure’ is presented as the causal factor for blow-outs rather than poor communication. In a similar way, if a topic or problem takes a long time to discuss it’s because it’s a ‘challenging issue’ (Extract Three, line 6), rather than the means of communicating being ineffective or sub-par. The rhetorical organisation of these rationalisations (that good communication cannot be achieved in a short amount of time) is contrasted against alternative claims that communication can be ‘efficient and effective’ (Extract Four, line 6). Similar ideas were voiced in answer to the question ‘what makes a surgeon a good communicator’. For example, answers included ‘They have to be fairly concise’ (Transcript 3); ‘an effective communicator has to be clear, concise’ (Transcript 8). These assertions shift responsibility for managing communication within a time constraint back on the shoulders of the surgeons.

The definition of ‘good’ or ‘effective’ communication depends on your perspective (Brown et al., 2006; Ishikawa et al., 2013). The ‘therapeutic alliance’ which underscores delivery of patient-centred care and shared decision making is considered the ‘ideal’ for physician-patient communication (Williams et al., 2007). This model involves the exchange of both biomedical and psychosocial information along with consideration of the patient’s emotional needs. However, in Extract Three, VF describes a number of ways in which time pressure makes surgeons ‘less communicative’ (line 10-15). Significantly, it is the patient-centred aspects of communication – asking open questions, showing empathy, encouraging patient concerns – that are sacrificed due to time constraints. JT expresses similar sentiments

about showing empathy, allowing the patient to talk and taking a shared approach to care in Extract Four (lines 18-22). For surgeons, being 'efficient and effective' means the ability to 'get across the key points in the time allotted' (Extract Two, line 7-8). Patient-focussed aspects of communication are tacitly conveyed as inessential luxuries to be sacrificed for the service of 'efficiency' and the surgeon's agenda of transmitting 'as much information as possible, enormous amount of information' (Extract Two line 18) takes precedence.

The notion that patient contributions are conceived of as 'wasted time' is most delightfully expounded in Extract Five and to a slightly lesser extent in Extract Six.

Extract Five – taken from Transcript 2

KW: […] what I was just saying about accepting wasted time in a consultation was something I've never (.) spoken about before, I've never kind of considered that but when I put it like that it seems actually really important because (.) it's um (.) because everyone's busy they're (.) I mean (.) it sounds kind of bad to call it wasted time, I'm sure there's someone in the literature who could come up with a clever way to describe it but accepting that ((knocking on desk)) every moment of your consultation is not going to lead you directly to the outcome that you're anticipating and expecting (.) that's that's and the same as on ward rounds and every interaction you just have to be mindful that (.) because every now and again what you think is wasted time won't be (.) I guess that's the thing it's that every now and again what you think is them just talking and not really going to change the outcome they might say something that surprises you (.) and it might be not that common, but it might actually say 'oh, actually I wasn't expecting that but hang on maybe that does change things' so yeah

Extract Six – taken from Transcript 1

Int: Okay (.) Erm (.) what makes a surgeon a <u>good</u> communicator do you think?

TK: (pause) Open communication (.) very open and honest communication (.) the ability to listen (.) y'know to what the patient says we often (.) we often are under time pressure and we want to get our point across which I guess we'll need at one stage but we'll need to listen very well especially in the beginning when the patient comes in and sort of (.) yeah let (.) <u>them</u> have the questions and let <u>them</u> talk first (.) <u>then</u> we can sort of yeah reply to these and (.) y'know start laying out the plan which we often have in mind already before the patient comes y'know because I have a referral and I sort of think already (.) yep that's probably gonna be the problem and that's what we're gonna do (.) yeah

In these accounts the pressure of time is again taken for granted ('everyone's busy', Extract Five, line 4; 'we often are under time pressure', Extract Six, line 3-4). The surgeon's primary agenda is emphasised i.e. steering the patient towards a predetermined outcome (Extract Five, lines 6-8; Extract Six, lines 7-10). In this scenario, 'accepting wasted time in a consultation' (Extract Five, line 1) or 'what you think is them just talking' (Extract Five, line 11) is an alternative way of saying 'we'll need to listen' (Extract Six, line 5). However, these formulations foreground the general sense that most of the time patient contributions are typically regarded as inessential noise even if 'every now and again' (Extract Five, line 9, repeated line 10) something is said that the surgeon deems relevant enough to change 'the plan' (Extract Six, line 7).

It should be noted most participants described the appointment system as having some flexibility built in to accommodate differences in the projected consultation time required.

Extract Seven – taken from Transcript 1

1 Int: How much time do you normally have
2 TK: We're normally booked for review appointments or a patient comes back y'know it's
3 every fifteen minutes (.) a new patient might get half an hour
4 Int: Okay
5 TK: Half an hour for a new patient with a cancer diagnosis is not enough

Time allocations are based on assumed patient requirements as a result of type of appointment (Extract Seven, lines 2-3) or nature of complaint (Extract Seven, line 5). As such, times are allocated according to a biomedical rather than patient-centred agenda. While this may seem perfectly reasonable from the point of view of allocation of resources, one participant offers an alternative perspective. In Extract Eight, below, ER constructs what they consider to be the most important issue regarding communication in outpatient consultations: while the consultation may be routine for the surgeon (line 12) it's a highly significant thing to the patient, no matter how minor the problem (lines 4-9):

Extract Eight – taken from Transcript 4

1 Int: Okay is there anything else that you can think of about your experience
2 communicating with patients that would be useful or interesting to know?

ER: ((long pause)) Erm ((long pause)) I think (.) probably one of the most important lessons (.) to or facts to understand that (.) if someone is coming to see you no matter what the problem, it is the most important thing to them in their life (.) and I think you've got to treat it as such (.) it's not just a minor problem (.) because if it was they wouldn't be there so you've got to, I think you have to treat every problem with the same y'know as a serious issue and (.) come to er a (.) conclusion that is satisfactory

Int: So it's routine for you to see the patients but for them it's (.) a big deal

ER: ((emphatically)) Absolutely, exactly, that's (.) a good summary (.) yeah it may be I've seen this particular thing a thousand times but for that person that is unique (.)

The system that insists on physicians having a patient-centred communication focus may not be set up to support this approach.

3.2: Role for communication training

Responses to the closed question 'have you ever received communication training?' were surprisingly varied, many conveying a level of uncertainty. Negative responses ranged from the definitive 'no […] if you need it you've got problems' [ZH, Transcript 3] to the qualified 'Not formal training, no' [VF, Transcript 10] and the tentative:

> ER: Er ((pause)) no (.) I've done a number of sessions of communication within the operating theatre, and erm, er (.) treating with respect etcetera but (.) y'know with trainees and junior doctors, but not particularly with patients [Transcript 4]

Affirmative responses were similarly mixed, varying from the dismissive:

LS: […] oh the med school does go through a little bit of basic stuff in terms of breaking bad news and that kind of thing but it's minimal [Transcript 5]

to the appreciative:

AC: Yeah, I mean luckily the College of Surgeons, because as I said before they value communication as one of the core non-technical competencies, and we're constantly assessed on that throughout our training program [Transcript 6]

Nuanced responses such as these convey the diversity of participants' experiences and perceptions about 'what counts' as communication training. For example, neither VF nor ER had undertaken 'formal' communication training but, as senior consultants, both talked about their involvement in teaching and assessing communication of junior staff. The implication being what they had *learned through experience* about communication qualified them to teach others. Throughout the dataset a subtle distinction was drawn between communication as a generic skill set that could be taught as opposed to an idea of communication as something that alters naturally over time. Participants also drew on a perspective which presented communication as an innate, rather than learned, ability.

Participants' talk about the role of communication training drew on several repertoires that form a kind of continuum. At one end, the *communication as generic skill set* repertoire focusses on communication as a set of discrete behaviours that can be explicitly taught. At the other end of the spectrum, the *communication as fixed trait* repertoire locates

communication as an innate ability or personality trait that cannot be taught. In between these two extremes lies a multi-faceted middle ground that revolves around the role of experience. The *communication changes with experience* repertoire embraces two contrasting common sense positions. Closer to the *communication as fixed trait* point of view, lies the assumption that experience naturally leads to improvement in communication ('practice makes perfect'). Closer to the *communication as generic skill set* end, the notion that 'bad habits' may develop over time admits a role for training in terms of maintaining standards rather than acquiring new skills.

3.2.1: Communication as generic skill set

When participants spoke about communication education, they used a *communication as generic skill set* repertoire which conveyed the idea of communication as something that can be compartmentalised. In the following extract, VF describes their experience of teaching 'communication components' (Extract Seven, line 6).

Extract Nine – taken from Transcript 10

1 Int: […] I do want to ask you about communication education (.) have you ever had any
2 communication training?
3 VF: Not formal training, no
4 Int: Okay, not formal, any sort of informal training?
5 VF: Er yeah yeah (.) um certainly through the College of Surgeons er I've helped to (.)
6 teach on some of the communication components (.) er so there's there's a course
7 called (.) um the Critically Ill Patient, Surgical Patient, it's called CCRiSP and in that

it has (.) it's got a heavy emphasis on communication and I found that really useful ((laughing)) because it talked about things like patient centred communication and what that was (.) er what that is (.) now that's been around for y'know twenty years or fifteen years, so those concepts were new to me (.) I graduated without actually hearing the term 'patient-centred communication' so whether it was a relatively new term or not I don't know, but probably is or was at the time (.) so that was really useful and then (.) erm and then there's been programs around open disclosure (.) through all the health jurisdictions and that was actually quite helpful to understand erm how you would go about doing open disclosure

Int: So these courses are these quite practical or more theoretical?

VF: The CCRiSP course is very practical, y'know they have patient scenarios, they have simulated patients (.) erm they have scenarios and then the junior doctor's asked to er role play and then it's observed by a couple of surgeons and then there's feedback (.) so whilst surgeons ourselves haven't had any formal training we're then suddenly teaching (.) even though some, things that we've never been formally taught on (.) but I did find that very educative (.) erm to actually be involved at that level (.) the open disclosure's not formally taught, that was just a process that's defined by the Department of Health but when you put that into practice it's actually quite a useful guide at least to tell you how to do that, breaking bad news is I guess a similar skill set (.) erm (.) what else is there (.) no-one's actually (.) taught about how to get patient consent and things like identifying material risk and all that (.) I still haven't seen a (.) module that teaches that

VF draws on what Hodges (2006) calls the discourse of 'competence-as-performance'. This repertoire utilises concepts like 'patient scenarios', 'simulated patients'

and ‘role play’ (lines 19-21). It is a ‘module’ (line 30) or ‘course’ (line 19) that can be identified by a specific name, in this case CCrISP, and its purpose is to teach a particular ‘skill set’ (line 27-28) such as ‘breaking bad news’ (line 27), ‘identifying material risk’ (line 29), or ‘patient centred communication’ (line 13). These are recognisably the components of Communication Skills Training.

Predictably, the communication skills repertoire was evident when participants talked about their experiences of communication training at medical school, as in the following extracts:

Extract Ten – Taken from Transcript Seven

Int: But one last question, is there <u>anything</u> else that you think I need to know that would be important for me to know about your experience?

FP: I think communication is very important, it makes life so much easier after ((knocking on table for emphasis)) if you have a good rapport with the patient (.) even if you have a complication you may not have, you may not run into trouble (.) if you have a good rapport, a good established rapport with the patient (.) erm and I think communication is difficult to teach (.) easy for me to say some people have it, some people don’t (.) I think that’s partly true but I think it can be but it needs (.) I don’t know how you do it, I can’t I don’t know how they do it in medical school these days (.) erm because it is not a (.) telling an eigh- nineteen year old (.) person, first year medical school (.) out of out of high school saying they want to learn everything else about (.) all exciting stuff, to spend three hours sitting (.) in a classroom between two to five is my experience (.) in the afternoon, post prandial, after a big lunch, right

sitting around a table or round facing each other asking ‘what do you think’ or watching a video and saying ‘let’s break that ((slaps table)) break that video down, that skit down and say what did they do right, what did they do wrong’ (.) I think that’s the way you’re gonna you’re gonna deliver the skills but it is not popular (.)

Int: That’s how you learned?

FP: That’s the way I learned

Int: And why was it not popular, what was the problem?

FP: Because we just wanted to not be there from two to five (.) y'know we could be learning something else, or (.) yeah

Int: So it …

FP: The significance of good communication was not (.) we weren’t aware of it

Int: Because you weren’t dealing with patients

FP: Not dealing with patients, yeah eighteen or nineteen year old kids (.) you got the marks, you got into medicine (.) okay (.) erm because my dad told me I was gonna be a doctor (.) I got it, I got in, there you go (.) okay (.) sit around a table someone asking you ‘so what do you think (.) they did well, what went wrong there?’ and you go oh yeah, it’s the usual answers y'know not making eye contact, their body posture, all those things (.) yeah

Extract Eleven – Taken from Transcript 8

MB: So (.) we had communication training, I mean it was a module at medical school (.) which seemed like a whole lot of nonsense but actually was probably really quite helpful

Int: Why did it seem like nonsense? Can you …

MB: Because it was all a bit, a bit jokey y'know (.) it's really difficult to suddenly realise that y'know you are having these conversations with real people and actually having a few tips and tricks on how to manage that is really helpful and you don't realise that when you're with a bunch of friends and talking about (.) whatever it is they're asking you to talk about (.) and that's been really (.) and of course I think the key things are things like breaking bad news which we had separate modules for which were really interesting (.) but I think where it really comes to the fore is as you go on (.) the communication modules I've done subsequently have probably I've gained a lot more from and I've taken so much more seriously

The practice of representing communication as a 'module' (Extract Eleven, lines 1, 10 and 12) has a trivialising effect particularly evident in the phrase 'tips and tricks' (Extract Eleven, line 7). In comparison to the other skills required by surgeons – 'all exciting stuff' (Extract Ten, line 12) – communication seems insignificant and 'a whole lot of nonsense' (Extract Eleven, line 2). Rather than being regarded as the foundation of medical interaction, communication is constructed as something separate from, and of lesser status than, the other business of being a surgeon. These ideas are spelled out explicitly in the following extract:

Extract Twelve – Taken from Transcript 10

Int: If you were offered further communication training, would that be of interest to you?

VF: Erm, yeah, I mean (.) ah (.) maybe I sound a bit hesitant but I just think that there's communication training and there's communication training (.) and I think one of the (.) um (.) yeah one of the pitfalls of communication training is that you mention it to any level of doctor nowadays and they'll (.) you can, you can just hear the internal

groan or the roll, you can see the rolling of the eyes because they've had lots and lots of communication (.) training (.) so I think it needs to be really specified as to what aspect of communication you're talking about (.) are you talking about team communication, are you talking about (.) er patient communication and if you're talking about patient communication what are you specifically talking about

Int: What do you think is the source of the eye-rolling and the inner groaning? Is it the way that it's been delivered in the past or is it just it doesn't seem rel- or y'know has it not been practical, is it not something that you can actually use or

VF: Yeah ((pause)) it's a good question, I'm not quite sure (.) I suspect it's a combination of (.) one communication continues to be harped on a lot so maybe it's (.) it's over done but (.) in many aspects there's many parts of communication that is under done and so people go 'oh not again', so there's that element of it (.) I also think there's a value judgement placed on these skill sets and (.) and it's still probably if you had to ask people y'know rank the skills and the competencies 'y'know communication would rank probably reasonably high but it wouldn't be the top (.) and it would be ranked under things like, for surgeons anyway, psychomotor skills and knowledge and decision making (.) when in fact communication's probably the enabler for all the other competencies (.) so I still think that there's a perception, a very common perception that these non-technical skills are rankable and they're not seen as (.) as necessary

While VF sets up the practice of *teaching* communication skills as 'really useful' (Extract Nine, line 9), 'actually quite helpful' (Extract Nine, line 16) and 'very educative' (Extract Nine, line 24), communication education is generally dismissed as 'a bit jokey' (Extract Eleven, line 5), 'not popular' (Extract Ten, line 17) and liable to elicit an 'internal

groan' or 'rolling of the eyes' (Extract Twelve, lines 6-7). Instead of being valued as 'the enabler for all the other competencies' (line 24), VF's account (and others that use the communication skills repertoire) positions communication as supplementary to other medical knowledge and of lower importance (Extract Twelve, lines 20-26).

3.2.2: Communication changes with experience

Some ideas about the way communication changes with experience were organised around sporting metaphors. On one hand, practice makes perfect. On the other, experience may lead to complacency and require the services of a coach. Alternatively, experience will get you so far but there's always room for improvement. Consider the following extracts:

Extract Thirteen – Taken from Transcript 3

1	Int:	Hm, again I'm just looking, probably got <u>two minutes</u> so very quickly erm (.) ask you
2		about education? Communication education (.) um, what makes a surgeon a good
3		communicator?
4	ZH:	[…] So I think it's time in the pilot seat
5	Int:	Yeah
6	ZH:	I mean the old saying goes you've got to hit eight thousand of everything, eight
7		thousand squash balls, eight thousand putts, eight thousand patients, you've got to
8		have flight time (.) <u>in the job</u> (.) don't read about it (.) don't look at videos about it,
9		you've gotta do it
10	Int:	It's all experience, practice
11	ZH:	It's gotta do it, you've gotta do it

Extract Fourteen – Taken from Transcript 7

FP: […] even Roger Federer has a coach (.) and we are sort of like elite athletes, we are performing high risk proce- procedures (.) and even when we finish training there comes a point where ((knocking on table for emphasis)) you need to get a coach to come and assess what you're doing because you may have picked up bad habits (.) short cuts, okay, throughout your working career (.) after you've finished your training you've picked up erm little short cuts, little things that that others you wouldn't have done when you finished your training and it's worthwhile having a senior person, a retired surgeon maybe come and see watch you operate

In Extracts Thirteen and Fourteen, being a surgeon is compared to other high-stress, highly proficient roles. ZH uses a metaphor 'time in the pilot seat' (line 4) and 'you've got to have flight time in the job' that equates being a surgeon with being a pilot. FP draws a sporting parallel in line 1 - 'we are sort of like elite athletes.' Other participants use less colourful descriptions to present the expert status of surgeons. In Extract Fifteen (below) KW reasons that the extended educational requirements to reach fellowship (lines 4-6) must automatically lead to competence (line 12-14). What unifies these descriptions is the notion that to become a professional like a surgeon takes time and time inevitably leads to expertise.

Extract Fifteen – Taken from Transcript 2

Int: How do you get that insight? Do you think it would be a good idea to have like regular observations of consultations?

KW: ((sighing)) I think really this stuff should be picked up (.) I don't really feel like at a specialist level this work should still need to be happening, I think by the time you've been out of medical school for ten years I think that should've all been done well before then because what's been happening for the last decade? The basics of patient interaction are the same from when you start medical school to when you're a specialist (.) um and everyone can always get better er and we need to be mindful of it but the foundations need to be laid early and, look, maybe as a specialist trainee integrate it into some courses and things (.) um (.) but yeah I think the idea of like constantly getting specialists to be reviewing it it should be done before then honestly if someone's become a specialist they should be competent in that skill, they should be, it's a failure of the system if they haven't been trained adequately in that

ZH uses a cliché 'as the old saying goes' to appeal to common sense understanding that practice makes perfect – 'you've got to hit eight thousand of everything, eight thousand squash balls, eight thousand putts' (Extract Thirteen, lines 6-7). In Extract Sixteen, JT expresses this idea as 'we're constantly in meetings, we're constantly (.) and we're constantly communicating' (lines 8-9).

Extract Sixteen – Taken from transcript 11

Int: If you were offered any further communication training would that be of interest to you at all?

JT: I think (.) yeah (.) it has to be in the sort of right ((inaudible)) I think I probably have enough things going on that to devote extra time to it (.) I mean, I mean I feel that I can communicate reasonably well (.) patients give me the impression I can

communicate reasonably well, I'm sure I could be better, everyone can be (.) but it's probably (.) I'd do it if it's y'know (.) related to some other something else, and we do those (.) communication discussions, we're constantly in meetings, we're constantly (.) and we're constantly communicating and erm but you do get into bad habits I imagine (.) so you can always learn (.) I think it's like your golf swing you can y'know you think you can play a round of golf but a pro can always tell you how to make you do it better ((laughing))

ZH's dogmatic position 'don't read about it, don't look at videos about it, you've gotta do it' (Extract Thirteen, lines 8-9) was rare. Most participants expressed more nuanced opinions which balanced the notion of 'practice makes perfect' with the idea that there's always 'room for improvement'. For example, while JT defends his self-assessment 'I can communicate reasonably well' (Extract Sixteen, line 5) on the grounds that he has had ample practice communicating, he also concedes 'you do get into bad habits I imagine, so you can always learn' (lines 9-10). This formulation works to present JT as balanced and fair whereas in Extract Fourteen, 'you may have picked up bad habits' (line 4) is used to suggest that a coach may assist in maintaining standards. In Extract Fifteen, however, KW uses the room for improvement rhetoric as a way of bolstering the initial argument that experience leads to expertise. In this extract, KW employs a conversational structure that 'makes a show' of their concession (Antaki & Wetherell, 1999) by proposing an idea (that ongoing assessment of communication is unnecessary), conceding counter-evidence ('everyone can always get better and we need to be mindful of it', line 8), and then restating their original proposition ('it's a failure of the system if they haven't been trained adequately in that', lines 13-14).

3.2.3: Communication as fixed trait

In Extract Ten (lines 3-6), FP equates good communication with having a 'good rapport' with the patient. This idea that communication is fundamentally facilitated by a mutual relationship between physician and patient was expressed by most surgeons. For example:

Int: What are the things that really help communication?

MB: Yeah, communication wise I think some of it is when you have this immediate rapport ((clicks fingers)) when you click with someone (.) and that's y'know (.) and you should be able to do that with everyone but sometimes it's a bit more natural [Transcript 8]

PG: […] a lot of it's personality and if you build a rapport with someone quite quickly then it often makes things easier (.) some people take a bit more time to build that rapport [Transcript 9]

By associating communication with 'rapport', these descriptions construct communication as something that is natural and instinctive (an aspect of personality) rather than something that can be learned. The strongest form of this argument – an outright rejection of communication training on the grounds that communication is an innate ability – was voiced by only one participant, ZH:

Extract Seventeen – taken from Transcript 3

Int: Mm and have you ever had any explicit communication training as part of your training

ZH: No

Int: Is that something that would be of interest to you?

ZH: I think if you need it you've got problems

Int: Mm

ZH: That's my, my, I'm a believer if you need that kind of thing which is a basic trait of a doctor (.) you've got, you've got problems (.) that should be a given (.) it's almost like if I'm gonna be an NBA basketballer I need a certain wingspan and a certain height (.) I can't train height and I can't train wingspan

When the interviewer asks the question about 'explicit communication training' (line 22) the participant delivers a categorical 'no'. Such a direct response to a question is not anticipated in an interview situation. In this context, even closed questions such as this are expected to invite some form of elaboration. This response signals some conversational expectation is being broken for effect and cues the listener some kind of revelation is about to be made known (Seymour-Smith, Wetherell, & Phoenix, 2002) – in this case the outright rejection of the idea that communication can be taught. ZH positions communication as 'a basic trait of a doctor' and 'a given' (lines 28-29). The clinching argument is a further sporting analogy which is hard to argue against, 'I can't train height and I can't train wingspan' (line 31).

Typically, responses were constructed to present the speaker as fair and reasonable and the rejection of communication training was achieved in more subtle ways. In Extract Eighteen, for example, KW positions communication in consultations as being mediated by

'personality' (line 3 and 4). KW then uses the 'Show Concession' device, drawing on the 'communication skills' repertoire to bolster the argument that communication actually 'just comes down to people's personality' (line 4):

Extract Eighteen – taken from Transcript 2

Int: Okay, is there anything that would make the consultations easier do you think? Is there any sort of approach or practice that could ((pause))?

KW: I don't think so. I think a lot of it is personality. And (.) erm ((pause)) yeah and a lot of it just comes down to people's personality obviously you can learn this stuff and you do learn it in medical school how to interact with patients and there are surgical courses where you can go and practice your communication with patients and stuff, and I think some people find that a lot easier than others ((pause)) um

Int: Why do you think that is?

KW: Um ((pause)) don't really know, don't really now (.) I think it's to do with erm (.) people who feel they need to be ((knocking on the desk)) right all the time and erm (.) not pride but it's almost like some people can't kind of <u>accept</u>, they want to set the patient straight as to why they've done something and justify it and they can come on a bit strong in doing that ((pause)) whereas some people are happier just to ((pause)) I dunno just give a gentle explanation rather than be emphatic about why this must have been done this way because there's usually grey areas in medicine and surgery all the time and if you're, I think if you're emphatic all the time and you have to set a patient straight about why they're wrong about their discontent then I think that can be hard, that can make your communications harder

KW refutes the interviewer's proposition that some sort of 'approach or practice' (line 2) could make consultations easier. KW then states their own position 'a lot of it is personality' (line 3). The speaker then moves to defend against the danger of being challenged on this claim by making an explicit show of conceding that 'you can learn this stuff' (line 4), beginning with the concessionary marker 'obviously' (lines 3-6) and then reprising the original position 'some people find that a lot easier than others' (line 7). This draws attention to KW's awareness of the problem and easily rebuts it. The original position is now 'fireproofed' against challenge and KW goes on to elaborate that position (lines 10-18). This structure bolsters the speaker's position that good communication comes down to 'personality' and by implication weakens the counter-case that training can assist.

CHAPTER 4

Conclusion

4.1: Overview

This study explores the ways in which surgeons routinely discuss the nature of communication in outpatient consultations. The implications for training are also considered. Analysis focusses on participants' descriptions and accounts of these topics. The purpose of this approach is to identify how different methods of accounting construct different kinds of 'truths' and to consider what is accomplished by these versions (Potter & Wetherell, 1987). Five interpretative repertoires have been generated. Two repertoires, *It's not us who are the bad communicators* and *Time is the enemy,* locate communication difficulties as an unavoidable consequence of the social and organisational context. Three repertoires, *Communication as generic skill set*, *Communication changes with experience* and *Communication as fixed trait,* draw on different and sometimes contradictory ideas about communication to construct a case *against* communication education in its current form.

4.2: Barriers and Facilitators

Participants' accounts of outpatient consultations draw on two repertoires which present communication difficulties as inevitable. The first repertoire, *It's not us who are the bad communicators,* is formulated around assumptions that surgeons' access to medical knowledge and resources automatically places them in charge of the interactional context. As gatekeepers to the operating room, surgeons depict themselves as agentic at all stages of the interaction. Communication is depicted as a largely one-way interaction dependent on surgeons' ability to 'read' the patient and 'tailor' the interaction accordingly. Even 'listening' is positioned as an exercise in control being portrayed as a means of ensuring the patient is 'receptive' rather than an opportunity for the patient to participate. By contrast, patients are

presented as deficient in social and emotional capital, being either too submissive or too defiant to be considered an equal partner in interaction.

The second repertoire, *Time is the enemy*, is formulated on the assumption that patient-centred practice (listening, showing empathy, encouraging patient contributions) is impractical because it is too time-consuming, even 'a waste of time'. By comparison, the surgeon agenda of conveying 'enormous amounts of information' is crucial. The pressure of time is taken for granted. Deciding what should be sacrificed to meet these demands is therefore presented simply as a matter of common sense.

Since its inception in the late 1960s, research on physician-patient interaction has portrayed the relationship as unequal, even oppressive, with medical professionals dominating the agenda at the expense of patient concerns (Pilnick & Dingwall, 2011). Subsequent calls for physicians to adopt more egalitarian styles of interaction have resulted in communication skills training programs which generally promote the ideal of 'patient centred' practice (Harvey & Adolphs). Nevertheless, empirical studies suggest there has been very little change in this dynamic over the intervening decades (Peräkylä, 2006). The findings of this report demonstrate surgeons orient to the potential problems inherent in the power asymmetry (e.g. the 'difficulty' of obtaining truly *informed* consent in the face of patient acquiescence). However, rather than locating the problem at the level of the individual (surgeon or patient), surgeons' accounts present communication difficulties as an unavoidable consequence of the social and organisational context.

4.3: Communication training

Responses to a direct question regarding participants' experience of communication training were uncertain or negative and even affirmative answers were sometimes ambiguous. In particular, senior consultants justified a lack of 'formal training' on the grounds that clinical experience was adequate preparation for teaching or assessing communication. The equivocal nature of replies is explained when we consider the range of ways participants made sense of the notion of 'communication'. Participants drew on three repertoires, *communication as generic skill set*, *communication changes with experience* and *communication as fixed trait*, each producing a different kind of 'truth' about the phenomenon.

The predominant way in which surgeons talk about communication education draws on the *communication as generic skill set* repertoire. While this formulation allows that communication can be taught it also frames communication as a set of discrete skills or isolated module, something that can be separated from the other (more important or more highly valued) skills required by a surgeon. This has the effect of trivialising communication and justifying participants' reluctance to engage in further training.

Alternatively, communication training is undermined by the *communication as fixed trait* repertoire. When communication is represented as being instinctive (innate) it is made to seem logical that the idea of communication 'training' is redundant. The *communication changes with experience* repertoire provides another set of ideas about communication that allows participants some flexibility in how they construct their attitudes and opinions. Appealing to the logical proposition that over time one may fall into 'bad habits' or recognising that there's 'always room for improvement' allows participants to ameliorate

statements that could otherwise be considered boastful (i.e. considering oneself to be good at communication) or lacking judgement (i.e. that communication is unimportant). Then again, the rhetoric of 'practice makes perfect' enables participants to make claims for having achieved communication competence on the grounds that they communicate frequently and on a regular basis as part of their role.

These findings are consistent with previous studies that identify how medical professionals and students commonly talk about communication competence as an innate ability that naturally improves with age and clinical experience (Denniston et al., 2019; Fadlon et al., 2004; Mendick et al., 2015; Turner et al., 2011). This argument is frequently used to justify rejection of communication training. However, this study may offer a new perspective in recognising that physicians also draw upon the common-sense idea of 'bad habits' developing over time. This construction makes the idea of employing a 'communication coach' seem like a reasonable option to consider.

While previous research indicates the communication skills approach is frowned upon for being 'artificial' (Mendick et al., 2011, 2015; van den Eertwegh et al., 2014), this study also notes something else. The practice of talking about communication as a set of discrete skills, 'components' or 'modules' has the effect of making communication seem like an entity that can be detached from other aspects of a surgeon's abilities. Using this logic, participants are able to make claims about the 'value' of communication relative to other skills or justify curtailing communication due to the demands of time.

4.4: Implications

Analysis of surgeons' own descriptions of communicating with patients in outpatient consultations suggests three potential answers to the question *What seems to be the problem?*

The five interpretative repertoires outlined above create a discursive environment that allows only a limited role for communication training. In particular, the *communication as skills set* repertoire frames communication as an 'optional extra' which has less importance than other aspects of surgical practice. This representation can be used as justification for rejecting CST and for adopting a more paternalistic position in consultations than the current focus on patient-centred care suggests is acceptable. Critiques of the CST methodology often cite its artificial nature as being a problem. This study suggests another potential pitfall – and the answer may be counter-intuitive. The 'modular' language through which CST is conceptualised and delivered may be self-defeating. Communication is an integral aspect of the medical interview and as such perhaps would benefit from being taught in a more integrated way rather than as a separate module. In other words, if it is to be taken seriously, communication may need to become invisible.

The *communication changes with experience* repertoire provides for a rationalisation that surgeons may develop 'bad habits' over time. This formulation suggests a possible role for communication coaching. Indeed, it has already been noted that receiving personalised feedback after watching oneself perform in real situations is a powerful motivator for learning (van den Eertwegh et al., 2014). Rather than continuing the program of generic skills training, communication enhancement programs could focus on individualised assessment and self-reflection.

Finally, surgeons' frustration with the focus on CST can be understood by reference to the *It's not us who are the bad communicators* repertoire. While most health communication research calls for further and improved training of health professionals it may be pertinent to consider what aspects of the social and organisational context can be changed to support both physicians and patients and which aspects are necessary features of the medical institution.

4.5: Strengths

This research contributes to the small but growing literature on surgeon-specific communication and offers a novel perspective on the topic. The exploratory nature of this qualitative project focuses on the way surgeons represent and make sense of their interactions with patients in outpatient consultations. The discursive environments created through these formulations have clear practical consequences for the ways in which surgeons interact with their patients and the ways in which surgical outpatient consultations are conducted. Using thematic discourse analysis it was possible to identify how the language used by surgeons enables certain points of view to be established as 'true' or reasonable and others to be rejected. This may shed some new light on areas of surgeon communication that have previously been studied in other ways.

Although the use of interviews as a means of gathering qualitative data has been criticised (Potter & Hepburn, 2005; Silverman, 2007), in this study the method generated rich, detailed responses that provided evidence of the different and sometimes contradictory ways a particular phenomenon can be approached (Talja, 1999).

4.6: Limitations and future research

There were three key limitations of this research. First, this study worked with data from a variety of surgical specialties. Collection and analysis of data from one specialty area might reveal different patterns of concerns particular to a surgical field. Second, data were gathered from surgeons with different levels of experience and this may have affected results depending on how recently participants had left the education system. Future research that focussed on a particular cohort may reveal whether the contemporary emphasis on communication training has had any impact. Third, this research was conducted in two hospitals in metropolitan South Australia. While health education and training is broadly similar across westernised nations such as Australia, UK and USA further research on how surgeons routinely discuss communication in other jurisdictions would be an interesting next step.

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APPENDIX A

Date:

Interview protocol and question guide

Welcome and introduction

- Thank you for participating
- Information sheet
- Consent form - sign
- You can withdraw your consent at any time
- As noted in the information sheet I will now start recording the interview

Overview of the research project

- I want to know about your experiences of communicating with patients in an outpatient consultation – what helps, what hinders, and whether there is a role for training in this area

General/ice-breaker questions

- The focus of this interview is your specific experience of consultations, but to get started, can you first tell me a little bit about your area of expertise?
  - Prompt: what type of surgery do you perform?

  - Do you always meet with a patient before surgery?
  - Prompt: How many times?
  - Prompt: How long do consultations last?

  - In your view, what's the purpose of the consultation?
  - Prompt: Why …
  - Prompt: How do you do …
  - Prompt: How do you deal with …
  - Prompt: How do you recognise …
  - Prompt: What sort of things do you regularly see in body language …
  - Prompt: How do they appear …
  - Prompt: How do they convey …

Experiences of communication in outpatient consultations

  - Do you tend to follow a particular system or routine when meeting with patients?
  - Prompt: Why …
  - Prompt: How do you do …
  - Prompt: How do you deal with …
  - Prompt: How do you recognise …

- Prompt: What sort of things do you regularly see in body language …
- Prompt: How do they appear …
- Prompt: How do they convey …

- How long have you been practising as a surgeon?
- Think back to when you first started – has your experience of conducting outpatient consultations changed at all?

Questions about constraints

I want to understand some of the difficulties you might encounter. So …

In your experience, what makes some consultations more difficult than others?
Perhaps recall a consultation that went really badly.

- What happened? Why?
- Is there anything you would do differently having had that experience?
- What's the hardest thing to do in an outpatient consultation?
- Prompt: Why …
- Prompt: How do you do …
- Prompt: How do you deal with …
- Prompt: How do you recognise …
- Prompt: What sort of things do you regularly see in body language …
- Prompt: How do they appear …
- Prompt: How do they convey …

Questions about facilitators

- Why do some consultations go better than others?
- Prompt: Why …
- Prompt: How do you do …
- Prompt: How do you deal with …
- Prompt: How do you recognise …
- Prompt: What sort of things do you regularly see in body language …
- Prompt: How do they appear …
- Prompt: How do they convey …

- What would make outpatient consultations easier for you?
- What factors influence patient satisfaction with communication in consultations?

Questions about communication education

I want to ask you some questions about communication education.

- What makes a surgeon a good communicator? Perhaps think of people you know who are good or not so good at it.
- Prompt: Why …
- Prompt: How do you do …
- Prompt: How do you deal with …
- Prompt: How do you recognise …
- Prompt: What sort of things do you regularly see in body language …
- Prompt: How do they appear …
- Prompt: How do they convey …

Have you ever had any communication training?

- If so, when was that? What do you remember about it?
- If not: how did you learn what to do/ what was expected in a consultation?

If you were offered further communication training, would that be of interest to you?

- If so, what would you hope to achieve from it?
- If not, why not?

Should communication in outpatient consultations be assessed?

- If so, how do you think communication in consults should be evaluated? Who by?
- If not, why not?

Finally:

- Is there anything else you'd like to tell me about your experience of communicating with patients?
- Prompt: Why …
- Prompt: How do you do …
- Prompt: How do you deal with …
- Prompt: How do you recognise …
- Prompt: What sort of things do you regularly see in body language …
- Prompt: How do they appear …
- Prompt: How do they convey …

Thank you

APPENDIX B

PARTICIPANT INFORMATION SHEET

PROJECT TITLE:	**Surgeon communication in outpatient consultations**
CAHLN HREC REF NUMBER:	[redacted]
PRINCIPAL INVESTIGATOR:	**Amanda Le Couteur**
STUDENT RESEARCHER:	**Megan Riley**
STUDENT'S DEGREE:	**Bachelor of Psychological Science (Hons)**

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?
This project is being conducted to explore surgeon's views about the nature of communication in outpatient consultations.

Who is undertaking the project?
This project is being conducted by research student, Ms Megan Riley. This research will form the basis for a thesis submitted as part of the degree of Honours Bachelor of Psychological Science at the University of Adelaide under the supervision of Associate Professor Amanda Le Couteur.

Why am I being invited to participate?
As a surgeon or surgical fellow with the Central Adelaide Local Health Network (CALHN) your experiences and opinions about communicating with patients are sought. This project aims to improve understanding of how communication gets done in actual interaction with patients, starting with the views of surgeons. A diverse range of perspectives, focusing on what works and what doesn't, is welcomed.

What am I being invited to do?
You are invited to participate in a face-to-face interview at the hospital which will last approximately 30 minutes. The interview will be audio-recorded and transcribed for analysis. Materials will be de-identified to protect participants' anonymity, and any information that might serve to identify individuals will be removed during transcription.

How much time will my involvement in the project take?
It is anticipated interviews will take approximately 30 minutes.

Are there any risks associated with participating in this project?
There are no foreseeable risks associated with participating in this project.

What are the potential benefits of the research project?

This research has the potential to inform understanding of surgeons' experiences of communication with patients.

Can I withdraw from the project?
Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time and all data collected from you will be destroyed.

What will happen to my information?

Confidentiality and privacy:
All data will be de-identified by allocating participants a unique identification number / pseudonym upon commencement. Data will then be stored securely on password-protected devices. Any information in interviews that might serve to identify participants will also be altered/pseudonymised during transcription. Data will be stored on a university server and not on personal devices.
Storage:
All audio-recordings and interview transcripts will be stored on password-protected devices that will only be accessible by the Principal Investigator and Student Researcher.
Transcripts will be retained in the School of Psychology storage facility in a password-protected format for 5 years.
Paper-based data (including consent forms) will be stored in a secure (locked) storage facility in the School of Psychology. After 5 years data will be shredded and disposed of in university locked bins that are designated 'confidential waste'.
Publishing:
Project outcomes will be presented in an Honours thesis with the possibility of also being published as a journal article.

Sharing:
An executive summary and full report of findings will be offered to participants upon completion of the project. The findings of this study may be used as the basis for development of communication training in future. It is not anticipated that data will be re-used, however, anonymized transcripts will be stored for 5 years to allow for re-use if required.

Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?
If you want any further information regarding this project or if you have any particular concerns during or after your participation, you can contact either of the following people:

Primary contact person

Name: Associate Professor Amanda Le Couteur

Position: Principal Investigator

[redacted] [redacted]

[redacted] [redacted]

Secondary contact person

Name: Megan Riley

Position: Student Researcher

[redacted]

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2019-70). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact please contact Deputy Convenor, Human Research Ethics Subcommittee [Diana Dorstyn] on:
Phone: 08 8313 0649
Email: diana.dorstyn@adelaide.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?

Please supply name and contact details on the attached form and post in the sealed box located with the surgical unit secretary.

Yours sincerely,

Associate Professor Amanda Le Couteur
Principal Investigator

Ms Megan Riley
Student Researcher

APPENDIX C

Human Research Ethics Committee (HREC)

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	**Surgeon communication in outpatient consultations**
Ethics Approval Number:	[redacted]

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.

3. Although I understand the purpose of the research project, it has also been explained that my involvement may not be of any benefit to me.

4. I agree to participate in the activities outlined in the participant information sheet.

5. I agree to be:
   Audio recorded ☐ Yes ☐ No

6. I wish to view a transcript of my interview: ☐ Yes ☐ No

7. I understand that I am free to withdraw from the project at any time.

8. I have been informed that the information gained in the project may be published in an Honours thesis or journal article.

9. I have been informed that in the published materials I will not be identified and my personal results will not be divulged.

10. I agree to my information being used for future research purposes as follows:
    - Research undertaken by these same researcher(s) Yes ☐ No ☐
    - Related research undertaken by any researcher(s) Yes ☐ No ☐
    - Any research undertaken by any researcher(s) Yes ☐ No ☐

11. I understand my information will only be disclosed according to the consent provided, except where disclosure is required by law.

12. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____ Signature: _____ Date:_____

Researcher/Witness to complete:

I have described the nature of the research
to

_____

(print name of participant)

and in my opinion she/he understood the explanation.

Signature: _____ Position: _____ Date: _____