Clinical communication training in medical education : a conversation analytic approach

Ng, Gim Thia

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**NANYANG
TECHNOLOGICAL
UNIVERSITY**

SINGAPORE

**CLINICAL COMMUNICATION TRAINING IN
MEDICAL EDUCATION: A CONVERSATION
ANALYTIC APPROACH**

**NG GIM THIA
SCHOOL OF HUMANITIES
2019**

Clinical Communication Training in Medical Education: A Conversation Analytic Approach

NG GIM THIA

School of Humanities

A thesis submitted to the Nanyang Technological University
in partial fulfilment of the requirement for the degree of
Master of Arts

2019

Statement of Originality

I certify that all work submitted for this thesis is my original work. I declare that no other person's work has been used without due acknowledgement. Except where it is clearly stated that I have used some of this material elsewhere, this work has not been presented by me for assessment in any other institution or University. I certify that the data collected for this project are authentic and the investigations were conducted in accordance with the ethics policies and integrity standards of Nanyang Technological University and that the research data are presented honestly and without prejudice.

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This thesis contains material from 0 paper(s) published in the following peer-reviewed journal(s) where I was the first and/or corresponding author.

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Ng Gim Thia

To Bao

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ABSTRACT

Good clinical communication is increasingly recognised as pivotal to the success of medical practice, with much research having shown that the quality of communication greatly influences such factors as patient satisfaction and eventual health outcomes. Yet while communication skills training has already been widely incorporated into the curricula of medical schools around the world, doctors and other healthcare practitioners have mindsets so deeply entrenched in biomedicine that the human dimension continues to be side-lined in healthcare delivery. It is no wonder, then, that clinicians continue to struggle in their medical interactions on an everyday basis, despite the increased focus on patient-centred care globally. By examining clinical communication training with simulated patients (SP) in a young medical school in Singapore, this thesis aims to reflect and reflect upon the current efforts of medical educators endeavouring in the field.

Video recordings of SP-based simulation training were collected from the school's Clinical Communication Practicum for third-year undergraduate medical students. Using the emic, qualitative methodology of Conversation Analysis, these interactions were analysed via detailed inspection of the video data aided by transcriptions made from these recordings according to Jeffersonian conventions. Comprising a total of six simulated scenarios and 18 students, over five hours of footage was transcribed and analysed from a larger corpus of twice the size. Each session encompasses a simulated consultation between a student and an SP, as well as a facilitator-led feedback discussion involving both parties and other students.

A scrutiny of the simulated consultations shows that the delivery and explanation of patient diagnoses and/or conditions follow largely similar trajectories. Students begin by first stating their intent, before attempting to establish the SP's prior knowledge about the diagnosis/condition. Leveraging on this in the actual delivery, they then give an account of its causes and symptoms. Later, in explaining the diagnostic and/or treatment plan, they often

make use of strategies such as signposting to construct a methodical framework. Nevertheless, the overall organisation of the consultation ultimately varies according to the scenario in question. Two scenarios that are considerably different from the rest separately required students to dissuade an SP against hospital discharge and persuade a senior colleague to conduct a diagnostic test. Across the board, however, the students' consultations are characterised by two pervasive features: (1) an orientation towards information sharing over empathic understanding, and (2) an inadequacy in their calibration of language use.

The feedback discussion then commences after the simulated consultation is complete. Facilitators guide this second segment using Pendleton's rules as the adopted framework, which required them to garner feedback from all participants in terms of "what was done well" and "what could be improved". The analysis shows this structured approach as both a boon and a bane for student learning. While facilitators' stringent adherence to the rules ensure that students receive feedback from all parties, it subjects the discussion to a rigid configuration that limits input to certain forms which may otherwise turn out more substantial with free debate. On the other hand, when facilitators do not formulate their guiding prompts in a manner that clearly demarcates the two questions, feedback received is either imbalanced or imprecise. Skilful use of the rules in facilitation is therefore needed to ensure that students receive (and themselves produce) rich feedback that enhances their learning.

From the various findings, recommendations have been made to improve the teaching and learning of clinical communication in medical education. These target the design of the scenarios, representations made by SPs and students, the role of facilitators, and the use of the data as teaching materials. Nonetheless, caution must be exercised in implementation to ensure that these suggestions do not culminate in yet another prescriptive framework, but instead benefit SP training participants by raising their awareness of different conversational approaches and aiding them in deploying their own strategies of handling clinical interactions.

CHAPTER ONE: INTRODUCTION

1.1 Communication and Medicine

The English word “communicate” comes from Latin *communicatus*, past participle of *communicare*, meaning “to impart; to reveal; to participate; to bestow”, literally “to make common” (Donald 1872:81; Partridge 1966:576). In contemporary times, a diverse range of communication theories have evolved in response to different conceptualisations of this commonplace but complex phenomenon. While definitions vary in their emphasis on such dimensions as level of observation, intent, and normative judgment (Dance 1970; Littlejohn and Foss 2008), it is perhaps useful to think of communication as a transformational process of developing shared understanding, as opposed to a transactional activity of information exchange (Manojlovich et al. 2015).

Good communication is increasingly recognised as pivotal towards engendering successful outcomes in medical practice vis-à-vis clinical encounters such as doctor–patient consultations and healthcare professional inter-actions. Over the years, a significant body of research has shown that the quality of healthcare communication greatly influences patient satisfaction, compliance, recall and understanding of medical advice, as well as eventual health outcomes (Di Blasi et al. 2001; Brinkman et al. 2007; Joosten et al. 2008; Haskard Zolnieriek and DiMatteo 2009; Ha and Longnecker 2010; Begum 2014; Bachmann et al. 2017). For example, in examining over 12,000 patient/family complaint narratives, Pichert et al. (1998) reported that 20% of patient dissatisfaction arises from problems in communication whereas 10% stems from some form of perceived disrespect. When it comes to the after-effects, Gattellari, Butow, and Tattersall (2001) found that cancer patients whose doctors involved them in shared decision making (SDM) that was consistent with their preferences experienced significantly greater decrease in anxiety at post-consultation compared to those who felt a mismatch (Arora 2003).

1.1.1 A Progressive Awakening

Since the mid-1960s, interest in healthcare communication—exemplified by an exponential rise in number of published papers—has grown considerably amongst clinicians and researchers (Roter, Hall, and Katz 1988; Anderson and Sharpe 1991; King and Hoppe 2013; Pun et al. 2018). In particular, German American paediatrician Barbara Korsch and colleagues’ pioneering work (Korsch, Gozzi, and Francis 1968) that drew on 800 tape recordings of initial consultations in a children’s hospital and interviews with the patients’ mothers is widely considered the cornerstone for inquiry into the doctor–patient relationship as well as a milestone in the development of the new discipline (Association of American Medical Colleges [AAMC] 1999; Blatt, Spinazzi, and Greenberg 2014). Across the Atlantic, Britain’s first Professor of General Practice, Patrick Byrne and his educationalist collaborator, Barrie Long did a ground-breaking study of nearly 2500 tape-recorded primary care consultations by some 100 doctors in the country. Titled *Doctors Talking to Patients: A Study of the Verbal Behaviour of General Practitioners Consulting in Their Surgeries*, Byrne and Long (1976) is credited as one of the first empirical studies to concentrate on patient-centred medicine and having stimulated the use of audio recorders/video cameras in doctor–patient communication research (Gray 1984; Pawlikowska et al. 2007; Heritage and Clayman 2010).

This progressive awakening within the medical community has consequently been accompanied by various governmental and organisational policies recognising and affirming the importance of communication in yielding desirable treatment outcomes. In the United Kingdom, for instance, the early works of medical practitioners like Hungarian psychoanalyst Michael Balint, Swiss American psychiatrist Elizabeth Kübler-Ross, and British psychiatrist Peter Maguire were influential in bringing about the 1993 Audit Commission report on communication within the National Health Service and other subsequent policy reforms (McDonald 2016). Advancement in the United States, on the other hand, was made

predominantly within the structures of medical certification through the efforts of various independent organisations. Since the late 1990s, the National Board of Medical Examiners, the Federation of State Medical Boards, and the Educational Commission for Foreign Medical Graduates have come together to include clinical skills tests that address key dimensions of doctor–patient communication into the US Medical Licensing Examination, culminating in the introduction of the Step 2 Clinical Skills examination component in 2004 (Klass et al. 1998; Whelan 1999; AAMC 1999; Makoul 2003; Hawkins 2005).

Today, the importance of communication in medicine is widely recognised by various stakeholders across the board, including patients, clinicians, caregivers, researchers, governments, and regulatory bodies. Organisations with a specific focus in the field have been set up in many regions, such as EACH: International Association for Communication in Healthcare (originally the European Association for Communication in Healthcare) based in the UK, the Academy of Communication in Healthcare (ACH), the Institute for Healthcare Communication (IHC) in the US, and the Institute for Communication in Health Care, Australian National University (ANU ICH), among others (ANU 2018; ACH 2019; EACH 2019; IHC 2019). On the research front, studies have approached the subject from diverse perspectives, e.g. addressing specific topical concerns like patient adherence to treatment procedures, investigating the effects of interventions on communication behaviours, analysing structural patterns of professional–patient talk, etc. (Pressman and Dickinson 2016; Pun et al. 2018).

1.1.2 An Entrenched Mindset

Yet despite the remarkable progress, old habits die hard, and even more so, institutionalised practices. Authoritarian, paternalistic ways have already characterised healthcare delivery for millennia before patient-centred care became a professional pursuit (Kaba and Sooriakumaran 2007; Siegler 2011). Since the advent of modern medicine, the

biomedical model has become the dominant paradigm towards understanding illness throughout most of the last two centuries. While biomedicine has successfully led to discoveries and inventions that resolved many of humanity's health challenges in recent history, an overemphasis on physical processes often led to the neglect of other health determinants of a social, environmental, or psychological nature (Annandale 1998; Russell 2013). Under such influence, it is no wonder that communication was regarded up till recent decades as mere "bedside manner", part of "medical history-taking", or described ambiguously as "the art of medicine" (Freemon et al. 1971; Korsch 1989; AAMC 1999; Makoul 2003). Although the biopsychosocial model formulated by American psychiatrist George Engel in 1977 drew attention to the roles of psychological and social factors without denying biological ones and helped promote a more holistic view of health and illness, biomedicine continues to be the dominant model influencing medical theory and practice to this day (Russell 2013; Lane 2014).

At present, effective clinical communication remains a challenge for many healthcare practitioners on the ground. This is the case even for junior doctors who have most recently been exposed to communication skills training as medical students (Kee et al. 2018). Throughout the world, established physicians and other healthcare professionals are liable to growing patient complaints and increasing litigation as a result of problems in communication despite greater focus on patient-centred care (Huntington and Kuhn 2003; Hamasaki, Takehara, and Hagihara 2008; Skär and Söderberg 2018; Sun and Rau 2017). The situation reflects, perhaps, a more educated public with higher expectations of healthcare delivery, but it equally underscores the importance of polishing the skillsets of our medical providers. It is therefore imperative to evaluate the current practices of communication training for clinicians in greater detail to further advance the progress that has been achieved over the years. This thought is the very inspiration for, and the key premise of this thesis.

1.1.3 A Note on Nomenclature

The language in the preceding text has been purposefully varied to give the reader an impression of the different referential descriptors around. In fact, a number of semantically-associated labels relating to this young and growing field of study itself exist in the literature. Popular terminology used includes: (1) *health* communication; (2) *healthcare* communication; (3) *medical* communication; (4) *clinical* communication; (5) *doctor/physician–patient* (or vice versa) communication/interaction; and (6) *patient-centred* communication.

(1) *Health communication*. This term is used most frequently in US-based writings (e.g. Calderón and Beltrán 2004; Thomas 2006; Schiavo 2013; Hamilton and Chou 2014). In the American context, health communication is often (but not always) conceptualised broadly along a spectrum, varying in order of magnitude and ecological domain from micro-level, interpersonal talk to macro-level, mass-media public advocacy. Consolidating the different definitions available, Schiavo (2013:9) reformulated health communication as:

A multifaceted and multidisciplinary field of research, theory, and practice concerned with reaching different populations and groups to exchange health-related information, ideas, and methods in order to influence, engage, empower, and support individuals, communities, health care professionals, patients, policymakers, organizations, special groups, and the public so that they will champion, introduce, adopt, or sustain a health or social behavior, practice, or policy that will ultimately improve individual, community, and public health outcomes.

Defined in this manner, health communication may include topics as diverse as interpersonal and group interactions in clinical situations, health literacy, communications technology such as communications management systems, health promotion with the internet and multimedia channels, etc. (Thomas 2006). While communication does indeed occur at several levels, including interpersonal, group, organisational, mass and technological, and can be oral,

written or computer-mediated in form, interpersonal communication remains the linchpin of medical practice (AAMC 1999), and correspondingly, the focus of this paper. As such, the label ‘health communication’ will be avoided to circumvent any possible ambiguity.

(2) *Healthcare communication*. Notwithstanding the obvious but subtle difference in word meaning, the use of ‘health’ versus ‘healthcare’ as a noun modifier to ‘communication’ seems rather synonymous on face value. In the literature, however, this term generally refers to clinical interactions at an interpersonal level that includes patients’ encounters with doctors/healthcare professionals as well as that between healthcare professionals, largely excluding other broader notions of communication (e.g. Hugman 2009; Angeli and Campbell 2017; Gasiorsek and van de Poel 2018; Pun et al. 2018).

(3) *Medical communication*. This appears to be the least popular label used by authors in referring to the field, possibly to avoid confusion with a separate subject known as “medical communications”, which concerns the provision of consultancy services to the pharmaceutical industry in raising awareness of drugs through medical writing (Graves and Baker 2000; Moon 2018).

(4) *Clinical communication*. Often found in Anglo-centric publications, this term is widely used as an overarching concept for the plethora of interactions that occurs in a clinical setting, ranging from interactions between healthcare professionals and patients, to inter-professional communication and that between clinicians (Brown et al. 2016; Cooper and Frain 2018). In contemporary usage, it has also taken on the definition of a specific communication skillset through which the complex process of relationship building, information gathering, information sharing and SDM is achieved by healthcare professionals (Bates, Reinartz, and Wiskin 2016; Silverman 2016).

(5) *Doctor/physician–patient communication/interaction*. As the name suggests, papers that have used this sort of terminology report exclusively on interaction between

doctors and patients, which remains the bulk of all research done on interpersonal communication in healthcare settings. Other variations of ‘doctor–patient’ and ‘physician–patient’ include ‘provider–patient’ (e.g. Anderson and Sharpe 1991) and ‘clinician–patient’ (e.g. Joosten et al. 2008), as well as ‘health professional–patient’ or simply ‘professional–patient’ (e.g. Pun et al. 2018) when referring to more general clinical encounters.

(6) *Patient-centred communication*. This usage followed the pronouncement from the US Institute of Medicine (IOM) in 2001 that medical care should become more patient-centred (King and Hoppe 2013), i.e. “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (IOM 2001:6). A response to doctor-centredness or disease-centredness, patient-centredness emerged in North America and northern Europe since the 1970s as a concept to guide doctor–patient interactions, amongst other broad factors underlying the relationship (Bensing 2000; Mole et al. 2016; Brouwers et al. 2017). Regarding the best way to understand the patients’ point of view as through listening to them, Bensing (2000) asserts that patient-centred communication represents the bedrock of the patient-centred paradigm, calling it “the royal pathway to patient-centered medicine” (p. 23).

As will shortly be described in the current and next chapters, the focus of this thesis is on communication skills training for medical students situated within a specified clinical context. For the purpose of consistency, ‘clinical communication’ shall henceforth be used throughout the paper as a standard reference to the field, unless otherwise appropriate (e.g. when specifically referring to the doctor–patient interaction or invoking the principle of patient-centred communication).

1.2 Clinical Communication and Medical Education

Given the growing awareness of the inseparable relationship between communication and medicine, it follows naturally, then, that medical education—with its primary purpose of

producing qualified medical graduates for society—ought to include communication skills training so that these future clinicians are adequately prepared for real-world practice. No longer is medical education focused purely on the dissemination and assimilation of factual scientific knowledge. Many, if not most medical schools around the world today incorporate clinical communication training into their course curriculum, albeit to varying degrees and adopting different theoretical positions.

Several factors have been identified as contributing to the rising importance of clinical communication in medical education. Of the reasons cited in Brown (2008) for this phenomenon in the UK context, factors which are also broadly relevant worldwide include political influences like the effects of neoliberalism on society and professions that have challenged traditional notions of respect for medicine; sociological influences such as the effects of a ‘marketised’ society on medicine, increased litigation against doctors, and the emergence of globalised information through the internet; as well as the historical influence of change within medical education from an apprenticeship model with an inflated factual curriculum towards one that recognises the importance of student attitudes and different skills.

Nevertheless, there is considerable variability in the way medical schools teach and assess clinical communication skills. By the late 1990s, most medical schools in the US already use a combination of discussion, observation and practice in imparting these skills. In order of frequency, such primary teaching methods comprised small-group discussions and seminars, lectures and presentations, student interviews with simulated patients, student observation of faculty with real patients, and student interviews with real patients (AAMC 1999). Commonly used theoretical models till today for both teaching and assessment include the Calgary–Cambridge Observation Guide, Bayer Institute for Health Care Communication E4 Model, Three Function Model/Brown Interview Checklist, SEGUE Framework for Teaching and Assessing Communication Skills, Patient-Centered Clinical Method, etc.

(Bayer–Fetzer Conference on Physician–Patient Communication in Medical Education 2001; Brown and Bylund 2010). Yet while each of these methods and models brings to the table different learning experiences and structured guidelines for medical students to follow, most of what is provided remains skeletal and generic. An inherent lack of sustained effort in directing attention to specific communicative episodes offered by these instruments alone belies effective education in clinical communication. To make up for this shortfall, training with simulated patients is often used to supplement theoretical knowledge with practical experience in modern medical education.

1.3 Teaching Clinical Communication with Simulated Patients

Simulated or *standardised* patients (SPs) are individuals trained to act like real patients and simulate the symptoms of medical conditions, utilised in medical education to help students hone their clinical skills in realistic, lifelike scenarios (Bressmann and Eriks-Brophy 2012). These clinical skills may include history-taking, physical examination, clinical investigation, diagnostic reasoning, professionalism, and team-working, all of which are underpinned by good clinical communication (Kneebone and Nestel 2005). Alongside the development of manikins (itself a major innovation of the same era that gained earlier acceptance), the SP methodology presents medical educators with an alternative modality of high-fidelity simulation (Rosen 2008, 2013; Coffey et al. 2016). Indeed, as compared to the use of inanimate models and isolated tasks, the involvement of live human beings in a simulated environment “increases realism, emphasises the link with clinical reality and provides an authentic and powerful learning experience” (Kneebone and Nestel 2005:90).

1.3.1 Theoretical Traditions

Theoretically, there is also a distinction between *simulated* and *standardised* patients. In addition to the realistic portrayal of the patient role, standardised patients are tasked to

specifically enact a particular patient problem consistently (Bokken et al. 2009). This is deemed important during graded assessments where SPs function as the examination question and fairness is to be ensured for students. The term ‘standardised patient’ is preferred in North America, where an orientation to testing has dominated SP practice; whereas in UK and Australia, the more commonly used term is ‘simulated patient’. For the latter tradition, SPs involved in assessments have their *behaviour* instead of their *being* described as ‘standardised’ (Nestel and Bearman 2015). In line with the focus of this thesis on issues of facilitation and learning rather than testing, ‘simulated patient’ will be the preferred reference when using the abbreviation ‘SP’, though the practical difference is herein minimal.

1.3.2 Early Developments

The use of SPs in medical education has come a long way since its inception in 1963 at the University of Southern California. First devised by neurologist and medical educator Howard Barrows, the SP methodology had a protracted, arduous journey entering mainstream medical curricula as it was not seen in the beginning as a legitimate educational tool for serious medical practice. While originally designed to evaluate the clinical skills of his third-year medical students with greater rigour, Barrows went on to use this approach in teaching, research, and curricula reform, eventually achieving the goal of having a clinical skills examination (CPX) with SPs implemented nationally as the aforementioned Step 2 Clinical Skills component of the US Medical Licensing Examination (Wallace 1997; Rosen 2013).

Barrows saw the potential in teaching clinical communication with SPs early on, noting that, “A trained simulated patient can report objectively on the student physician's skills, physician-patient rapport, manner, approach, etc.” (Barrows 1968:674). Without calling into question whether SPs actually give objective feedback (or if true objectivity even exists), this preliminary recognition of SP training as a means of developing interactional

competence could be seen as the starting point of how clinical communication teaching and assessment have evolved around the world today.

1.3.3 Current Practices

In SP-based simulation today, much effort is placed on enacting scenarios to address core components of clinical practice such as communication, professionalism, and patient safety. Focusing on the information exchange between clinicians and patients across topics as diverse as history-taking, developing management plans, and delivering unpleasant news, these scenarios may require SPs to simulate the clinical characteristics of either acute or chronic illnesses implicating any body system. In more advanced *hybrid simulation*, SPs may be aligned with task trainers (also known as benchtop models) to train clinicians on specific procedural or operative skills. For added realism, specially designed costumes or props along with the application of moulage can even be incorporated to transfer the appearance of SPs completely. At the same time, the role of SPs has been greatly expanded to include not just patients per se, but also relatives of patients, trainees, healthcare students, and even healthcare professionals (Nestel, Morrison, and Pritchard 2015).

Given the huge significance of SP methodology in contemporary medical education, educators are invariably concerned with its implementation in learning and assessment. Honing clinical communication skills with SP training is clearly a form of experiential learning that consolidates knowledge acquired from classroom teaching through actual practice. However, present-day implementation of the SP methodology not only emphasises practical experience but also encompasses reflection and feedback from observers who enhance the skill development of the student at the centre of the simulation exercise. In terms of evaluation, feedback from facilitators, peers and SPs can also be used as formative assessment for the planning of future practice opportunities before end-of-semester, year or programme summative assessments (Thistlethwaite and Ridgway 2015).

1.4 Advancing Clinical Communication Training

Thus far, we have seen how clinical communication came to be gradually recognised as indissoluble from medical practice and accorded significant value in medical education today, with the SP methodology now widely used in relevant training. A number of studies describing and evaluating the professional implications and educational importance of clinical communication have also been delineated above. Having accomplished considerably in half a century, however, it appears that the field has reached a developmental bottleneck: issues of implementation remain in clinical practice without much of the extant scholarly output affording any clear direction for moving forward.

This thesis was therefore undertaken not just to reflect and reflect upon the current efforts of professionals working to bring good communication into medicine. More importantly, the goal is to advance the state of research in the field such that real-world solutions may actually emerge. In the present study, I review the latest practices of clinical communication training in a medical school using the SP methodology by examining the various interactions present—simulated or real—during both role-play and discussion stages of each training encounter. A discussion of the methodological and methodical considerations involved is presented in the next chapter. Subsequently, notable conversational practices relevant to the warp and weft of social interaction situated within an institutional setting are analysed (Chapters 3 and 4) alongside its clinical and pedagogical significance (Chapter 5). It is hoped that the observations and issues highlighted can not only supplement the scholarship in communication, discourse and conversation analysis, but also practically inform the medical and educational communities at large.

CHAPTER TWO: METHODOLOGY AND METHOD

2.1 The Approach

Most of the primary studies described in the first chapter are experimental or quantitative in nature, relying on a priori research designs such as randomised control trials (characteristic of biomedicine) or employing the use of constructed assessment tools like standardised tests and surveys (commonly used in the social sciences). Such approaches are valuable in their own rights but beset with the problem of being ‘contrived’, ‘obtrusive’ or ‘researcher-provoked’, where human behaviour becomes artificially manipulated and de-contextualised (Atkinson and Heritage 1984; Heritage 1984; ten Have 2007; Speer 2008). Even where the data is naturalistic or ‘unprompted’, as in the case of video recordings and field notes, there is a general orientation towards quantification or ‘numerification’ (ten Have 2004). Observations or participant behaviours are often codified, aggregated, and subjected to statistical analysis, despite being purportedly ‘qualitative’. Undoubtedly, these modes of investigation have helped establish the field to what it is today and cannot be simply dismissed or disregarded. In this thesis, however, I describe a chosen methodology unregimented by the theoretical and structural shortcomings of most motivated inquiry—Conversation Analysis—which I have deemed fitting for re(de)fining research in clinical communication and medical education.

2.1.1 *Conversation Analysis*

Conversation Analysis (CA) is the systematic study of social action as accomplished through the means of ‘talk-in-interaction’, i.e. “talk produced in everyday situations of human interaction” (Hutchby and Wooffitt 1998:13; Antaki 2008). It offers a powerful qualitative toolkit that allows for fine-grained details in social interaction to be brought into sharp relief, which may otherwise remain unnoticed and unanalysed, by revealing the tacit and organised

reasoning procedures that inform the production and management of naturally-occurring talk (Hutchby and Wooffitt 1998; Maynard and Heritage 2005; Heath, Luff, and Svensson 2007). This is done via the unobtrusive collection of audio/video recordings and a detailed inspection of the data aided by transcriptions made from these recordings (ten Have 1990).

Founded in the early 1960s by sociologist Harvey Sacks and his collaborators, Emmanuel Schegloff and Gail Jefferson, at the University of California (primarily Berkeley, Los Angeles and Irvine) out of a dissatisfaction with the dominant methodologies and theories of the time, CA has become a multidisciplinary enterprise and the leading approach to studying social interaction today (ten Have 2007; Antaki 2008; Clayman and Gill 2004; Sidnell and Stivers 2013). While Sacks and Schegloff were partly influenced by Erving Goffman's 'interaction order' in observing direct face-to-face interactions, Harold Garfinkel's 'ethnomethodology' (EM) was the major force that inspired CA's early developments (Psathas 1995; ten Have 2007; Maynard 2013). According to Heritage (1984), a seminal book explaining Garfinkel's theoretical contributions, EM approaches the study of particular subject matter as "the body of common-sense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves" (p. 4). It was the early conversation analysts' theoretical alignment with EM that CA became grounded in a "descriptive phenomenology of the mundane world" (Psathas 1995:7).

Nonetheless, while 'pure CA' was originally concerned with "the institution of interaction as an entity in its own right", from the late 1970s onwards, there emerged another strand of 'applied CA' that "studies the management of social institutions in interaction" (Heritage 1997:162, 2004:223; ten Have 2007). In fact, the first conversational data collected by Sacks—tape recordings of telephone calls to a suicide prevention centre—were already institutional in nature, albeit being used to illustrate more general principles of talk-in-

interaction. CA studies have since been extended to other institutional settings such as courtrooms, classrooms, media interviews, and of course, clinical interactions; with applications to the study of children and atypical populations; spanning fields as diverse as sociology, anthropology, psychology, linguistics, communication, education and medicine (Hutchby and Wooffitt 1998; ten Have 2007; Sidnell and Stivers 2013).

2.1.2 *Medical Conversation Analytic Studies*

According to Gill and Roberts (2013), and from my own interrogation of the literature, the first conversation analysts to employ CA to medical encounters began such research almost unanimously in the late 1970s to 1980 and started publishing them in the early 1980s. Their pioneering efforts could be seen as part of the applied CA ‘movement’ that had already gained traction in other institutional settings like courtrooms (e.g. Atkinson and Drew 1979) and classrooms (e.g. Mehan 1979), and were preceded by a number of ethnomethodological (e.g. Sudnow 1967; Turner 1971; Coulter 1973), ethnographic (e.g. Strong 1979), as well as discourse analytic (e.g. Shuy 1974, 1976, 1977) studies in medicine and other therapeutic settings such as psychotherapy.

In the US, the earliest foray into ‘medical CA’ (as coined by Gill and Roberts 2013) was made by sociologists Richard M. Frankel and Candace West, who started their research along independent lines but forged a working relationship over the years, with each having helped review the other’s personal manuscripts (e.g. Frankel 1983, 1984, 1990; West 1983, 1984a, 1984b, 1990; West and Frankel 1991). Frankel was teaching a course in basic clinical interviewing skills while on the faculty of Wayne State University medical school when he sought to better educate students in offering humane patient care. This was much in response to growing discontent among the public regarding the disconnection between the way in which doctors were educated and the everyday realities of healthcare delivery in America (Gill and Roberts 2013). Having studied with Sacks in the early 1970s, Frankel and his

colleague Howard Beckman began videotaping actual medical interactions from 1980 to 1982 for use as an educational tool with students (Frankel and Beckman 1982; Beckman and Frankel 1984; Treichler et al. 1984). These early investigations revealed insights about the overall architecture of medical encounters, such as how presenting complaints and other information are exchanged, the way normal features of conversation like turn-taking and story-telling play into the consultation, and the roles of coordinated actions on the part of both doctor and patient in the interaction (Frankel 1983, 1984)

West, on the other hand, began CA research on doctor–patient interactions along a separate vein of concern. Originally interested in cross-gender talk and dominance (e.g. Zimmerman and West 1975; West 1978, 1979), her influential title, *Routine Complications: Troubles with Talk between Doctors and Patients*—the first full book on medical CA—was inspired by a private group exchange during a 1977 conference on female authority in the health professions, where she witnessed professionally-acclaimed women academics articulating their troubles in eliciting straight answers from their own doctors (West 1984a). This work, including subsequent publications (West 1990; West and Frankel 1991), centred on turn-taking interruptions, question-and-answer (Q&A) sequences, conversational ‘misfires’ and social commentary in medical dialogues, drawing much attention to the differentials observed from asymmetries in gender and social status between doctor–patient dyads, and the ways in which power and control are actually exercised interactionally.

Elsewhere, other scholars also partook in fronting this wave of research. In Britain, Atkinson and Heath (1981) represented a collection of ethnographic and CA papers on the practices and reasoning of participants in medical settings (Silverman 1981; Gill and Roberts 2013). Of medical CA studies, the book contains analyses of medical jargon negotiations in doctor–patient interactions (Meehan 1981), the managed use of names in counsellor–client consultations (Watson 1981), and the varied ways in which general practitioners (GP) design

the opening sequences of their interviews (Heath 1981). The last paper mentioned became the first of a series of articles written by Christian Heath on medical interactions involving the use of technology and non-verbal resources (e.g. Heath 1983, 1984, 1985). Last but not least, sociologist Paul ten Have of the Netherlands was also notable in early medical CA research for having published on the opening sequences and overall sequential organisation of GP consultations since 1980, albeit predominantly in Dutch at the start (ten Have 1980, 1981, 1983; Gill and Roberts 2013).

2.1.3 *Other Medical Interactional Studies*

At this point in time, it is perhaps prudent to discuss in brief a couple of other relevant interactional studies of different analytic traditions. As mentioned at the start of the previous subsection, medical CA research was preceded by a few studies that employed the use of discourse analysis (DA) to medical encounters. The distinction between CA and DA has long been argued among theorists, and indeed, some have subsumed CA under DA, despite differing origins in the various methodologies that have been given this collective label (see Tracy 1995; Shen 1998; Potter 2004; Antaki 2008). Without resorting to a lengthy treatise of the historical and methodological issues underpinning the debate, and to afford the reader a broad conception of what research might be considered discourse analytic, I have chosen to adopt Antaki (2008) ‘all-encompassing’ conception of DA that naturally arises from a liberal definition of “discourse” as simply, “what people say or write” (p. 431).¹ Apart from CA, DAs that exist would thus include approaches as diverse as speech act theory, narrative analysis, critical discourse analysis (CDA), Foucauldian DA, action-implicative DA, interactional sociolinguistics, ethnography of communication, discursive psychology, etc. (Wooffitt 2005; Antaki 2008). Nonetheless, following the subject matter at hand, the

¹ One seeking the difference between CA and DA would encounter Wooffitt (2005), a monumental volume that compared the two and argued for the author’s theoretical alignment with the former. While deeply illuminating, I have chosen not to base my literature review of medical DA studies on the book’s operational delimitation of DA, due to its exclusive focus on the variety following Gilbert and Mulkay, and Edwards, Potter and Wetherell.

literature reported below necessarily includes only interactional studies involving oral communication (as opposed to ones that employed written DA methodologies).

In the same year that Byrne and Long released their monumental research *Doctors Talking to Patients* (1976),² American linguist Roger Shuy had already published his second paper on clinical communication that became one of the most prominent early DA papers on the topic. Using the approach of interactional sociolinguistics, he focused his effort on communication problems in the medical interview. From over 100 tape recordings collected, Shuy (1976) claimed that the doctor–patient divide stems from an inability or unwillingness on the part of doctors to speak in a manner which patients can understand, and the greatest breakdowns in communication happened “when patients could (or would) not speak doctor language and doctors could (or would) not understand patient language” (p. 372). One key observation was that patients made clear, conscious efforts to speak in an ‘appropriate’ register to doctors, e.g. Black female patients tended towards using short and formal responses to doctors’ questions so that stigmatised grammatical features of African American speech are avoided, faltering only in non-medical/near-social utterances, hypercorrections, or emotional circumstances. Such displays—among other ways that patients learn to understand and speak ‘doctor talk’—were understood to illustrate the disadvantaged position patients find themselves in in the medical consultation. Working to ensure clear, trouble-free doctor–patient communication therefore became a recurring theme in a successive line of publications by the author (Shuy 1974, 1976, 1977, 1983).

² Though audio recordings were collected, the authors of Byrne and Long (1976) used their interactional data mainly to identify phases in the consultation (six) and diagnostic styles of doctors (seven) rather than analysing it discursively per se (Pawlikowska et al. 2007; Heritage and Clayman 2010). This influential study and its American ‘counterpart’ in significance, (Korsch, Gozzi, and Francis 1968), which used an “interaction process analysis” coding scheme, have not been characterised in the extant literature as ‘DA’ and hence do not land themselves for discussion in this subsection.

2.2 The Data

Video recordings of SP-based simulation training were collected from the Clinical Communication Practicum (CCP) for undergraduate medical students at the Lee Kong Chian School of Medicine (LKCMedicine), Nanyang Technological University, Singapore. Jointly established with Imperial College London in 2013, LKCMedicine features a clinical communication curriculum woven through all five years of the Bachelor of Medicine and Bachelor of Surgery (MBBS) programme. The training progressively increases in task complexity and challenge. For instance, Year 1 students start off with learning basic clinical communication skills like rapport building and information gathering/history-taking, whereas Year 5 students are taught to tackle more ‘advanced’ topics such as the sharing of difficult news and dealing with strong emotions exhibited by patients during the medical consultation. Experienced medical practitioners are invited to lead SP sessions as facilitators on a voluntary basis. The SPs themselves receive training before being allowed to participate in lessons for students.

2.2.1 Data Collection and Set-Up

The practicum was conducted within the premises of the medical school in six consultation rooms specially designed and designated for SP training. Each room of the Communication Suite was specially fitted with two cameras (‘desk’ and ‘bedside’) located at opposing ends of the ceiling to capture a complete view of all participants at any given time. This was accomplished using the Scotia Medical Observation and Training System (smots™), a system of hardware and software that unobtrusively records medical procedures and simulation (Scotia UK 2019).

36 medical students (20 males and 16 females) in their third year were engaged for the project, yielding approximately 11 hours of footage in total. The training was part of the existing course schedule and was not specially held for this research, with all participants

accustomed to video recording as part of the regular teaching routine. Year 3 students were chosen for study because they were at the point of transition between basic skills training and further clinical exposure. Informed consent from participants in the March 2017 run of the CCP—including students, facilitators and SPs—was individually obtained at the venue by research collaborators for permission to video record the proceedings (see Appendix A for the informed consent form). Participants who were unwilling to partake in the study could inform the investigators their decision and were excluded entirely from it. The videos taken encapsulates the entire Year 3 CCP ‘circuit’ undertaken by students at this current stage and comprises of six simulated scenarios involving three medical conditions. A summary of each scenario is shown in the table below (see Appendix B for the actual vignettes given to students and SPs).

Table 1

Simulated Scenarios in the Clinical Communication Practicum

Condition	Station	Interlocutor	Case Summary/Task
Dengue Fever	1A	Patient	Explain diagnosis and treatment plan to patient
	1B	Patient	Speak to patient wishing to be discharged against medical advice (AMA)
Acute Appendicitis	2A	Patient	Update patient on management plan for possible appendicitis
	2B	Senior Doctor (Radiologist)	Call duty radiologist for approval of urgent computed tomography (CT) scan to diagnose appendicitis
Acute Myocardial Infarction (AMI)	3A	Next-of-Kin (Daughter)	Update daughter about patient’s condition following heart attack
	3B	Patient	Educate patient on medication adherence and risk factors management for heart disease

The 36 students involved in the study were equally divided into six teams (herein labelled I to VI), all of which went through the circuit in the same morning, rotating from one

consultation room to another. Each consultation room featured one full station, i.e. both Parts A and B of each given medical condition. Two parallel cycles of the circuit were run concurrently, with Teams I, II and III forming one, and Teams IV, V and VI constituting the other. This effectively meant that the first three teams encountered a different set of facilitators and SPs from the latter three. Having two rooms per station (3 stations $\times$ 2 rooms) rather than one scenario per room (6 scenarios $\times$ 1 room) ensured that Part A of each station was administered before Part B to each team. The circuit flow for each student is represented in the diagram below.

Dengue		Appendicitis		Acute Myocardial Infarction	
1A	1B	2A	2B	3A	3B
Team I/IV Student 1		Team II/V Student 1		Team III/VI Student 1	
	Team I/IV Student 2		Team II/V Student 2		Team III/VI Student 2
Team III/VI Student 3		Team I/IV Student 3		Team II/V Student 3	
	Team III/VI Student 4		Team I/IV Student 4		Team II/V Student 4
Team II/V Student 5		Team III/VI Student 5		Team I/IV Student 5	
	Team II/V Student 6		Team III/VI Student 6		Team I/IV Student 6

Figure 1. Flow of the Clinical Communication Practicum circuit.

As can be seen from Figure 1, each student was allocated to a single scenario and the individual sessions proceeded according to a clockwork schedule. For Teams I/IV, Students 1 and 2 first carried out Stations 1A and 1B respectively, before the whole team moved to another room for Students 3 and 4 to separately finish Stations 2A and 2B. Stations 3A and 3B were then correspondingly completed by Students 5 and 6 in a different room. In the same fashion, Teams II/V and III/VI went about their own rotas according to the plan illustrated.

Each session consisted of two distinct but related segments: (1) simulated consultation and (2) feedback discussion. The first involved the medical student role-playing with the SP, while the second comprised a structured discussion of the simulated activity led by the facilitator(s) together with the role-playing student, other students and the SP. In each session, all students in the group were given two minutes to read the vignette for the scenario in question (Part A or B of the particular station) before the exercise started. The role-playing student was then allocated ten minutes to perform the task. After a minute of reflection, the facilitator(s) conducted a discussion lasting about 15 minutes. Finally, two minutes of buffer time was provided before the students moved on to either the next part or station, where the same procedures were repeated. All sessions were conducted purely in English, the working language of Singapore. Table 2 below shows the structure of a typical session as described.

Table 2

Structure of Each Session in the Clinical Communication Practicum

Segment	Duration	Component
Mock Consultation	2 min	Students read vignette
	10 min	Role-playing student performs task
Feedback Discussion	1 min	Reflection
	15 min	Discussion and feedback from facilitator(s) and SP
	2 min	Buffer for Q&A and summary by facilitator(s)

At any given time while a particular student was “in the ‘hot seat’”, the remaining five students in each team served as observers in the simulated consultation and participants in the feedback discussion. Figure 2 shows two separate screenshots from one of the sessions respectively depicting a student role-playing with an SP and the rest of the students carrying out observations, both taken from the same time point of the session-in-progress.

(a) Desk view: Student (centre left) role-playing with SP (centre right)

(a) Bed view: Other students in the team observing the role-play with the facilitator (far right)

Figure 2. Screenshots of a session-in-progress from two camera angles (colour-negated and pixelated).

2.2.2 Data Processing and Management

For the purpose of this thesis, only videos from the first three teams were selected. This was nonetheless half the corpus and amounted to over five hours of data to be processed and prepared for analysis. While largely irrelevant to this CA qualitative study, in which population or gender representativeness is considered inconsequential, there happen to be an equal number of male and female students featured in this dataset of 18 videos.

As per the norm for CA studies, the video data was transcribed into a written form for detailed inspection and discovery of interesting phenomena. Student research assistants (RAs) trained in the Jeffersonian transcription system were employed for this purpose. The process required transcribers to play back the videos time and again—sometimes frame by frame—as they translate the data into text. Incident Player (version 13.2.0.17), which allows simultaneous screening of multiple camera angles from smots™ (see Figure 3 below), as well as other commonly used media software such as VLC Media Player, QuickTime Player, and Windows Media Player, were used for video playback. All conversational material, along with non-verbal interactions of noticeable import, was entered into Microsoft Word.

Figure 3. Screenshot featuring the simultaneous viewing of two camera angles in Incident Player (anonymised).

After a first round of transcription was performed, each transcript was cross-checked by a separate transcriber to ensure that the data was adequately reflected in the text document and that errors were minimised. A second inspection done by me marked the completion of the transcripts. Finally, when specific portions of data were selected for analysis, I subjected the relevant excerpts to further scrutiny myself and added in finer-grained details where necessary. It is however important to note that transcriptions are necessarily selective and can

never depict the recordings in their full detail (ten Have 1990). Serving as a convenient representation of the recorded material, they are not intended to substitute the original videos (Psathas and Anderson 1990). The transcription conventions used follows Jefferson (2004), a summary of which can be found in Appendix C. The progress of the transcription was tracked using a spreadsheet on Google Sheets, which could be shared with and edited by the research assistants over the internet. No personal identifiers were put up online that could potentially compromise the anonymity of the participants or jeopardise the confidentiality of the data.

While viewing the videos, and subsequent to my initial inspection of the transcripts, Microsoft Excel was used to collate a collection of practices and phenomena of interest, indicated by ‘tags’ in one column for easy reference during analysis.

Scenario	Student	Transcription	Phenomenon	Formulation/Comments
1A	Team 4 Student 1	Hi (0.3) my name is Brian. I am a medical student attached to the: hospital team that is treating y	Self-Introduction	Invokement of Epistemic Status
1A	Team 4 Student 1	[So uhm Miss Tan] I am here to explain to you uh: why you are in the hospital and (0.4) what are	Statement of Intent (Opening)	No Ascription
1A	Team 7 Student 5	Okay. Has anyone (.) spoken to you about like wha- er (0.5) what the diagnosis was	Establishment of Prior Knowledge (Opr Format 3: Information from Others	
1A	Team 7 Student 5	No. So do you have any idea what this: >could've< *mm* (0.3) be caused by	Establishment of Prior Knowledge (Opr Format 1: Self Background Knowledge	
1A	Team 8 Student 3	so:: (0.4) can I ask do you kn[ow why you're here]	Establishment of Prior Knowledge (Opr Format 2 Variant	
1A	Team 8 Student 3	=S-So is it I'm I'mm-in a very serious condition @now?	SP's Concern about Condition	
2A	Team 4 Student 3	My name is (Suhaisa). I'm (the-) (.) >THIRD year medical student?< (.) I'm attached to the (.) surg	Self-Introduction	Invokement of Epistemic Status
2A	Team 4 Student 3	So Susan. (.) um: I've been @asked to speak to you <regarding> (.) >why you come in< to the hos	Statement of Intent (Opening)	Instructed by Undisclosed Authority
2A	Team 7 Student 1	Okay. How are you feeling now.	Display of Concern (Opening)	Standard
2A	Team 7 Student 1	Did you know what (0.8) what's roughly have been happening	Establishment of Prior Knowledge (Opr Format 2: Self-Awareness	
2A	Team 8 Student 5	So today I've been uh told to actually come and talk to you about this pain that you have in your	Statement of Intent (Opening)	Instructed by Undisclosed Authority
2A	Team 8 Student 5	so do you know what happened to you?	Establishment of Prior Knowledge (Opr Format 2: Self-Awareness	
3A	Team 4 Student 5	Hi:: (.) my name is Shawn? I'm a year 3 medical stu[de]nt. I'm attached to the (.) primary care t	Self-Introduction	Invokement of Epistemic Status
3A	Team 4 Student 5	Hi Amelia. Yah so as you know erm *yah@ so your* (.) father (.)erm *suffered a (.) <heart attack>.	Delivery of Diagnosis	Point-Blank Approach
3A	Team 7 Student 3	So <@okay?> (.) has anyone spoken to you about your father's condition?	Establishment of Prior Knowledge (Opr Format 3: Information from Others	
3A	Team 7 Student 3	>HOW- HOW is he now?<	SP's Concern about Condition	
3A	Team 8 Student 1	So basically urm (0.5) the consultant uh: in charge of your father has [actually] asked me to just U	Statement of Intent (Opening)	Instructed by Disclosed Authority
3A	Team 8 Student 1	Is he okay now?	SP's Concern about Condition	
1B	Team 4 Student 2	Good Morning.=My name is Kimberly.=I am third year medical student. Ya.=So I am part of the te	Self-Introduction	Invokement of Epistemic Status
1B	Team 8 Student 4	[H- h- how how are you feeling? Are you feeling better?	Display of Concern (Opening)	Variant
2B	Team 4 Student 4	=Uh yah sorry to disturb. my name is Uh: Benedict Tan I'm a medical student with the surgical on	Self-Introduction	Establishment of Identity
3B	Team 4 Student 6	Um Mr Tay I'm Xin Er I'm a third year medical student. [I'm] part of the primary care team taking	Self-Introduction	Invokement of Epistemic Status
3B	Team 7 Student 4	so er just want tuh check with you how you're feeling today,	Display of Concern (Opening)	Slight Variant Eliciting Standard Response
3B	Team 8 Student 2	So um before I start th'um (0.6) th'um: the consultation I'll just like to ask if you are feeling oka: Display of Concern (Opening)		Variant

Figure 4. Screenshot of collection of phenomena in Microsoft Excel, colour-coded by scenario and student. Note that rows have been hidden to showcase all 18 videos analysed.

Where pictorial representations of the data are necessary to illustrate a point or give the reader an idea of the overall set-up (such as in Figure 2 above), colour negation was first applied to the videos in VLC Media Player (version 2.2.4 Weatherwax) and captured with Windows 10 Snipping Tool. The resultant screenshots were then subjected to further

anonymisation in Adobe Photoshop CS6 Extended (version 13.0 x64) by pixelating participants' faces using the mosaic filter. (In the case of Figure 3, I chose not to render the image colour-negated but pixelated the full bodies of the participants instead so that the actual screen of the media player can be seen clearly.)

CHAPTER THREE: THE SIMULATED CONSULTATION

3.1 Learning Domains

Third-year communication training in this medical school features scenarios that emphasises the delivery of medical information to the participating SP based on a good understanding of clinical content and grasp of basic communication skills acquired in the first two years of study. As briefly described in the preceding chapter, the scenarios encapsulated in this study highlight a myriad of common situations which medical students—be it in their current capacity or future role as doctors—are bound to face in a hospital environment either on a daily or variable basis. More importantly, the professional and interpersonal communication skills needed to discharge their duties in relation to information giving are brought to the forefront for learning in this practicum. In this section, I discuss the students' performances during the simulated consultation in three learning domains identified.

3.1.1 *Delivering the Diagnosis/Condition of Patient*

One key area that aspiring doctors need to be proficient in is the ability to relate their *diagnosis* to patients, family members and other medical co-workers. Closely associated to this but a focally distinct endeavour is conveying the patient's *condition*, or state-of-being, to these very same stakeholders. This responsibility is presented in all stations either explicitly (1A, 2A and 3A), implicitly (1B and 2B), or emerges invariably during the consultation (3B).

For Stations 1A, 2A and 3A, the students' tasks were plainly stated in the vignettes as “*The consultant has asked you to speak to Miss Cheryl Tan regarding her diagnosis of dengue fever and treatment plans*”; “*your registrar has asked you to update Ms Tan and explain to her the team's plans*” (in which the ‘update’ would necessarily entail the given provisional diagnosis of “possible appendicitis”); and “*your consultant has asked you to update Mr Richard Tay's next-of-kin, his daughter Ms Amelia Tay*” (where ‘update’ would

involve both the provisional diagnosis of acute myocardial infarction and the patient's current condition). In contrast, the task of explaining the diagnosis or condition of the patient was less obvious in Stations 1B and 2B. For Station 1B, while it was indicated at the start that *"You have just spoken to your patient, Ms Cheryl Tan, on her diagnosis of dengue fever and further management plans"* (which suggests that the SP already has sufficient knowledge of her condition), the written instruction was *"Your consultant has requested to speak to Ms Tan first and explain why she is not medically fit for discharge"* (which requires a discussion of the SP's medical state). Station 2B represents a radical departure from the other stations in that the students' interlocutor was not an SP per se, but the facilitator acting as a senior doctor over the phone. The vignette specified that *"The plan is to keep the patient nil-by-mouth (NBM) and arrange for a CT scan of the abdomen and pelvis (CTAP) to confirm the diagnosis"* and that *"your registrar has tasked you to call the duty radiologist for approval for the CTAP"*. The students' job would then be to describe the provisional diagnosis to the facilitator in a manner convincing enough for him to agree to the scan. Lastly, the given instructions in Station 3B were *"Your consultant has requested that you discuss with Mr Tay and educate him on medication adherence, and managing modifiable risk factors for ischaemic heart disease"*. Though an explanation of the SP's diagnosis/condition was never spelled out nor implied, the topic surfaced naturally perhaps because the consultation was supposedly held a day after the emergency and the SP was still 'unaware' of the situation.

Regardless of the scenario, the nearly universal way of commencing the simulated consultation is to begin with a direct statement of intent after a brief self-introduction to the SP, as in the following examples below (not exhaustive). Out of the 18 videos analysed, there were in fact only two students (Team 1 Student 5 and Team II Student 3) who did not flag their objectives at the get-go, but proceeded with forwarding their agenda immediately after introducing themselves.

Excerpt 1. Station 1A/Team I Student 1: 04:11 Opening Statement of Intent

8 Med Student : Hi (0.3) my name is XXX.
9 Sim Patient : Hi:..
10 Med Student : I am a medical student attached to the: hospital
11 team that is treating you,
12 Sim Patient : ↑Oh: okay okay [mm mm:].
13 Med Student : [So uhm Miss Tan] I am here to
14 explain to you uh: why you are in the hospital and
15 (0.4) what are the test we have done for your
16 condition.
17 Sim Patient : Oh: okay.=

Excerpt 2. Station 2A/Team I Student 3: 00:04 Opening Statement of Intent

3 Med Student : My name is XXX. I'm (the:-) (.) >THIRD year medical
4 student?< (.) I'm attached to the (.) surgical team:
5 who's in charge of your care right now.
6 Sim Patient : ↑Orh.=
... ..
14 Med Student : So Susan. (.) um: I've been ↑asked to speak to you
15 <regardi:ng> (.) >why you come in< to the hospita:l=
16 Sim Patient : =mmm.=
17 Med Student : =>and just to< go through the team's plans o[ka:y?]
18 Sim Patient : [<orh.>]

Excerpt 3. Station 2A/Team III Student 5: 00:08 Opening Statement of Intent

3 Med Student : >Okay uh< my name is XXX, >I'm- I'm- I'm< a third
4 year medical student.
5 Sim Patient : Mmm.
6 Med Student : So today I've been uh told to actually come and talk
7 to you about this pain that you have in your
8 stomach.
9 Sim Patient : >Mm mm<.

Excerpt 4. Station 3A/Team III Student 1: 00:04 Opening Statement of Intent

1 Med Student : Hi. Uh: My name is XXX, I'm actually the: um medical
2 student attached to the medical team that was
3 treating your father Miste:r [Richard Tay,]
4 Sim Relative : [Oh. Okay.]
5 Med Student : °Yah okay° sorry uh just take a seat °first° (0.8)
6 So basically um (0.5) the consultant uh: in charge
7 of your father has [actually] asked me to just
8 Sim Relative : [°Mm. °]
9 Med Student : UPdate you about what happened to your father la.=
10 Sim Relative : =Okay.

In Excerpt 1, the student asserts his identity to the SP as “a medical student attached to the: hospital team that is treating you,” from Lines 10 to 11 before stating his intention of explaining the reason “why you are in the hospital” and “what are the test we have done for your condition” from Lines 13 to 16. Drawing on his epistemic status as an informed member of the team responsible for the SP’s medical treatment appears to be seen by the student as a strategy conferring sufficient legitimacy for him to broach the topic of diagnosis with the SP. The approach also seems good enough for the SP to acknowledge the opening sequence affirmatively (Line 17) and is used to similar effect in the other excerpts above.

Excerpts 2, 3 and 4, however, differ from the first example in the students’ additional claims to having been instructed to deliver the message. The students in Excerpts 2 and 3 pronounce ambiguously that they were “asked” and “told” to speak to the SP (Ex. 2 Lines 14 – 16 and Ex. 3 Lines 6 – 8 respectively), while the student in Excerpt 4 declares directly that she has been “asked” by “the consultant in charge” of the simulated relative’s (SR) father (the fictional patient) to supply the update (Lines 6 – 10). This referencing of and deference to a higher authority is in concordance with the hospital hierarchy, where medical students are the lowest in rank amongst all medical professionals. Moreover, despite being a part of the said medical team in the different scenarios, students are not qualified medical practitioners and have limited credibility in advising patients. The mention of a senior figure, or simply an unnamed power, can thus be seen as a bid by the students in ‘borrowing’ epistemic authority so as to lend/lend credence to their own words during the ensuing interaction.

Following the opening statement, many students also prefaced their delivery with a show of concern by asking variants of “How are you feeling?” This is appropriate where the SP is playing the role of the patient in question rather than a simulated colleague or relative, and thus is noticeably absent in the consultations of Stations 2B and 3A, but is relevant across all other scenarios and was found in seven out of the 12 applicable videos. A basic format for

this question is shown in Excerpts 5 and 6 below (featuring Team I Student 1 and Team I Student 3), which continue immediately from Excerpts 1 and 2 respectively.

Excerpt 5. Station 1A/Team I Student 1: 04:24 Opening Display of Concern

18	Med Student	: =Before I begin °can I° can I ask how are you
19		feeling now?
20		(0.5)
21	Sim Patient	: Uhm:::not very comfortable,
22		(0.5)
23	Sim Patient	: [Ya:] there is some=
24	Med Student	: [Mm.]
25	Sim Patient	: =pain behind my eyes so it's like.
26		(1.6)
27	Med Student	: Hmm: (I understand) you are having fever (0.6) and
28		joint pain (0.7) and then you also have (.) the
29		headache.
30		(0.3)
31	Sim Patient	: Ya: °I have headache° mm hm.
32		(0.3)

Excerpt 6. Station 2A/Team I Student 3: 00:24 Opening Display of Concern

19	Med Student	: So um: (.) ↑currently ho- >how are you doing< right
20		now?= (0.2)
21	Sim Patient	: <u>Still</u> <PAINful:>.
22	Med Student	: Mmm.
23	Sim Patient	: But <u>just</u> now even <u>worse</u> la:.. (.) when I came in.=
24	Med Student	: =Oh ↓dear:.. >You got this-< (0.2) You've this pain
25		in your- >your <u>RIGHT</u> hand side< there: (.) for
26		>quite a while already< right?
27	Sim Patient	: Uh:.. (.) Since <one A-M> this morning lo. °Mmm.°=
28	Med Student	: =Ok one A-M this morning:, (0.3) THAT aside from
29		thats. ↑ <u>Anything</u> else? °that you've been feeling a
30		<u>bit</u> (.) feverish?° (.) °°(maybe) or:??°°
31	Sim Patient	: <Uh::m> (0.4) a↑bit la:..

As can be seen from the two excerpts, asking “how are you feeling” (Ex. 5 Lines 18 – 19) or “how are you doing” (Ex. 6 Lines 19 – 20) elicits a response from the SPs about their current physical state with respect to their own somatic experience of pain (Ex. 5 Lines 21 – 25 and Ex. 6 Lines 21 & 23). The students then supplemented additional relevant information from the vignettes (Ex. 5 Lines 27 – 29 and Ex. 6 Lines 24 – 26 & 28 – 30) that prompted the

SPs to elaborate further on their symptoms (Ex. 5 Line 31 and Ex. 6 Lines 27 & 31). We shall see later that this became a conversational resource for the students in advancing their agenda. The next two excerpts show two other variants of this empathic display.

Excerpt 7. Station 1B/Team III Student 4: 00:06 Opening Display of Concern

11	Med Student	:	H- h- how how are you feeling:?
12			Are you feeling better?
13			(0.4)
14	Sim Patient	:	Mm: it's more or less the [same:].
15	Med Student	:	[More] or less the same
16			uh.
17	Sim Patient	:	Ya.
18	Med Student	:	Ya.=
19	Med Student	:	=Okay so: my name is XXX uh.= I'm part of- I'm a ss
20			medical student () in this (team) taking
21			care you uh:. Do you mind if I talk to you awhile,
22			because I- I heard that you know you: (0.4) would
23			like to get discharged right?
24	Sim Patient	:	Yes.

Excerpt 8. Station 3B/Team III Student 2: 00:09 Opening Display of Concern

12	Med Student	:	So um before I start th'um (0.6) th'um: the:
13			consultation I'll just like to ask if you are
14			feeling oka:y. 'Cause I understand you .hh just
15			underwent a procedures. >we all< we just want to see
16			whether you are okay to ↓have the interview now.
17	Sim Patient	:	Ya: >I-I-I<-I'm okay. [Can you] tell me what
18			happen to me doctor.
19	Med Student	:	[°Yah okay°]

In Excerpt 7, the student appends a second question, “Are you feeling better?” to the original formulation (Lines 11 – 12), framing it as an invitation for a preferred response. This however is met by a disagreement, “it’s more or less the same:.” from the SP, prefaced by a delay device “Mm:” in Line 14 (see Pomerantz 1984; Sacks 1987). Sensing the lack of positive uptake, the student immediately abandons the sequence and moves on to introducing himself and stating his intent (Lines 19 – 23), both of which were not done earlier. The abrupt shift in topic is marked by the use of “Okay” at the start of Line 19, signalling a closure of the

prior activity and a simultaneous transition to the next-positioned matter (Beach 1995). Given the speed at which the topic shift occurred and the sequential position of the empathic display, it appears that the student's concern is presented as a greeting or 'small talk' in this case rather than a true attempt in actually seeking patient input.

On the other hand, the student in Excerpt 8 designs his turn to encompass a display of concern accompanied by a justification for doing so (Lines 12 – 16), in a bid to ensure the progressivity of the consultation he is initiating; for the SP has just survived a heart attack the night before in this scenario and may hypothetically be unfit to talk (though this would be an impossible situation here since the SP is slated for discharge from hospital). Consistent with the scenario, this is met with an anxious question from the SP to find out more about what had happened to him (Lines 17 – 18), leading directly to a medical update thereafter (omitted from truncated excerpt).

As illustrated above, the simplest formulation of concern by students often yielded complaints from the SPs about prevailing physical symptoms. Excerpts 9 and 10 below (following from Ex. 5 and 6) illustrate how two students, Team I Student 1 and Team I Student 3 used these symptoms in delivering the diagnoses to their SPs.

Excerpt 9. Station 1A/Team I Student 1: 04:41 Establishment of Prior Knowledge & Delivery of Diagnosis

33	Med Student	: Okay what is your understanding of (.) what this is
34		about?
35		(0.7)
36	Sim Patient	: What is my understanding uh:m the doctor was saying
37		said and- I need to wait for the blood test ↑result
38		then I will know what is it going on.
39		(0.7)
40	Med Student	: [Okay.]
41	Sim Patient	: [Ya] ↑mm hm.
42	Med Student	: So based on the based on the (0.5) what what your
43		symptoms are: and (0.5) what we have tested,
44	Sim Patient	: Mm.=
45	Med Student	: =We (.) we think that you have dengue fever.

Excerpt 10. Station 2A/Team I Student 3: 00:44 Delivery of Diagnosis

32 Med Student : Mmm oka:y. (0.2) ↑SO um. right now (.) what the-
33 >what the< medical team has (state-) has thought?
34 (.) fro:m your symptoms? and fro:m (.) the- blood
35 test they did <earlier?> (.) is that >is this< thing
36 called (0.2) acute appendicitis. (0.2)

In Excerpt 9, the student latches onto the symptoms reported by the SP (refer to Ex. 5 Lines 21 – 25 & 27 – 29) to establish her state of knowledge regarding her illness, asking “Okay what is your understanding of (.) what this is about?” (Lines 33 – 34). Establishing prior knowledge is an element of the communication training taught to medical students in the lower years for the purpose of ascertaining the information gap that needs to be bridged for patients. Upon receiving a response from the SP that clearly demonstrates an unawareness of the diagnosis (Lines 36 – 38), the student delivers the finding of dengue fever to her based on the earlier discussed symptoms, in addition to some clinical ‘test results’ (Lines 42 – 43 & 45). No checking of prior knowledge was performed in the case of Excerpt 10, however. Here, the student delivers the diagnosis straightaway, also with reference to the SP’s symptoms and test outcomes (Lines 32 – 36), immediately after his opening display of concern (Ex. 6 Lines 19 – 20 & 24).

Apart from that seen in Excerpt 9, a number of other formulations designed for the same purpose of eliciting the SP’s prior knowledge but approaches it from a different angle exist in the data. These are illustrated in the following examples.

Excerpt 11. Station 2A/Team III Student 5: 00:22 Establishment of Prior Knowledge

13 Med Student : =Uh:: so do you know what happened to you?
14 Sim Patient : I had this uh stomach pain at the lower (.) part of
15 my tummy then at one A-M lah, >then< it slowly
16 slowly migrate to the right hand side.
17 Med Student : <Okay>.
18 Sim Patient : Then is uh I took Panadol but it doesn’t help so I
19 come to the °E-D-R°.

Excerpt 12. Station 3B/Team I Student 6: 00:33 Establishment of Prior Knowledge

26 Med Student : So before I start may I ask you more about um what
27 do you know about your situation right now,
28 Sim Patient : Uh I [was] admitted last night [in the A] and E,
29 Med Student : [Mm] [Mm hmm,]
30 (0.7)
31 Sim Patient : [And] uh they told me that I have a heart attack.
32 Med Student : [Mm]
33 Med Student : Mm hmm?
34 Sim Patient : °Yah°.
35 (0.5)

Excerpt 13. Station 1A/Team II Student 5: 00:38 Establishment of Prior Knowledge

25 Med Student : Okay. So has anyone (.) spoken to you about like
26 wha- uh (0.5) what the diagnosis was?
27 Sim Patient : Uh ↑no,
28 Med Student : No. So do you have any idea what this: >could've<
29 °mm° (0.3) be caused by?
30 Sim Patient : I'm not very sure,=
31 Med Student : =Not very [sure.] Okay.
32 Sim Patient : [Mm::.]
33 (0.5)

Excerpt 14. Station 2A/Team III Student 5: 00:37 Establishment of Prior Knowledge

20 Med Student : Oh okay. So uh at the E-D they did some tests. Uh do
21 you know what are the results of the tests?
22 Sim Patient : Don't know. They took- they:: they sent me for blood
23 test and uh=
24 Med Student : =Mm=
25 Sim Patient : =X-ray.
26 Med Student : Okay. So did they tell you anything? [About]
27 Sim Patient : [No no.]

Excerpt 15. Station 2A/Team II Student 1: 00:37 Establishment of Prior Knowledge

30 Med Student : Okay. So- so far what did- what 'ave they told you
31 anything? Did you know what (0.8) what's roughly
32 have been happening.=
33 Sim Patient : =I don kno:w.=
34 Med Student : =You don't kno:w.

A parallel question to the “what is your understanding of this” format, which aims to draw out the SP’s background knowledge of his/her own condition, Excerpts 11 and 12 show

an alternative construction “do you know what happened to you?” or the variant “what do you know about your situation?” respectively, both of which have a slightly altered focus on the circumstantial self. The responses in these excerpts, “I had this uh stomach pain at the lower (.) part of my tummy then at one A-M lah, >then< it slowly slowly migrate to the right hand side”, “Then is uh I took Panadol but it doesn’t help so I come to the °E-D-R°” (Ex. 11 Lines 13 – 16 & 18 – 19),³ “Uh I was admitted last night in the A and E”, and “And uh they told me that I have a heart attack” (Ex. 12 Lines 28 & 31) show the SPs’ orientation to their conditions as ‘experienced’ in chronological time. This is contrary to the case in Excerpt 9, where the SP’s reply concerns an ultimate diagnosis (Ex. 9 Lines 36 – 28).

A distinctly different formulation “has anyone (.) spoken to you about like wha- uh (0.5) what the diagnosis was?” is found in Excerpt 13 Lines 25 – 26. Here the student directly probes the SP’s knowledge of her exact diagnosis with a question designed to yield a “yes” or “no” response. If the SP responds affirmatively, she then becomes accountable in providing a candidate answer for the diagnosis. In this case though, the SP replies “Uh ↑no,” (Line 27), prompting the student to reformulate his question as “So do you have any idea what this: >could’ve< °mm° (0.3) be caused by?” (Lines 28 – 29), deferring instead to a design meant to elicit background knowledge (though a different construction from “what is your understanding”). Asking upfront whether someone else has told the SP his/her diagnosis is in fact not an uncommon strategy in the data, used by three students out of 12 applicable cases (minus Stations 1B and 2B ones). In Excerpt 14 Lines 20 – 21, a fourth student (Team III Student 5 of Excerpt 11) in fact asked a similarly designed but even more specific question, “do you know what are the results of the tests?” as a follow-up attempt to his initial check for understanding (Ex. 11 Line 13), which did not yield a response he was looking for (Ex. 11 Lines 13 – 16 & 18 – 19). This suggests that, for some students at least, knowledge of a

³ Panadol is a brand name of paracetamol, a common drug for fever and pain relief.

person's medical *condition* has to be surmised in a given *diagnosis*, especially in the context of the scenarios in question, i.e. these students design their probing questions such that they receive a response aligned with the diagnosis as specified in the vignette. Lastly, Excerpt 15 contains a combination of both questioning formats asked in immediate succession of each other. "So- so far what did- what 'ave they told you anything?" (Lines 30 – 31) is a direct solicitation for possible information that others have given the SP (albeit not confined to the *diagnosis per se*), while "Did you know what (0.8) what's roughly have been happening." puts more emphasis on the SP's physical circumstances and her self-awareness of it.

From the data, there are therefore at least three general types of questions used by students in establishing prior knowledge before delivering the patients' diagnoses/conditions:

- (1) Questions based on background knowledge or factual understanding;
- (2) Questions based on situational awareness of self;
- (3) Questions based on information from 'others'.

Thus far, the interactional work carried out by the students was done in preparation for and in advancement of their central agenda to deliver the patients' diagnoses/conditions, irrespective of the simulated scenario. Moving on, I now turn my attention to the actual delivery of diagnosis/condition and the ensuing explanation efforts that follow.

It was previously mentioned in the discussion of Excerpts 9 and 10 that leveraging on the symptoms educed from SPs' talk while showing concern is a way of delivering the diagnosis. This is in fact a common strategy used by seven of the 12 students who performed the scenarios amenable to it (all except Stations 2B and 3A). In the two examples, 'clinical tests' were also cited as an authoritative source of diagnostic information (Ex. 9 Line 43 and Ex. 10 Lines 39 – 40). Referencing to medical test results proved to be the primary way of securing legitimacy for diagnosis delivery, seen in five out of the six consultations across Stations 1A and 2A where such tests are relevant (not applicable to Station 1B as the SP

already knows her diagnosis, Station 2B because the very task is to secure the CT scan, and Station 3 since diagnosis of heart attack does not depend on laboratory testing).

Corresponding to Excerpts 9 and 10, which illustrate the aforementioned two main approaches in scenarios where the task is explicitly stated, Excerpts 16 and 17 below depict their use in informing SPs about their diagnosis/condition for scenarios where the task is supposedly more embedded (Stations 1B and 3B).

Excerpt 16. Station 3B/Team II Student 4: 00:13 Delivery of Diagnosis

11 Med Student : So uh just want tuh check with you how you're
 12 feeling today,
 13 Sim Patient : Urgh yes- yesterday I was in A and [E] °an- an-°=
 14 Med Student : [Mm]
 15 Sim Patient : =and >I don't know< I feel much better now.
 16 [()]
 17 Med Student : [Oh that's good.]
 18 Oh >so you have< no idea what (.) happened to you is
 19 it, [yesterday.]
 20 Sim Patient : [Yah] it's like got this (0.5) this
 21 crushing [(in)] (.) my (.) chest and so pain (and
 22 all) (0.5) almost like drowning like that.
 23 Med Student : [Mm.]
 24 (0.5)
 25 Sim Patient : Yeah.
 26 Med Student : °It's okay.°
 27 Sim Patient : And then I was warded in the A and E [la]st night.
 28 Med Student : [Mm.]
 29 °Okay.° So ur:m what you had was what ur:m people
 30 would (0.4) term a heart uh-teyk.
 31 Sim Patient : Oh I have a heart attack ah=

Excerpt 17. Station 1B/Team I Student 2: 01:22 Delivery of Condition

53 Med Student : °Okay° understand .hh (0.3) kay uh::m Miss: Tan
 54 actually the doctor wanted me to talk to you.=So we
 55 actually highly discourage you from being discharge
 56 today la.
 57 Sim Patient : Oh why: why why is it [so?]
 58 Med Student : [mm.]
 59 Sim Patient : Ya:..
 60 (0.4)
 61 Med Student : Like you say you are still feeling unwell.
 62 (0.2)

63 Sim Patient : Uh[hhh]

64 Med Student : [>So then] when we< check you condition yesterday

65 >You had you are- still having a fever<.

66 Sim Patient : Hmm hm.

67 Med Student : And then your platelets count were very low,

68 (0.6)

... ...

93 Med Student : Kay: ↑so (0.3) your platelet count is low.

94 Sim Patient : ↑Mm hm.

95 Med Student : And that normally (0.2) platelets count will be

96 about from one hundred to four hundred.

97 (0.2)

98 Sim Patient : ↓O:kay:..

99 Med Student : Yours is at thirty.

100 (0.6)

101 Sim Patient : ↑Oh:: mine: is at [thirty.

102 Med Student : [Yours is at thirty.=So=

103 =[we are worried that,

104 Sim Patient : =[Oh: dear:..

105 (0.6)

106 Med Student : some complications might developed and you will-

107 [have] bleeding so we actually want to (.) keep=

108 Sim Patient : [Mm hm.]

109 Med Student : =you in the hospital.

110 Sim Patient : Mmm hm.

The student in Excerpt 16 begins with a display of concern (Lines 11 – 12) analogous to that of Excerpts 5 (Team I Student 1) and 6 (Team I Student 3), to which the SP replies positively but in a manner suggesting a lack of clarity about what had transpired (Lines 13 & 15 – 16). Realising this, the student confirms her suspicion by asking, “Oh >so you have< no idea what (.) happened to you is it, yesterday.” (Lines 18 – 19), a question to establish prior knowledge of the type based on situational self-awareness. This successfully elicits information from the SP regarding the symptoms he had ‘felt’, namely “crushing (in) (.) my (.) chest” and “so pain (and all)” that was “almost like drowning like that” (Lines 20 – 22). The student then capitalises on the SP’s ‘own’ experiences in pivoting to her delivery of the diagnosis, “So ur:m what you had was what ur:m people would (0.4) term a heart uh-teyk.” Notwithstanding the task being an implied requirement, using the SP’s symptoms to deliver the diagnosis in Team II Student 4’s case resulted in a similar trajectory to that of Team I

Student 3's interview (Ex. 6 and 10). It thus appears that so long as students are able to identify the necessity of delivering the diagnosis, the explicative or implicative nature of the task becomes inconsequential to the eventual manner in which the consultation plays out. This means that the subsequent action is dependent upon a greater understanding of the task requirements over and above what is simply stated — a sort of pragmatic competence which students appear to possess sufficiently.

In Excerpt 17, the student tells the SP that the medical team (initially “the doctor”, then an upgrade to “we”) strongly recommends against her discharge from hospital (Lines 53 – 56). When questioned by the SP (Line 57), she cites the SP's own admission of ill health (Line 61) and delivers her current condition, “>So then when we< check you condition yesterday >You had you are- still having a fever<.” (Lines 64 – 65) and “your platelets count were very low,” (Line 67), a symptomatic description and test-based parameter respectively. The student goes on to highlight the stark difference between the normal platelet count of 100 to 400 and the SP's current low level of 30 (Lines 95 – 96 & 99). The use of this diagnostic index turned out rather effective, for there was a shift in the SP's understanding marked by the change-of-state token “↑Oh:.” (Line 101) and an exclamation “Oh: dear:.” (Line 104) regarding the severity of her condition. Note that the starting point of this conversation is different from the other examples so far, given that the students' primary task for the scenario in question (Station 1B) is not to deliver a diagnosis/condition, but to counsel the SP on discharge AMA (see Section 3.1.3 below).

In terms of turn design, there are numerous ways in which students can formulate the diagnosis delivery utterance. Those arising from the two aforesaid strategies in shifting the topic to the diagnosis/condition could possibly take the form of “Based on your symptoms and/or tests results” (e.g. Ex. 9 and 10) and other variants, or involve a more protracted exchange of these points, where an utterance specifically designed to convey the

diagnosis/condition may (Ex. 16) or may not (Ex. 17) be present. The next two excerpts demonstrate two other constructions seen in the data.

Excerpt 18. Station 3B/Team III Student 2: 00:09 Delivery & Explanation of Diagnosis

12 Med Student : So um before I start th'um (0.6) th'um: the:
 13 consultation I'll just like to ask if you are
 14 feeling oka:y. cause I understand you .hh just
 15 underwent a procedures. >we all< we just want to see
 16 whether you are okay to ↓have the interview now.
 17 Sim Patient : Ya: >I-I-I<-I'm okay. [Can you] tell me what
 18 : happen to me doctor.
 19 Med Student : [°Yah okay°]
 20 Okay sure. So basically ↓um: what happen is: you
 21 actually had a heart attack, .hh uh: what we've done
 22 for you is we've actually did a procedure to insert
 23 um: something to to relieve the .h the: blockage
 24 of your artery in your heart la. To get the blood
 25 flowing again .hh So: uh: >what has happen< is
 26 you've actually been admitted um the hospita:l
 27 overnight so that we actually observe you, .h and
 28 what will happen if is if all goes well tomorrow we
 29 actually uh discharge you.
 30 Sim Patient : ((Nods head))
 31 °Mm° okay. I have a heart attack.

Excerpt 19. Station 2A/Team III Student 5: 01:04 Delivery of Diagnosis

37 Med Student : Okay? Okay so <from the test results>, uh we
 38 >actually note that< you actually have slight fever,
 39 of about thirty-eight point two degrees Celsius.
 40 Sim Patient : °Oh.°
 41 Med Student : Yeah so that's slightly high.
 42 Sim Patient : °Orh.°
 43 Med Student : And then we also rea- >because you also< um said
 44 that you have this:: uh lower abdominal pain
 45 Sim Patient : Mm::.
 46 Med Student : That started here and then move down to the right,
 47 right?=
 48 Sim Patient : =Mm mm.
 49 Med Student : So >basically< this is actually quite classical of
 50 what we call an appendicitis.

Unlike Excerpts 9, 10, 16 and 17, Excerpt 18 above (an extension of Ex. 8) shows a direct approach without any evidential basis. After having expressed care and concern for the

SP that was met with positive receipt (Lines 12 – 19), the student immediately delivered the diagnosis “So basically ↓um: what happen is: you actually had a heart attack” (Lines 20 – 21). However, note that this was done in response to the SP’s question about his circumstantial condition (Lines 17 – 18), and is the only instance observed in the data where the student did not substantiate his conveyance of the SP’s diagnosis/condition with symptomatic or diagnostic information.

Out of the formulations abound, one that stood out as constructed with exacting finesse is found in Excerpt 19. Like much of the data, the student made use of the SP’s ‘test results’ and reported symptoms in making a case for his delivery of diagnosis (Lines 37 – 39, 41, 43 – 44 & 46 – 47). Yet instead of the usual design, the utterance “So >basically< this is actually quite classical of what we call an appendicitis.” from Lines 49 to 50 frames the diagnosis as one which bears a high degree of face validity but stands to be corrected, effectively highlighting its *provisional* status. This serves as a starting point for the student to subsequently convey the necessity of a CT scan in ascertaining the diagnosis and preparing for treatment. As a construction, however, “this is classical of” has restricted utility and applies more to provisional rather than final diagnoses, since using it for a definite diagnosis would introduce a tinge of uncertainty to the consultation and undermine patients’ confidence in the medical student or doctor.

Stating the diagnosis/condition is of course merely the start of the entire delivery. The next few examples illustrate how students explain the diagnoses/conditions and the issues that arise during their accounts.

Excerpt 20. Station 1A/Team 1 Student 1: 04:53 Delivery & Explanation of Diagnosis

42	Med Student	:	So based on the based on the (0.5) what what your
43			symptoms are: and (0.5) what we have tested,
44	Sim Patient	:	Mm.=
45	Med Student	:	=We (.) we think that you have dengue fever.
46			(0.2)

47 Sim Patient : Dengue fever.
48 Med Student : Uh.
49 Sim Patient : [Hhh.]
50 Med Student : [Are] you familiar with that °term°?
51 (0.4)
52 Sim Patient : (Me) I have heard of it before but I am not exactly
53 fami↑liar mm.=
54 Med Student : =Okay maybe I can explain to you a bit about dengue
55 fever.
56 Sim Patient : Okay:.,
57 Med Student : So dengue fever is a (.) is an infection that is
58 spread by mosquitos.=
59 Sim Patient : =Uh hh.=
60 Med Student : Like (0.5) usually the fever is about one week.
61 And,=
62 Sim Patient : =<One week.>
63 (0.3)
64 Med Student : Um: and you have (0.3) symptoms like joint pain
65 rashes this kind of thing.=
66 Sim Patient : Alright alright.=
67 Med Student : =(Those symptoms that you can feel it),

Excerpt 21. Station 2A/Team I Student 3: 00:44 Delivery & Explanation of Diagnosis

32 Med Student : Mmm oka:y. (0.2) ↑SO um. right now (.) what the-
33 >what the< medical team has (state-) has thought?
34 (.) fro:m your symptoms? and fro:m (.) the- blood
35 test they did <earlier?> (.) is that >is this< thing
36 called (0.2) acute appendicitis. (0.2)
37 Are you familiar with this?
38 Sim Patient : Not really.
... ...
51 Med Student : So wh- so WHAT appendicitis is: (.) is that it is
52 the infection? and (0.2) inflammation of your
53 <appendix:>?
54 Sim Patient : °Mmm.°
55 Med Student : So: what the appendix >is is that< is this: (.) >is
56 this °like-°< finger like ob- (.) finger like part of
57 your: large intestine. Th- (A) part of your
58 digestive tract. (0.3) So what's happened to it is
59 that's (.) there's some ↑infection? There's a lot of
60 germs in the area:? (.) And it's been inflamed. So:
61 right now there's a lot of (0.2) >your-your< immune
62 cells are trying to fight these (.) >fight off all
63 these< germs. However that is what is causing all
64 these pain °and° (.) all your fever and the other
65 (complications).

In Excerpt 20 (continuing from mid Ex. 9), after the student has stated the diagnosis (Line 45), the SP echoes it in acknowledgement of the news (Line 47). The student then asks a question, “Are you familiar with that ‘term’?” to establish the SP’s prior background knowledge of dengue fever (Line 50). When the SP conveys her lack of factual understanding with regard to the illness, the student seeks clearance from her to provide an explanation of it (Lines 54 – 55) and launches into a medical narrative of its cause and symptoms (Lines 57 – 58, 60, 63 – 64 & 66). This is similarly done by the student in Excerpt 21 (extending from Ex. 10), where after supplying the diagnosis (Lines 32 – 36), he appends a similar question (Line 37) to which the SP responds in the negative (Line 38). A side sequence (omitted) involving the student signposting his agenda for the consultation then ensues, before he begins explaining the diagnosis, which includes a single-utterance overview of appendicitis (Lines 51 – 53) and a lengthier elaboration of the disease aetiology and expression (Lines 55 – 65).

As such, it may be posited that delivering and explaining the diagnosis/condition commonly involves the following components:

- (1) Stating the diagnosis/condition;
- (2) Establishing patient’s prior knowledge of it;
- (3) Clarifying its cause(s);
- (4) Describing the symptoms.

Together, these two examples demonstrate this general structure observed in seven out of the nine consultations from Stations 1A, 2A and 3A. Having departed from the ‘norm’ for a similar reason, one of the two ‘deviant’ occurrences is presented in the next excerpt to account for the ‘anomaly’ in the data.

Excerpt 22. Station 1A/Team II Student 5: 00:57 Delivery of Diagnosis without Explanation

39 Med Student : Um (0.5) so- (0.4) Uh we drew some blood from you
 40 just now and we [test]ed it for: (.) dengue.
 41 Sim Patient : [Mm.]

42		Dengue.
43	Med Student	: The [dengue yah.] So- the blood test came back as
44	Sim Patient	: [Uh huh.]
45	Med Student	: positive lah. [So] this is um a case of
46	Sim Patient	: [Oh dear.]
47	Med Student	: dengue fever.
48	Sim Patient	: Okay. [()]
49	Med Student	: [Okay.]
50		So- um: (0.7) at the same time when we run your
51		blood test we uh also ran like a blood count, [(.)]
52	Sim Patient	: [Uh.]
53	Med Student	: to >like- to look at the number of like types of
54		cells in your, the NORMAL blood cells in your (.)
55		blood,
56	Sim Patient	: °Uh huh.°
57	Med Student	: And then we found that your platelet count is low.
58		(0.7)
59	Sim Patient	: <Oh kay,>
60	Med Student	: >Okay.<=
61	Sim Patient	: =So you are saying that I'm having dengue.=
62	Med Student	: Yes.
63	Sim Patient	: Oh dear. (0.7) Will this spread to my husband and
64		my family?
65		(0.4)
66	Med Student	: Uh: (1.0) in the first week of having dengue fever:
67		um the virus is still in your blood. So if a
68		mosquito bites you,
69	Sim Patient	: Mm.
70	Med Student	: Uh the mosquito <u>could</u> be infected and if it bites
71		say like your family, [(.)] then uh the virus
72	Sim Patient	: [Mm mm]
73	Med Student	: could theoretically be passed to them lah.
74	Sim Patient	: Mm mm.
75	Med Student	: In this way. Mm. Do you stay like in uh: >like a
76		den<gue cluster or like-
77	Sim Patient	: <Exactly:> [(ah.)]
78	Med Student	: [Oh you stay] in [a dengue °clur-°]
79	Sim Patient	: [Yah I- I] do
80		see the banner of the hot spot >that kind of things<
81		but I din expect myself to get it? [Yeah.]
82	Med Student	: [Okay.]
83		(0.7)
84	Med Student	: Okay. (.) So um: (0.9) if- (.) are you very
85		concerned that like it will spread to your family?
86	Sim Patient	: Yes of ↑ <u>courrse</u> . Becaurse I was told that >I mean< I
87		heard that dengue can actually .h cause death, (0.3)
88		[so-] y'know it's kinda like [dange↑rous?] Yeah.
89	Med Student	: [Okay.] [Yes.]

From Excerpt 22, we can see that the student's 'logical' next step in explaining the diagnosis after delivering it is 'derailed' by the SP's question. Here, the student first uses the SP's blood test results to convey the diagnosis of dengue fever (Lines 39 – 40, 43, 45 & 47), supporting it with the finding of low platelet count (Lines 50 – 51, 53 – 55 & 57). After confirming the diagnosis with the student (Lines 61 – 62), the SP raised a concern from Lines 63 to 64, "Oh dear. (0.7) Will this spread to my husband and my family?" The student then addresses her question, stating the plausibility of that happening (Lines 66 – 68, 70 – 71 & 73), and follows up with a question of his own, "Do you stay like in uh: >like a den<gue cluster or like-" as an acknowledgement of her worry and show of concern for her situation (Lines 75 – 76). He displays the same empathy again from Lines 84 to 85 after receiving a confirmatory response from the SP (Lines 79 – 81), this time formulated as a verification of her apprehension, "So um: (0.9) if- (.) are you very concerned that like it will spread to your family?" Thus, instead of following the usual structure, the student had to address the patient's concerns for her family's safety, which she surfaced before he could carry on his explanation. While being an impediment of sorts, this is not necessarily detrimental for the student given that questions from patients may arise at virtually any junction of the real-life consultation, and it remains the responsibility of the attending doctor to provide a satisfactory resolution to patient queries. In this example, it is nonetheless noteworthy that there was no subsequent attempt made by the student in explaining the diagnosis *per se* throughout the rest of the consultation. What ensued thereafter were instead a negotiation of the treatment plan (the topic of the next subsection) and a Q&A sequence about the SP's symptoms. This pattern was likewise observed in the other 'irregular' case.

For Stations 1B, 2B and 3B, the delivery and/or explanation of diagnosis/condition in each scenario follows different trajectories because of circumstantially vastly different task requirements. The explanation work that students perform in Station 1B centres on reasoning

with the SP why she is unfit for discharge from hospital, rather than explicating the diagnosis/condition in isolation. Station 2B focuses exclusively on convincing a senior doctor to approve a diagnostic test, which involves rationalising the patient's symptoms in medical terminology before the facilitator instead of delivering the usual consultation to an SP. These two lines of justification will be explored in Section 3.1.3. As for Station 3B, the crux of the matter lies not in the diagnosis/condition, but in illuminating what has occurred since the SP's admission to the hospital, i.e. the emergency treatment procedures performed. The next two excerpts illustrate similar examples of the students' account in Station 3B that did not vary significantly despite differing epistemic stances taken by the same SP.

Excerpt 23. Station 3B/Team II Student 4: 00:40 Delivery of Diagnosis & Explanation of Treatment Given

29	Med Student	:	°Okay.° So ur:m what you had was what ur:m people
30			would (0.4) term a heart uh-teyk,
31	Sim Patient	:	Oh I have a heart attack ah.=
32	Med Student	:	=>Yah yah yah< a heart attack. So WHAT they did for
33			you um I'm not sure if- (.) you were aware that they
34			did some procedures [like] doing a [sca:n] as
35	Sim Patient	:	[°Oh yah.°] [°Yah.°]
36	Med Student	:	well as uh they inserted a wire into you and then
37			(.) um doctor ↑explained that it was to help to um
38			to remove- like to: (.) (op-) remove like the
39			obstruction,
40	Sim Patient	:	°Mm.°
41	Med Student	:	So- to allow your heart to: regain the blood supply.
42	Sim Patient	:	°Mm.°
43	Med Student	:	Yeah, SO um (0.5) so- (0.5) uh:- (0.4) tha- that's
44			what they did for you, and it's good that you're
45			feeling better °today.°

Excerpt 24. Station 3B/Team I Student 6: 00:42 Delivery of Diagnosis & Explanation of Treatment Given

41	Sim Patient	:	[And] uh they told me that I have a heart attack.
42	Med Student	:	[Mm]:.
43	Med Student	:	Mm hmm?
44	Sim Patient	:	°Yah°.
45			(0.5)
46	Sim Patient	:	'Chee what happen to me ah doctor?
47	Med Student	:	Oh so ni- (.) you are not [too] sure ↓ah. 'Kay so

48 Sim Patient : [°Mm.°]
49 Med Student : what happened was .h you had a heart attack ↑right?
50 and then .h um they found that it was UHH:: (0.3)
51 they needed some uh:: >uh=some kind of an
52 intervention for it? So (.) what they did was is
53 they put a stent to your heart? And then they open
54 up the vessels so that blood can flow a'gein.
55 Sim Patient : [°Mm.°]
56 Med Student : [(.) A:]nd to allow your heart to pump (uh) .
57 Sim Patient : Mm:[:.]
58 Med Student : [Mm]: so- >actually the reason why you had a
59 heart attack was because there was a< clot that was
60 blocking the vessels.=
61 Sim Patient : =Mm: [yah I] remember [before] I admit I have
62 Med Student : [So meaning-] [Yeah.]
63 Sim Patient : a- (0.5) have a chest [pain and I] got
64 Med Student : [chest pain right,]
65 Sim Patient : problem breat[hing] (.) Yah so I call for
66 Med Student : [Mm.]
67 Sim Patient : [°ambulance.°]=
68 Med Student : [Ye:ah]=>it is a good thing< that you called
69 : at that [time.] (.)
70 Sim Patient : [Mm.]
71 Med Student : So- (.) what happened was actually for this your
72 heart didn't receive enough oxygen. [So:] (0.4) um:
73 Sim Patient : [Mm.]
74 Med Student : your heart couldn't pump (.) already so what they
75 did was to jus: (0.4) uhh: (0.5) just unblock it
76 lah:..
77 So that was the mai:n gist of what had happened.
78 Sim Patient : Mm: [°Mm.°]
79 Med Student : [Mm:.]
80 (0.4)

In Excerpt 23 (continuing from mid Ex. 16), the SP displays ‘realisation’ of the diagnosis delivered (Lines 29 – 30) with “Oh I have a heart attack ah” (Lines 31), implying at the same time sufficient background understanding of it. The student responds in the next turn with a confirmation of the diagnosis and proceeds to explain it not in definitional terms, which the SP is presumably aware of, but as an explication of the emergency treatment that had been administered by the team and the medical reasoning behind it (Lines 32 – 34, 36 – 39 & 41), stating “they inserted a wire into you... to remove- like to: (.) (op-) remove like the obstruction... So- to allow your heart to: regain the blood supply.” With reference to Excerpt

18 (involving the same SP), the student also continues explaining the surgical intervention after delivering the diagnosis (Lines 20 – 21), saying “what we’ve done for you is we’ve actually did a procedure to insert um: something to to relieve the .h the: blockage of your artery in your heart la. To get the blood flowing again” (Lines 21 – 25).

In contrast, the same SP in Excerpts 18 and 23 approached the simulated consultation in Excerpt 24 with a different position in relation to his knowledge of the diagnosis. In Line 41, he claims that “they” have already told him the diagnosis, but nevertheless requests for an update in Line 46 on what has happened to him. This did not change the conversational trajectory, however, for the student goes on to talk about the emergency treatment after acknowledging the SP’s lack of awareness regarding what had transpired (Line 47). She informs him, “So (.) what they did was is they put a stent to your heart? And then they open up the vessels so that blood can flow a’gein. A:nd to allow your heart to pump (uh).” (Lines 52 – 54 & 56), and explains the biomedical reason for the heart attack as “there was a clot that was blocking the vessels.” (Lines 59 – 60), and that “your heart didn’t receive enough oxygen. So: (0.4) um: your heart couldn’t pump (.) already so what they did was to jus: (0.4) uhh: (0.5) just unblock it lah:.” (Lines 71 – 72 & 74 – 76).

From the examples so far, it appears that an overarching organisation in the delivery of patients’ diagnoses/conditions exists across scenarios only if the task requirements are contextually similar. In this regard, the conversational trajectory is virtually uniform across Stations 1A, 2A and 3A because the delivery and explanation of a given diagnosis/condition features strongly (or more accurately, is understood by students to feature strongly) in all three. While each student and SP formulates his/her utterances differently, perhaps even bringing individual idiosyncrasies to the table, there are structural similarities that transcend the person and allow for talk to be produced in a given manner. In contrast, although the students who performed Station 3B also delivered the diagnosis of heart attack, they chose

not to explicate what it means or entails, and instead elaborated on the treatment procedures administered. This suggests that they have effectively oriented to the situational needs of the SP in yearning to know what he has undergone in the wake of this life-threatening episode. While at least two alternative reasons are possible: (1) the students think a heart attack does not warrant further explanation because most people know what it is; and (2) they believe it is more pertinent to narrate the treatment given because it is a greater emergency than the rest of the illnesses; these do not adequately account for the ‘omission’ since those assigned Station 3A went ahead with their explanations anyway despite it featuring the same event.⁴

Before advancing to the latter half of the consultation, I would like to make a separate note on the relationship between patient *diagnosis* and *condition* and their importance relative to each other. As previously described, many of the scenarios require students to deliver an exact diagnosis (be it final or provisional), while some others require focus on the current condition of the patient. Yet conceivably, and as shown by the data, SP/SRs are not merely concerned with diagnoses, but are also interested in their own/next-of-kin’s conditions. This is the case even for consultations where the framing of the scenarios draws spotlight predominantly to the diagnosis, as in the next two excerpts.

Excerpt 25. Station 1A/Team III Student 3: 01:41 Delivery & Explanation of Diagnosis Misaligned (Initially) with SP’s Concern

71	Med Student	:	So (0.3) basically (0.4) we’ve noticed that you’ve
72			been having like dengue fever. °°(Like)°° [()]
73	Sim Patient	:	[Wha-]
74			↑What? I’m having dengue fever?= ↑What?
75	Med Student	:	=Mm.
76			(0.8)
77	Sim Patient	:	↑Oh iz↑zit?
78	Med Student	:	Yeah.
	...		...
88	Sim Patient	:	°Mhm° because I heard that .hhh >you know people<
89			actually die from dengue fever?

⁴ This does not mean that students in Station 3A substituted their accounts of the emergency treatment with explanations of the diagnosis; notwithstanding the diagnostic explanations, these cases still contained elaborate treatment descriptions.

90 Med Student : Ohkay.=
91 Sim Patient : =<Ya:h:>.
92 Med Student : >°Yah.°<=
93 Sim Patient : =S-so is it I'm I'mm-in a very serious condition
94 ↑now?
95 Med Student : Okay so ↑like basically like dengue: (0.3) can
96 present in people different ways.
97 Sim Patient : Uh-↓huh.
98 Med Student : So sometimes it can be like quite mild in people
99 like, >you can have a< dengue (0.2) like, (0.2) >you
100 can have a dengue< infection but you might not be
101 very unwell but [with some people they- (0.2) they
102 Sim Patient : [°Mmm::..°]
103 Med Student : just tend to get more sick with it.
104 Sim Patient : Uh::: so so (0.3) um ↑mine i:s:: what kind of, (2.0)
105 so what is it going on with me no[w so I'm (oh)]
106 Med Student : [Oh kay.]
107 Sim Patient : I mean because you did mention some is mild, some
108 is not so so what about me?
109 Med Student : Okay so [for you:] (0.2) we noticed that your fever
110 Sim Patient : [Uh huh.]
111 Med Student : is pretty ↑high?=
112 Sim Patient : =Mhmm.=
113 Med Student : As well as like you have- (0.3) your heart rate is
114 quite (.) ↑fast [so] there's some things that
115 Sim Patient : [>Okay.<]
116 Med Student : like we're concerned about [tha]t's why we (.) we're
117 Sim Patient : [Mm.]
118 Med Student : admitting you as well like- >°because° we'd like to<
119 monitor you (0.4) [like ju]st check on you as you
120 Sim Patient : [°Oh.°]
121 Med Student : like- (0.2) yeah as you recover.

Excerpt 26. Station 3A/Team 1 Student 5: 00:53 Delivery & Explanation of Diagnosis Misaligned with SP's Concern

34 Med Student : So what has happened already to him is uh:: like
35 what you said?
36 Sim Relative : °Mmm.°
37 Med Student : It's an acute myocardial infarction. (.)
38 [>Otherwise]
39 Sim Relative : [°Mmm.°]
40 Med Student : known< as a <heart attack>.
41 Sim Relative : °Okay.°
42 Med Student : Okay? So (.) is- maybe- mmm >you could tell me< do
43 you- uh (.) what do you >actually< know about heart
44 attacks.
45 Sim Relative : My grandfather passed away from that.
46 Med Student : OH: okay, °yah°. So:: (.) do you know what it- it-

47 it's due to?
48 ((pen clicks)) (0.4)
49 Sim Relative : Uh:: [N°o::..°]
50 Med Student : [Not really] °ah↓°. Okay, no worries °uh°. So
51 a ↑heart attack happens: when your heart doesn't get
52 enough blood to pump. (.) Um- um- m- m- m- it does
53 not get enough um blood supply >it needs< so that
54 it can [pump the blood].
55 Sim Relative : [Bu- But how is] my father's condition now?
56 Med Student : ↑Oh okay. Yah, [so currently]-
57 Sim Relative : [because they] told me: he was in
58 the CCU.
59 Med Student : Ah:: yes yes yes I understand. So >currently< your
60 uh- what was done for your father- so what happened
61 was that >he came in< with thi:s (.) uh=
62 Sim Relative : =Mmm.=
63 Med Student : =<chest pain> °right°.=
64 Sim Relative : =Mmm.
65 Med Student : So we put- (.)so he was sent to the <A&E> and we:
66 um: <did an ECG> (.) >which is actually< um electro-
67 uh- uh- it's a machine that actually records: .hh
68 um: your heart <activity>.
69 Sim Relative : Okay [okay.]
70 Med Student : [Yes.] And we found that he actually had what
71 we call uh °uh uh° ST elevation (.) >myocardial
72 infarction.< Basically it's a >heart attack< [that]=
73 Sim Relative : [Mmm.]
74 Med Student : =re[quires]=
75 Sim Relative : [Mmm.]
76 Med Student : =<e:mergency treatment>.

In Excerpt 25, after the diagnosis has been established (Lines 71 – 78), the SP reveals that she lives in a dengue hotspot (lines omitted) and brings up the possibility of dying from dengue fever (Lines 88 – 89). At this juncture, she raises the concern “=S-so is it I'm I'mm-in a very serious condition ↑now?” (Lines 93 – 94), displaying not just great anxiety, but more importantly, keen interest in her present condition rather than the medical diagnosis. The student, however, falls short of orienting to the SP's needs and instead delivers a general account of the disease's possible prognosis (Lines 95 – 96, 98 – 101 & 103). Unsatisfied with the explanation, the SP follows up with an upgraded demand for an answer, “Uh::: so so (0.3) um ↑mine i:s:: what kind of, (2.0) so what is it going on with me now so I'm (oh) I mean

because you did mention some is mild, some is not so so *what about me?*” (Lines 104 – 105 & 107 – 108; emphasis added). Only then did the student supply the SP’s desired information about her condition adequately, stating “your fever is pretty ↑high?” and “your heart rate is quite (.) ↑fast” (Lines 109, 111 & 103 – 104), using it to justify the hospital admission (Lines 114, 116, 118 – 119 & 121).

For Excerpt 26, the diagnosis has already been mentioned previously at the start of the consultation (omitted), but the student reiterates it ‘formally’ where the extract begins (Lines 34 – 35, 37 – 38 & 40). He goes on to establish the SR’s prior knowledge of heart attacks in preparation for his explanation of the diagnosis (Lines 42 – 44). Instead of replying him with an account of medical facts or the lack thereof, the SR reports that her grandfather passed away from it (Line 45). Rather than respond empathically, the student pursues his question further (Lines 46 – 47), receiving a negative reply (Line 49). He then persists in explaining the diagnosis factually (Lines 50 – 54). At this point in time, the SR voices her actual concern in Line 55, “Bu- But how is my father’s condition now?” Unlike Excerpt 25, however, the student here totally misses the focus of the question on the patient’s present state-of-being and returns to a diagnosis-centric explanation, chronicling the emergency treatment given to the patient (Lines 59 – 61, 63, 65 – 68) and repeating the diagnosis with jargon, “ST elevation (.) >myocardial infarction.< Basically it’s a >heart attack< that requires =<e:emergency treatment>.” (Lines 70 – 72, 74 & 76).

These two examples reveal that patients may at times be more concerned with their condition than their diagnosis; it thus follows that the need to deliver and explain the former may supersede the latter in certain circumstances. Rather than being overly methodical with their consultations, or seek merely to fulfil stipulated task requirements, students ought to be mindful of their interlocutors’ actual needs at the moment—both factually and emotionally—as the interaction progresses. This issue will be further explored in Section 3.2.1.

3.1.2 *Explaining the Diagnostic/Treatment Plan*

Once doctors have informed patients of their diagnosis or condition and supplied them with an adequate explanation of it, it follows naturally that both parties would proceed to discuss the next medically-relevant course of action. This could involve either a diagnostic plan, in the case where further clinical tests need to be administered to ascertain the diagnosis; or a treatment/management plan to treat/manage the condition, which may equally include test measurements for long-term monitoring purposes in a real-world situation. Each scenario in the CCP contains a certain element of this built into the task requirements. However, to focus on the situation where a diagnostic/treatment plan is discussed with an SP/SR after the delivery of the diagnosis/condition, Stations 1B and 2B cases are excluded in this subsection.

Of the relevant scenarios, the only one that involves the explication of a diagnostic plan is Station 2A, where the students' tasks are to deliver the provisional diagnosis of acute appendicitis to the SP and explain to her the team's plan of arranging a CTAP to confirm the diagnosis. Another important matter to discuss with the SP is the surgical intervention that will take place once appendicitis has been confirmed, which was not explicitly mentioned in the vignette but recognised by both students and SP as a critical topic in this context. A straightforward example of a diagnostic plan discussion is found in the excerpt below.

Excerpt 27. Station 2A/Team II Student 1: 02:04 Explanation of Diagnostic Plan

80	Med Student	:	So .hh ur:m (0.8) ya:hh (0.4) so (0.7) °uh-° it is a
81			possible appendicitis, .hh so we'll need to double
82			check (0.3) that it is appendicitis before you
83			actually (.) move on to .h for example putting it
84			in:uh doing surgery or doing any drains.
85	Sim Patient	:	<Surgery> ah.
86	Med Student	:	Okay so >let's-let's-let's< take this one at a time.
87			So firstly .h what I need to do step one, (0.3)
88	Sim Patient	:	Mm.
89	Med Student	:	IS: (0.3) confirm that you have appendi°citis°.
90	Sim Patient	:	How to confirm.
91	Med Student	:	'Kay t(hh)o confirm appendicitis >we need to do a<
92			scan.

93 Sim Patient : °Oh[h:..°]
94 Med Student : [Of] you:r uh: abdomen. Have you heard of a C-T
95 scan °before°?
96 (0.6)
97 Sim Patient : Uh:: hh roughly ↓la. [But °not very sure°.]
98 Med Student : [Oh roughly uh.]
99 .h So have- you know you take X-ray just now right?
100 Sim Patient : >Uh uh uh uh.<
101 Med Student : So a C-T scan is a bit like X-ray [but] X-ray is
102 Sim Patient : [Orh.]
103 Med Student : one picture? C-T scan is >many many many< pictures
104 so you can see you:r(.) .hh your stomach in three
105 dimensions.=
106 Sim Patient : =Or[h:..]
107 Med Student : [Uh] So like 3-D scan. ↑So .hh what happens is
108 that they will put you through something like a
109 donut? So you'll have to lie down, (0.5) um and
110 then .hh (.) uh: they'll do a quick sca:n, .hh (0.4)
111 to check-to see your abdomen. It's very fast and
112 it's very safe.
113 Sim Patient : ↑Oh:.. Oh: okay.
114 (1.3)
115 Med Student : Uh so uh: la- (.) later before you go for that the
116 radiologist will tell you more about it, (0.5)
117 Um have you ever done something like this before?
118 Sim Patient : No:..=
119 Med Student : =No. Okay. So the C-T scan will allows us to double
120 check, tha:t um it is appendicitis.=
121 Sim Patient : =Oh[:]
122 Med Student : [Okay] so that's step one. Any questions?
123 Sim Patient : °Mmm:° (0.4) °no:..° So when do I go for the C-T scan.
124 Med Student : Um: .hh (0.5) so:- (0.3) that one <will have to>
125 double check to see when the radiology department is
126 free,=
127 Sim Patient : Oh[:.]
128 Med Student : [But] should be sometime tonight.
129 Sim Patient : Oh[:] okay.
130 Med Student : [Mmm.]
131 (0.9)

In Excerpt 27, the student first introduces the topic of diagnostic testing by explaining that the suspected appendicitis has to be confirmed before any further intervention can be done (Lines 80 – 84). However, her mention of surgery as a possible treatment (Line 84) causes some alarm for the SP, who reiterated the procedure to seek verification (Line 85). Realising that she may have jumped the gun and prematurely invited a question which would

be discussed later anyway, the student attempts to regain control over the progression of the conversation by stalling the issue with “Okay so >let’s-let’s-let’s< take this one at a time.” (Line 86). Her succeeding utterance, “So firstly .h what I need to do step one, (0.3) IS: (0.3) confirm that you have appendi°citis°.” (Line 87 & 89), creates a framework for her subsequent delivery, casting it as structurally tight and therefore perhaps less amenable to interruptions. Yet this did not stop the SP from asking the next logical question, “How to confirm.” (Line 90), which nevertheless provided the student with an opportunity to introduce the diagnostic test and forward her agenda. She presents the need to conduct a CT scan (Lines 91 – 92 & 94), followed by a question to establish the SP’s background knowledge of it (Lines 94 – 95). When the SP claims uncertainty (Line 97), the student explains the CT scan by relating its similarity to an X-ray (Lines 99, 101, 103 – 105), assumed to be a scan more highly recognisable by laypeople and which the SP has supposedly taken (as specified in the vignette). In analogising “X-ray is one picture” to “C-T scan is >many many many< pictures” (Lines 101 & 103) and invoking the commonly understood notion of “3D” (Lines 104 – 105 & 107), she leverages upon the existing laic schema of the SP to simplify a more advanced concept unsophisticatedly.

Next, the student briefly runs through the procedure of the CT scan (Lines 107 – 111) and provides the SP with reassurance (Lines 111 – 112 & 115 – 116). At this juncture though, she asks a question, “Um have you ever done something like this before?” (Line 117), where the answer could have been assumed to be “no”, since the SP has already expressed unfamiliarity with it in Line 97 previously. Expectedly, the SP’s response comes in the negative (Line 118), to which she reiterates the value of the scan in confirming the diagnosis (Lines 119 – 120). Finally, the student attempts to close the topic by invoking the serial organisation of her delivery that she established at the start of the excerpt and providing an opening for the SP to clarify her doubts with “Okay so that’s step one. Any questions?” (Line

122). The explanation of the diagnostic plan then ends with a Q&A sequence on the scheduling of the scan (Lines 123 – 130).

The example above shows a relatively smooth delivery of the diagnostic plan without any major impediment to the SP's comprehension of the proposition. Before turning to a contrastive example, let us continue to look at the same student's succeeding explanation of the treatment plan in Excerpt 28 (immediately after Ex. 27), which met with a minor hiccup.

Excerpt 28. Station 2A/Team II Student 1: 03:34 Explanation of Treatment Plan

132	Med Student	:	Um: (0.6) Okay so: that's first step. Next step is:
133			IF: we confirm is appendicitis[s,] there's some
134	Sim Patient	:	[Mmm.]
135	Med Student	:	possibility it's not but we think it's very likely:.
136			.hh um then (0.3) um then: (0.7) t'urm (0.4) the
137			likely- (0.9) the <u>best</u> way to get rid of a aflamed
138			appendix is to take it <u>out</u> .
139			(1.1)
140	Sim Patient	:	↑Orh[:.] (0.8) Take out that means operation la.
141	Med Student	:	[°Mmm.°]
142			°Uh:.° (0.9) So uh: we call this an appendectomy,
143			which means taking out your appendix. It's um: (tsk)
144			(0.7) quite small- (.) it is a- (.) i:t's a
145			operation that we would do:- that we would advise to
146			do: within the f- (0.4) coming few days? .hh And (.)
147			it's- uh the most >hundred-< it's the most effective
148			way of (0.3) uh: making sure that your appendix is
149			removed.
150	Sim Patient	:	°Mmm.°
151	Med Student	:	There are other od- other options such as um: fo-
152			for example putting in a drain, .h so that has a
153			higher risk of the pain coming back and the
154			infection coming back.
155	Sim Patient	:	°Mmm.°=
156	Med Student	:	=So usually uh: what- what the team will <u>advise</u> is
157			to do appendicitis, >UH appendectomy< so because
158			there's a possibility, that you <u>may</u> be doing a
159			surgery- (0.5) uh:the next few days, if you:- >if
160			it's< appendicitis and if you agree, .h uh we'll
161			just ask you not to drink or eat anything .hh fuh
162			now.
163	Sim Patient	:	Oh[: Okay] okay.
164			[.hhh]
165			(2.2)

After concluding the explanation on the diagnostic plan, the student presents the best treatment option for appendicitis as surgical removal of the appendix. She once again evokes the systematic premise of her approach (Line 132), and provides a caveat for the next course of action (Lines 133 & 135), before proposing that “the best way to get rid of a aflammed appendix is to take it out.” (Lines 137 – 138). Her usage of the expression “take it out” proves problematic for the SP’s understanding, however. While she may have done this either in a bid to “avoid jargon”, as per generic clinical communication advice; or to avoid invoking fear in the patient, since her usage of the term “surgery” had already worried the SP previously (Ex. 27 Line 84);⁵ her inadequate calibration of language use nonetheless becomes a hindrance to mutual intersubjectivity. Following a conversationally lengthy pause of 1.1 seconds in Line 139, the SP finally comes to realisation of the referent, “↑Orh:. (0.8) *Take out* that means operation la.” in Line 140, marked by a distinctive Singlish (Singapore Colloquial English) change-of-state token “orh”.

In response, and as the next natural progression of her delivery, the student gives a brief description of the surgery. She reveals its medical name “appendectomy” (Line 142), but persists in using the same ambiguous expression that had led to the confusion when stating that it “means *taking out* your appendix” (Line 143). Also, the student only applies the SP’s own preferred term “operation” while elaborating on the recommended intervention in advocacy of it (Lines 143 – 149). Thereafter, she presents an alternative treatment procedure but quickly cites its risk of having the appendicitis reoccur, as an attempt to prevent possible uptake by the SP (Lines 151 – 154). This invites agreement from her interlocutor (Line 155), and the student closes the treatment plan discussion by informing the SP of the NBM condition (no food or fluid intake) for undertaking the surgery (Lines 157 – 162), which is stated in the vignette as part of the station requirements.

⁵ Her worry is not unfounded though; for another student’s (Team I Student 3) indiscriminate use of the word “surgery” (notwithstanding how he talked about it) led to major issues for him (see Ex. 29).

Evidentially, Team II Student 1 in Excerpts 27 and 28 executed her explanation of the diagnostic and treatment plans methodically according to an organised structure that emerged from the need to address an ‘untimely’ question from the SP at the beginning of Excerpt 27. Her meticulous approach notwithstanding, some navigation work was still required around a few instances of problematic talk in her delivery, but the overall organisation nonetheless culminated in a successful discussion with the SP. I will return to this consultation in the next chapter to corroborate the observations brought up in the feedback discussion segment of this session with the analysis here. In the following example though, also involving Station 2A and the same SP, the consultation with Team I Student 3 proceeded with greater challenge.

Excerpt 29. Station 2A/Team I Student 3: 02:09 Explanation of Treatment Plan

80	Med Student	: So right <now:> um our plan is (0.3) well um:
81		there's: (.) there's two things I need to tell you
82		about? Firstly there's a- (.) we need (to) do a
83		s-sca:n? (0.3) to the- to <u>JUST</u> to make sure: there's
84		no ↓complications? And number two: is the: surgery
85		itself okay?
86	Sim Patient	: < <u>SUR</u> gery uh.> ((Slightly dropped jaw))
87	Med Student	: Okay. So I will go through the surgery first,
88	Sim Patient	: °Orh:..°
89	Med Student	: So um: >are you okay< so far?
90	Sim Patient	: Oka:y. > <u>I'VE ALREADY DONE</u> THE BLOOD TEST and X-ray
91		what<.= ((Raises left hand pointing index finger))
92	Med Student	: =Mmm.
93	Sim Patient	: °Ah:..°=
94	Med Student	: =So th[e-]
95	Sim Patient	: [(Th)en) >MY RESULT LEH<?
96	Med Student	: Okay. So: the blood test and X-ray what it's- (.)
97		>it's just a< (.) some general test? to check your
98		(.) blood levels?= 99 Sim Patient : =°Uh huh.°= 100 Med Student : =to check (.) um: is there any infection going on 101 and things like this. So >from the blood-< it's from 102 the blood test (.) and the X-ray that's why we think 103 that >it is< appendicitis. 104 Sim Patient : °Orh:°= 105 Med Student : =And that's why we are: (.) >we are able< to advise 106 you to go for surgery:, 107 Sim Patient : < <u>SUR</u> [gery]> so serious ↓ah? 108 Med Student : [°Mmhmm.°]

109			↑Okay. so um: (.) so what this surgery is? is that
110			(0.3) uh it's called an <appendecto[my:?>]
111	Sim Patient	:	[Mmm.]
112	Med Student	:	So what is going on is that the surgeon is going to
113			remov- um: to: (.) help you to remove your appendix.
114	Sim Patient	:	°Mmm.°=
115	Med Student	:	=Um: the reason why we do this is (.) um: .hh (0.2)
116			while appendis- (.) while appendicitis itself↓ (0.2)
117			um: >is not< (.) is not very serious, the main thing
118			is that we are afraid that the appendis- (.) the
119			appendix will bu:rst? When it burst then all the
120			<germs:> (.) all the dirty things inside will go to
121			the rest of your <belly:>. So >we do-< we don- >we
122			don't want that< okay?= 123 Sim Patient : =°Orh:..°
124	Med Student	:	<So:> the reason we are doing the surgery is to: .hh
125			>so that the surgeon< can go in there:? (.) and help
126			you to remove the appendix. (0.3) And clean up the
127			area as soon as possible. 128 Sim Patient : Orh:..=
129	Med Student	:	=Mmhhmm. (0.2) Okay. (0.2) ↑SO for the. (.) ↑SO um
130			just to: give you more ↓information? (0.4) There is:
131			(0.2) two main ways we can do it? We can do it (.)
132			either (.) <laparoscopically?> (.) or open:.. Most
133			likely it will be:: (0.2) laparoscopic. (.) so: what
134			this is is ↓that (.) the surgeon will make (.) four
135			small cuts:? (0.3) then (0.2) he will: >through this
136			cuts there will be< some tubes going in:? and a
137			camera. (0.2) So >the sur- the camera< he can look
138			around? (0.2) then he can help you: he can see where
139			to <cut (0.2) and also: how to ta- >and to take out
140			the< appendix. 150 Sim Patient : >Painful a not?< 151 Med Student : Um:: so: um:: >we will need< to give you a couple of 152 injections:? 153 Sim Patient : °Orh:..° 154 Med Student : And: (0.3) um for- same for the: (0.4) there are 155 some injections (.) but other than that <there:> 156 should not be a lot of pain. You will be >asleep< 157 throughout the <procedure>. 158 Sim Patient : Orh:.. 159 Med Student : <Post operatively?> (0.2) there may be a small- 160 >abit of< small pain in the area? (.) because I mean 161 there was a (.) >couple of cuts< so there might be 162 SOME pain. 163 Sim Patient : Orh:..= 164 Med Student : =BUT (.) we will um: (0.2) we will help you >get 165 through the pain la:< (0.3) (try) using <pain

166		killers:> and °these type of things°.
167	Sim Patient	: ↓Oh: ↑okay.
168	Med Student	: Okay. So I: mentioned ↑ <u>laparoscopic</u> . The other way
169		is >is open<. So >there will just be< one: (.) one
170		cut there. So based on the surgeon he will choose
171		which one (.) is: >is <u>better</u> :<. (0.4) Most likely
172		>it'll be< laparoscopic because that will help you
173		to heal <faste:r>.
174	Sim Patient	: Oh:.
175	Med Student	: °So far do you have any questions?°
176	Sim Patient	: ↑After surgery I'll be cured.
177	Med Student	: Mmm: okay. ↑So: um. (0.3) So- (.) so- this surgery
178		is curative. (.) <u>What</u> it does is that (.) it will-
179		(.) it's to remove your appendix (0.3) which is the
180		one causing all the <problems>.
181	Sim Patient	: °Mmhmm.°
182	Med Student	: So after surgery you may need <u>to</u> : stay in the
183		hospital (.) just for observation? (.) fo:r say um:
184		(0.2) a couple of <days:?> depending? <and:> (0.3)
185		this will just make sure there's no complications la
186		like (.) as in make sure your wounds heals <fine:>
187		(.) make sure there's no <infection:>.
188	Sim Patient	°Mmm.°
189	Med Student	: That (sort) (.) these things. Is that okay with you?
190	Sim Patient	: °Mmm ↑okay.° Then ↑<when when> can the operation be
191		done.
192	Med Student	: Um so for this I'll: >I'll: need to check with< the
193		team >when exactly it can be <u>done</u> :<? But. we will
194		try to do it as soon as possible. (.) to prevent
195		complications.
196	Sim Patient	: °Mmm:..°

Excerpt 29 begins with the student using the signposting technique to indicate his intention of explaining the medical team's plan for the SP. In a similar fashion to Team II Student 1's approach, he constructs a step-by-step framework for the delivery (Lines 81 – 82) and lists the diagnostic and treatment plan in sequential order (Lines 82 – 85). Again just as in Excerpt 27, the SP picks up on the mention of surgery and repeats, “<SURgery uh.>” (Line 86), with a slightly dropped jaw. Unlike Excerpt 27 though, the student produces a response ineffective in managing the exigency. While his expression shows some orientation to her

In the face of this fleeting pique, the student addresses the SP's question calmly and asserts that the diagnosis and the team's advice to undergo surgery is based on the blood test and X-ray results (Lines 101 – 103 & 105 – 106). Nevertheless, the SP still raises doubt about the necessity for surgery with “<SURgery> so serious jah?” (Line 107), to which the student begins a delivery of what the surgery is about and the medical reasoning behind the decision to operate on her, introducing the medical term “appendectomy” and the goal of preventing further infection (Lines 112 – 113, 115 – 122 & 124 – 127). Having evidently misunderstood the requirements of the station, which emphasis is on the diagnostic rather than the treatment plan (see Appendix B for vignette), he proceeds to provide elaborate details about the surgery, citing two kinds of appendectomy that can be performed, and expounds on the procedures of the first (Line 129 – 140). Before he could continue with the second type, the SP brings up two questions to clarify on a step mentioned (lines omitted) and about whether it will be painful (Line 150). This leads to successive Q&A side sequences (Lines 141 – 167) flanked by information giving on the two surgical methods, as the student goes on to talk about the other type of appendectomy (Lines 168 – 173). In closing, he opens up the floor for further questions (Line 175), which invites the SP to probe if she will be cured after surgery (Line 176). The student replies positively (Lines 177 – 180) and seeks her opinion on post-surgery ward stay (Lines 182 – 187 & 189). Seemingly satisfied with his response, the SP inquires when the operation can be done (Lines 190 – 191), signalling her readiness for it. Finally, the present discussion ends with the student giving the SP reassurance (Lines 192 – 195).

As can be seen from the length of the excerpt, the treatment plan explanation in Excerpt 29 is considerably long-drawn-out as compared to that of Excerpt 28, which features both the same SP and scenario. From the analysis, it turns out that the protracted exchange is partly due to the student having committed a faux pas in deciding to discuss the treatment plan before the diagnostic plan, in a context where preliminary diagnostics have already been

performed, but confirmation with another test is required to determine the diagnosis conclusively. The lack of a proper account for, and transition to, the sudden news of surgery led to the SP exploding in Lines 90 to 91 and 95. While it is impossible to entirely prevent the SP from flaring up at any given moment, presenting the innocuous diagnostics before the invasive treatment is likely to circumvent the problem as the rationale for the latter emerges naturally and clearly. In fact to begin with, it is stated in the vignette that students undergoing Station 2A are supposed to focus on informing the SP about the diagnostic plan to arrange for a CT scan and the requirement of NBM. Yet not only is the student's delivery procedurally problematic, he also mistakenly prioritises his explanation of the surgery over the scan and ends up supplying too much unnecessary information about it. Moreover, in comparison with Team II Student 1, there is significant hedging in her explanation that helped mitigate the SP's emotional escalation. For instance, she asserts that the scan is "to double check (0.3) that it is appendicitis" before "doing surgery or doing any drains." (Ex. 27 Lines 81 – 84), tries to contain the situation by saying, "Okay so >let's-let's-let's< take this one at a time." (Ex. 27 Line 86), and presented the operation as being conditionally applicable with "IF: we confirm is appendicitiss" (Ex 28 Lines 133 & 135 – 138). On the contrary, Team I Student 3 merely mentioned in Excerpt 29 that the scan is "JUST to make sure: there's no ↓complications?" (Lines 83 – 84). Taken together, these factors likely led to the unpleasant episode. As it so happens, his oversight is picked up by the facilitator during the feedback discussion (see Chapter 4). Before looking at other cases, the next excerpt presents the second half of his consultation (immediately following Ex. 29) on the diagnostic plan.

Excerpt 30. Station 2A/Team I Student 3: 05:31 Explanation of Diagnostic Plan

197	Med Student	: Um there <u>ARE</u> a couple of- (.) there <u>ARE</u> a couple of
198		things that we need to: (.) >to do< beforehand?
199		(0.3) So um: firstly? We need to keep you: (.) um:
200		>we need to keep you nil-by<-by mouth? for the- (.)
201		from now until the surgery. So <u>WHAT</u> this means is

202 that (sw-) (.) uh you can't- >we can't let< you eat
203 or drink °first°? (.) for this time period.

204 Sim Patient : °Oh:..°

205 Med Student : The reason behind this is that (.) because (.)
206 remember I said we'll be giving you the: (.) >some-
207 some< medicine to help you sleep?

208 Sim Patient : °Mmhm..°

209 Med Student : So um: (.) we are afraid that if you would eat
210 anything? (.) this: (.) <then: when> you go to
211 sleep? you may vomit it out and that will cause
212 >problems for your-< problems for your lungs.

213 Sim Patient : °Mm:..°
214 (0.4)

215 Med Student : Okay?

216 Sim Patient : °°Kay.°°

217 Med Student : Okay: um so: ↑secondly? (.) What >we also need< to
218 do is this thing called a <C-T scan>. Are you
219 familiar with it?

220 Sim Patient : No. (0.3) I've DONE the >X-ray already what<.=

221 Med Student : =Mmm. ((Nods in acknowledgement))
222 So a C-T scan is actually a (.) bit more sensitive
223 than a X-ray? (0.2) It allows you to see like the
224 <soft tissues:> (.) the structures in greater
225 detail.

226 Sim Patient : °Mmm..°

227 Med Student : >So we're doing this< to check for any
228 complications: (0.3) <of the:> appendicitis? (0.2)
229 or maybe any other cause of it.

230 Sim Patient : °Mmm..°

231 Med Student : Um for example have you seen in: (.) um: let's say
232 any <shows or movies before:> the- (.) there's this
233 um circular thing? (.) Like a doughnut? And the
234 patient will slide- (0.3) will: >lie on a table<
235 and go inside it? Have you seen that machine before?
236 (0.5)

237 Sim Patient : I think so uh.

238 Med Student : Yes. So that is: >similar to-< that is what C-T scan
239 is.

240 Sim Patient : Orh:..

241 Med Student : So: you'll be um- so just lie on <table>? Then
242 you'll go into this (.) this <long> machine. Inside
243 this <machine?> there will be um (0.2) they will
244 take several pictures of- SEVERAL pictures? (.) and
245 several cuts? [to] get the image of your body:,

246 Sim Patient : [°Mmm..°]

247 Med Student : So this is just to double check (0.4) um (.) are
248 there complications? Like (.) earlier I mentioned
249 the: <burst appendix?>

250 Sim Patient : °°Orh..°°

251	Med Student	: OR maybe (.) >is there< any other (bleeding) or any
252		other cause for the: for the pain you been having.
253	Sim Patient	: °Orh:..°

In Excerpt 30, the student turns his attention to the actual task requirements of the simulation that has been put aside thus far by employing a step-by-step approach, albeit not having gotten the overall sequence right previously. First giving a signpost (Lines 197 – 198), he then communicates the NBM condition using the medical jargon itself but explains it in lay terms thereafter (Lines 199 – 203), casting it as foremost in the list of matters to be settled before surgery. Next, he explains the rationale of the measure (Lines 205 – 207 & 209 – 212), which appears to be accepted by the SP (Lines 213 & 216). Following this, he brings up the CT scan by listing it serially as the second task to be done (Line 217). Before proceeding, he attempts to establish the SP's prior knowledge of the diagnostic procedure (Lines 218 – 219). The SP replies negatively and retreats to her original position during her gripe in the previous excerpt, "I've DONE the >X-ray already what<." (Line 220). Once again unfazed, the student acknowledges her viewpoint verbally and gesturally (Line 221). He advances by clarifying the purpose of the scan (Lines 222 – 225) and explaining the underlying reason for conducting it (Lines 228 – 229). After a feeble attempt at describing the appearance of the machine (Lines 231 – 235), which met with a delayed acknowledgement (Lines 236 – 237), the student supplies more information about the scanning process (Lines 241 – 245) before closing his delivery by reiterating the objective of the scan (Lines 247 – 249 & 251 – 252).

Apart from the critical error in the previous excerpt, the student's performance in this latter part of the consultation is significantly smoother, if considered in isolation. By laying out the two points he needed to address, he creates a methodical framework for the SP to understand the diagnostic plan easily, just as per Team II Student 1's case (Ex. 27). At a more miniscule level of organisation, giving an explanation of each matter and supplementing it with the appropriate medical reasoning after broaching the topic proved to be effective in

influencing the SP to accept the proposition. In the next few excerpts, I present other examples of the treatment plan discussion across the rest of the scenarios.

Excerpt 31. Station 1A/Team II Student 5: 02:16 Explanation of Treatment Plan

88 Med Student : ↑So dengue generally most cases of dengue are quite
89 mild (.) [like] (.) they present like how you're
90 [Mm.]
91 presenting and uh the treatment plan is actually uh
92 very simple we are going to admit you,=
93 =Mm mm.=
94 and then uh we going to give you something for your
95 fever,
96 Sim Patient : °Mm.°
97 Med Student : and then: (0.4) like like uh Panadol like that
98 °lah°. But the most important thing of why you admit
99 WHY you have to be admitted is because we have to
100 GIVE you (0.4) we have to like hydrate you lah.
101 Sim Patient : °Oh.°=
102 Med Student : =So we'll put °uh° (0.6) °uh° IV (line) uh like a
103 (0.4) like a needle or a- a little tube inside and
104 the we'll (.) be able to put um (0.9) °uh° like
105 fluids into you so you stay hydrated.
106 Sim Patient : It's it's not done during my admission you know
107 these >I mean< those that you mentioned it's not
108 done during my admission so
109 [is it a bit like ()]
110 Med Student : [Because now that we are] su:re that um it's dengue
111 THEN we can proceed to give you this treatment.=
112 Sim Patient : =Oh [okay,]
113 Med Student : [So.] (0.3) do you have any questions or
114 CONCERNS about that.

Excerpt 32. Station 3B/Team I Student 6: 04:13 Explanation of Treatment Plan (Medication)

171 Med Student : =So for your case right what we need to do is to in
172 order to control this [right] we need to give you
173 [Mm.]
174 Med Student : some medication.
175 Sim Patient : Orh::.=
176 Med Student : =So remember there's- right now right you are on
177 four (specific) medication.
178 Sim Patient : Okay,
179 Med Student : You don't need to know the name for [now la but] I
180 [Mm mm.]
181 Med Student : will just- it will be better for me to describe.
182 Sim Patient : [Mm.]

183 Med Student : [>Okay so<] two medication is for your high: .hh um:
184 (.) g- one medication is for your high blood
185 pressure,=
186 Sim Patient : =Mm.
187 (0.4)
188 Med Student : one medication is for your: .hh high cholesterol,=
189 Sim Patient : =Mm.
190 (0.4)
191 Med Student : and two more medication is to .hh (0.3) thin your
192 blood.
193 (0.5)
194 Sim Patient : Okay,
195 Med Student : So- (0.3) there's three main categories right. [So]
196 Sim Patient : [Mm.]
197 Med Student : (0.3) first (0.7) um one medication is called
198 known as the (0.5) Enalapril,
199 Sim Patient : Mm:..
200 Med Student : This is for your blood pressure. [>It reduces<] your
201 Sim Patient : [Okay.]
202 Med Student : blood pressure [in the long] run .hh (.) an:d uh:
203 Sim Patient : [Okay]
204 Med Student : this will actually reduce the disruption as I s-
205 said.
206 Sim Patient : Okay.
207 Med Student : Mm. (0.3) Then the second megi- medication is known
208 as uh: to stop your (0.6) l: blood cholesterol from
209 going higher and higher, [as-] (0.3) it's known as
210 Sim Patient : [Mm.]
211 Med Student : the Simvastatin.=
212 Sim Patient : =Mm.
213 (0.5)
214 Med Student : So this is also in:: used to reduce the cholesterol
215 Sim Patient : Mm[:.]
216 Med Student : [↑The last] two medication which I've not spoken
217 un[till now] is that (.) is known like as blood
218 Sim Patient : [Mm.]
219 Med Student : thinners.=
220 Sim Patient : =Mm.
221 Med Student : So (.) imagine in your blood if- (0.4) there's-
222 there's a something known as >lik'uh< protein that
223 would stick together,
224 Sim Patient : Mm.
225 (0.3)
226 Med Student : and this can activate like a clot formation, (0.5)
227 so while we are trying to do is to stop this um
228 (0.5) process from going on >so (0.4) uh: it's to-
229 (.) also reduce (0.3) um (.) clotting in the long
230 run and then (back) in turn the heart attack ↑lah.

Excerpt 31 shows how a straightforward approach to presenting the treatment plan may look like. The student begins with a preface, “uh the treatment plan is actually uh very simple” as a signpost for his ensuing talk (Lines 91 – 92). He next outlines a course of action involving hospital admission and Panadol prescription (Lines 92, 94 – 95 & 97 – 98), before informing that the main reason for the ward stay is to provide hydration (Lines 98 – 100) and then supplementing a description of the intravenous procedure (Lines 102 – 105). When the SP protests that she has yet to receive all these treatment (Lines 106 – 109), the student replies that they were not given because the diagnosis was previously unverified, but can now be administered with dengue confirmed (Lines 110 – 111). The excerpt ends with an offer to answer further questions (Lines 113 – 114), signalling a closure of his intended delivery.

In Excerpt 32, the student uses a stepwise method to explain the different medicines prescribed to the SP. Just before the excerpt, the student has clarified the relationship between heart attacks and high cholesterol as well as hypertension, in response to his question about it. Therefore, in Lines 171 to 172 and 174, the student latches onto the topic in conveying information about the medication, reasoning that the prescription will control these conditions. She flags as a reminder four medicines to be taken (Lines 176 – 177), providing a caveat that the SP need not be familiar with the drug names even though she will describe them (Lines 179 & 181). This may be to prevent overtaxing the SP with unnecessary jargon, and perhaps also to avoid giving the facilitator and other students the impression of doing so. Next, she provides the purpose of each medicine (Lines 183 – 185, 188 & 191 – 192) by placing them into three categories (Line 195) and using their names while explaining the details of each in the same order as before (Enalapril: Lines 197 – 198, 200, 202, 204 – 205; Simvastatin: Lines 207 – 209, 211 & 214; blood thinners: Lines 216 – 217, 219, 221 – 223 & 226 – 230). The SP appears to understand her structured description well enough, for his subsequent questions (not shown) concern how long he has to take the medicines rather than her delivery itself.

For Station 3A, instead of presenting the immediate treatment to be provided, students are expected to explain retrospectively the emergency treatment that has already been given to the SR's father after he arrived at the hospital's emergency department, as well as the long-term management plan in place for him. These tasks are all inferred from the instruction, “*your registrar has asked you to update Ms Tan and explain to her the team's plans*” and the situational context of the simulated consultation, rather than being outright stated. Excerpt 33 shows an example of the first expected undertaking.

Excerpt 33. Station 3A/Team III Student 1: 02:21 Explanation of Treatment Given

97	Med Student	:	=Um so there <u>is</u> a risk it will happen again =However
98			(0.4) uh currently he's been- he's been treated so I
99			just tell you what he was treated [uhh] for, .hh
100	Sim Relative	:	[°Mm.°]
101	Med Student	:	So basically we gave him some blood thinners,=
102	Sim Relative	:	=Okay.
103	Med Student	:	and what we did was that (0.7) um: we inserted (0.5)
104			uhh: we did <u>this</u> : uh procedure [called a]
105	Sim Relative	:	[°Mm. °]
106	Med Student	:	percutaneous: coronary intervnet- which is ↑basically
107			.hh um: we inserted uhh: >(kind of)< a stent (.)
108	Sim Relative	:	°Mm.°=
109	Med Student	:	=into the blood vessel that was clogged. [Just to]
110	Sim Relative	:	[Okay.]
111	Med Student	:	open it up=
112	Sim Relative	:	=Okay.=
113	Med Student	:	=to allow blood to go through [<u>there</u>] to: (0.4) um
114	Sim Relative	:	[Okay.]
115	Med Student	:	to supply the heart again.
116	Sim Relative	:	Mm.
117	Med Student	:	°Yes° .hh So um: >yah so-< basically after that
118			your father was quite stable, we checked [his uh:]
119	Sim Relative	:	[Okay.]
120	Med Student	:	.hh his blood pressure[::] .hh >and everything
121	Sim Relative	:	[Okay.]
122	Med Student	:	else and we noticed that everything was fine that's
123			why he was< transferred back to the general ward.
124			[So he's] stable now and we put him there for
125	Sim Relative	:	[Okay.]
126	Med Student	:	observation.

The excerpt begins in Line 97 with the student answering the SR's query on whether the patient's heart attack would occur again (not shown), which follows her earlier delivery and explanation of the diagnosis. However instead of elaborating on her answer, the student pivots to providing an account of the emergency treatment administered. After prefacing his narration with a signpost (Lines 97 – 99), she pronounces that the treatment involved giving the patient blood thinners (Line 101) and a stenting procedure (Lines 103 – 104, 106 – 107 & 109). Interestingly, the student abandons the use of medical jargon midway through her talk, “uhh: we did this: uh procedure called a percutaneous: coronary interv^{et}” (Lines 104 & 106), a repair of the preceding utterance, “and what we did was that (0.7) um: we inserted (0.5)” (Line 103), opting for the original formulation instead, “which is basically hh um: we inserted uhh: >(kind of)< a stent (.) into the blood vessel that was clogged.” (Lines 107 & 109). This is closely backed by the clausal glue-on increment (see Couper-Kuhlen and Ono 2017), “Just to open it up to allow blood to go through there to: (0.4) um to supply the heart again.” (Lines 109, 111, 113 & 115), that serves to justify the invasive intervention. The student then closes her explanation of the emergency treatment by characterising the patient's condition as “stable” following the treatment and well enough for transfer to the general ward (Lines 117 – 118, 120, 122 – 124 & 126).

The next excerpt shows the same student's delivery of the long-term treatment plan for the patient as it developed in two separate fragments of the consultation. This came about because the SR's leading question about the topic, raised according to expectations of the student known only explicitly to the SR, was not adequately addressed initially.

Excerpt 34. Station 3A/Team III Student 1: 04:24 Explanation of Treatment Plan (Long-Term)

169	Sim Relative	:	Then right now >what- what- (wan)< what should we be
170			do- be <doing> for him.
171	Med Student	:	MM okay. .hh so- (.) uhh: now: (.) now what we'll
172			do (is to) (0.4) we'll keep him in the general ward
173			[first] for now to <u>jus</u> : keep him up- to keep him

174 Sim Relative : [Okay.]

175 Med Student : under observation, .hhh so um .hhh (0.5)

176 Med Student : I think- (0.5) what we'll do next is to be talking

177 to your father about how he can further manage his:

178 heart condition lah.

179 Sim Relative : Okay.=

180 Med Student : =So make sure that it doesn't deteriorate any

181 further, (.) [so] th- there can be like um: (0.5)

182 Sim Relative : [Okay.]

183 Med Student : certain things that can be done such [as-]

184 Sim Relative : [Can-] can you

185 also let me know so at least we can monitor [his]

186 Med Student : [Mm.]

187 Sim Relative : conditions at home .hh [so there's] anything we can

188 Med Student : [Sure.]

189 Sim Relative : also help him with it.

190 Med Student : Mm definitely .hh yah so um what we'll do is to

191 tell your father what the- what are the things that-

192 now we can do- now he can [↑]do to [like] uh protect

193 Sim Relative : [Mm.]

194 Med Student : his heart and also >what are the< things we will do

195 for him .hhh and if you- if you would like to sit in

196 for it I think that will be fine as well. So just

197 to listen.

198 Sim Relative : Oh okay. (0.5) °Okay.° He- he won't be able to tell

199 me now so- will be later on.

200 Med Student : Uh:: yah later when we talk to your father as well

201 lah.

... ...

269 Sim Relative : So: so basically now he just has to:: take care of

270 what he (0.5) .hh eats and all these things and

271 >that that< would help him,

272 Med Student : Yah. You definitely one thing he would have to do

273 is: try to stop smoking. (0.5) 'Cause yah smoking is

274 a very uh lar- big risk fac[to:r.]

275 Sim Relative : [Yah] but I think

276 because his job was very stressful [so] (tsk) I

277 Med Student : [Mm.]

278 Sim Relative : think he::: he smokes when [he-] he feels stressed.=

279 Med Student : [Mm.]

280 Med Student : =Mm. °That's definite°. Okay [↑]so um:: (yah mit-)

281 so that would be one issue you w'd have to tackle

282 together lah.

283 Sim Relative : °U[h°-]

284 Med Student : [Uh] an:d- also:- uh- >any other< (.) °uh° issues

285 that you might be concerned [↑]about?

286 Sim Relative : No I- I just want to know how old- how one- how he

287 going to move on from here so what are the things we

288 can do for him. (.)

289 Med Student : O[kay.]

290 Sim Relative : [And then] and whether he needs to further take
291 medication for long-term or anything.

292 Med Student : Sure [sure.]

293 Sim Relative : [Yah.]

294 Med Student : 'Kay so uh- maybe I just briefly tell you so-
295 basically there are some lifestyle changes that

296 Sim Relative : [Mm mm.]

297 Med Student : [he can do? So] one smoking [stop] smoking. (.)

298 Sim Relative : [Mm.]

299 °Yah.°

300 Med Student : Alchoh:l stop alcohol al[so,] .hh um: Exercise would
301 Sim Relative : [Mm.]

302 Med Student : be good >if he can< [exercise] at least 'bout
303 Sim Relative : [Mm.]

304 [Mm.]

305 Med Student : [hundred] fifty minutes a week, (tsk) Um: (0.5) also
306 uh- (eat-) (0.4) his diet wise maybe he can eat uh:
307 <low fat (.)

308 Sim Relative : °Mm.°

309 Med Student : higher fibre> diet.

310 Sim Relative : O[kay.]

311 Med Student : [Uh] and if HE'S: overweight maybe he can try
312 °lose weight°.

313 (0.4)

314 Sim Relative : Mm. ((Nods head))=

315 Med Student : =Yes. .hh and then medication-wise uh .hh so- we'll
316 be: assessing him and then we'll- we'll see what
317 kind of medication you need for the long term.

318 (0.4)

Excerpt 34 continues from the previous excerpt after separate Q&A sequences on the prior topic and the symptoms of a heart attack to look out for in the future. After the student has answered her query on warning signs, the SR follows up with another question, “Then right now >what- what- (wan)< what should we be do- be <doing> *for him*.” to progress on to discuss about long-term management for her father’s condition — listed in the SR’s vignette as a matter students are expected to address (Lines 169 – 170). In reply, the student reiterates the current plan of keeping the patient under general observation (Lines 171 – 173 & 175), before somewhat orienting to the topic, “I think- (0.5) what we’ll do next is to be talking to your father about how he can further manage his: heart condition lah.” (Lines 176 – 178).

Possibly because her response is formulated from the angle of educating the patient rather than a direct delivery to her interlocutor, the SR interjects the student's next utterance, asking "Can- can you also let me know so at least we can monitor his conditions at home .hh so there's anything we can also help him with it." (Lines 184 – 185, 187 & 189), in a bid to steer the conversation back on track. Still, the student continues along the same trajectory and pronounces that the medical team will speak to her father about the management plan (Lines 190 – 192 & 194 – 195). Her ensuing statement "and if you- if you would like to sit in for it I think that will be fine as well. So just to listen." (Lines 195 – 197) further reveals no understanding of the SR's actual line of inquiry.

After an extensive discussion about the SR's concern of heredity and a short sequence where she expresses worry for her father (lines omitted), the SR brings up the topic of long-term management once again by raising possible examples of what her father can do, in a bid to steer the conversation back to the stipulated task (Lines 269 – 271). This time, she receives an appropriate acknowledgement of the subject from the student, who cites smoking as the biggest risk factor for the patient (Lines 272 – 274). Yet this exchange only goes on briefly (Lines 275 – 282) before the student opens up a slot for queries (Lines 284 – 285), suggesting an orientation to the SR's utterance from Lines 269 to 271 as a standalone question rather than as a topic initiator. At last, the SR plainly asks the student about the future plans and what may be done for her father (Lines 286 – 288 & 290 – 291), which finally elicits the anticipated rejoinder "'Kay so uh- maybe I just briefly tell you so- basically there are some lifestyle changes that he can do?" (Lines 294 – 295 & 297). The student proceeds to list a few general modifications to everyday life that the patient can adopt (Lines 297, 300, 302, 305 – 307, 309 & 311 – 312), and the discussion ends with her claiming that further assessment is needed regarding medication (Lines 315 – 317).

This excerpt shows that in simulated consultations, progression may be guided by the SP (or SR) according to the task requirements instead of being driven by the student's active fulfilment of them, if the set-up is such that information asymmetry exists between both parties. The CCP here clearly demonstrates such a design, given that the vignettes of each scenario provided to the SP contain more information than that issued to the students. This is especially the case in Station 3A, where the instructions to students are worded in ambiguous terms "update" and "explain the team's plans", whereas the SR received clear guidelines such as the following (refer to Appendix B for the full vignette):

After visiting Mr Tay in the ward you requested a full update from the team. You understand that the team consultant has asked the embedded medical student to provide you with as much information as possible and you welcome the update.

The student should be able to provide you, in clear and simple language:

- (1) An account of Mr Tay's presentation at the ED and the diagnosis
- (2) The reasons for the urgency of the emergency intervention
- (3) A brief description of his transfer to CCU
- (4) An explanation of how plaque rupture/embolism results in the symptoms, signs, and ultimately myocardial infarction
- (5) *A management plan that includes medication, risk factor modification, and close follow-up*

Considering the above instructions, especially Point 5, it is no wonder that the last example contains extensive scaffolding from the SR. The stark difference in the student's performance between Excerpts 33 and 34 reveals that she understood the task of "updating" correctly to mean explaining the emergency treatment given, but interpreted "explain the team's plans" simply as telling the SR that the patient will be kept under observation for a few days, rather than devising and explaining a long-term plan to manage the patient's illness.

This mismatch in expectations between what the student thinks she should deliver and what the SR knows the student ‘ought to’ deliver resulted in the protracted and drifting exchange seen in Excerpt 34.

More generally, the excerpt highlights a design feature of the CCP and perhaps, a prevailing practice in SP-based communication training: students and SPs are given specific instructions on what to say and how to act during the simulation. Even though the simulated consultation is supposed to reflect actual ones in clinical practice, it may be panned that the vignette directives invariably prime both parties with cues on how the consultation should proceed, thereby affecting interactivity between participants and compromising its realism. On the other hand, there are also advantages to the asymmetrical construction of this set-up in particular. Due to the ambiguity of the instructions stated in the student vignette, students are given free rein to deliver their consultation in a naturalistic manner, according to how they perceive the undertaking; while SP/SRs are also provided critical points to look out for that may simulate, at least to some extent, the chief concerns of an actual patient/relative. Indeed, the arrangement of intentionally giving students and SP/SRs disproportionate information and instructions may confer didactic benefits that outweigh the demerit of overall artificiality.

The examples given in this subsection illustrate that explanations of the diagnostic or treatment plan varies significantly in focus depending on the task requirements. While there are similarities across the board in the use of signposting and listing as methods for delivering a structured explanation, this is not a universal characteristic. Indeed, it appears that they can only be used effectively in well-defined tasks such as delineating treatment procedures or explaining medicine prescriptions, but loses value in more complex situations where multiple factors or issues are in play, for instance the conception of a long-term management plan for a chronic disease. There is thus huge responsibility placed upon students to understand the nature of the delivery required and act accordingly.

3.1.3 Convincing the Patient/Senior Colleague

Aside from being able to discharge the everyday responsibilities of a doctor in delivering the diagnosis/condition and explaining the diagnostic/treatment plan with the patient or family members, students are also expected to be proficient in dealing with difficult situations and people in these very contexts and beyond. Within this territory, one specialised skill critical to the consultation is persuasion based on sound medical reasoning. Convincing others to adopt a given course of action is never an easy feat. In the Year 3 CCP, the students' ability to do so is put to practice in Stations 1B and 2B, which involve dissuading an SP from hospital discharge AMA and persuading a senior doctor to approve a diagnostic procedure respectively. Examples from both stations are presented in this subsection to illustrate the difficulties students face in tackling these uphill tasks.

For Station 1B, it is noteworthy that none of the three students who were assigned this scenario managed to convince the patient to stay in hospital: one relented and acceded to the SP's request, one deferred the undertaking to the consultant, while one reached a stalemate with the SP. In the next few excerpts, I present the situations in the first and last cases, which represent student performance with contrasting levels of clinician-assertiveness and conversely, patient-centredness. A play of power ensues between both parties as each try to convince the other, with students deploying epistemic authority derived from their medical expertise and the SP exercising her deontic authority, or ultimate right over her own body, in the process. As the examples will illustrate, which prevails depends on each individual's push and formulation of their endowment. Notwithstanding the varying stances adopted and eventual outcome achieved, both students were quick to accommodate the SP's viewpoints in the intercourse, ostensibly orienting to the patient-centred paradigm and plausibly pandering to consumerist notions in modern healthcare. The next three excerpts trace Team I Student 2's acquiescence to the SP's demands after her multiple attempts at persuasion proved futile.

Excerpt 35. Station 1B/Team I Student 2: 02:35 Explanation of Treatment Plan

117 Sim Patient : .hh >I<[↑]mean- >you you now that you mention the<
118 [platelet] is really low at thirty and [>()<]
119 Med Student : [Mm.] [Mm.]
120 Sim Patient : is like hundred to four hundred.=So (0.4).hhh how
121 how are you going to make me better or my platelets
122 and all.= How are you are recover the the (0.8) the
123 numbers [that] you are aiming [↑]at,
124 Med Student : [Mm.]
125 (0.2)
126 Sim Patient : How how are you going to [do that.]
127 Med Student : [Okay.]
128 (0.3)
129 Can see you are very worried.
130 ((Smiling))
131 Sim Patient : [[↑]Ya because] thir[ty] is really low, (.) ya:..
132 Med Student : [>You are very<] [Hmm.]
133 Kay we have a very good team here for you.
134 Sim Patient : Hmm: hm.=
135 Med Student : =Kay so uh >I tell you< what >we will be doing<.
136 (0.4)
137 Uh::m (0.3) so normally we don't- >we don't< give
138 you anything.
139 Sim Patient : Hmm hm.=
140 Med Student : =Until: (.) you start being symptomatic meaning that
141 for example if you notice that you are bleeding from
142 your gu:ms:.
143 (0.2)
144 Sim Patient : [↑]Mm hm.=
145 Med Student : =Or when you pass motion there is bleeding from uh:
146 bleeding in your stools as well.
147 (0.2) |((Sim Patient nods once))
148 (GULP) ((Med Student swallows saliva))
149 Med Student : Ya so (0.3) if your:: >if you are not< (.) getting a
150 new symptoms,
151 Sim Patient : [↑]<Mm[:.>]
152 Med Student : [Then it's] okay for us to just watch you and
153 then only- only (0.2) s:start int (0.3) uh coming in
154 (0.5) when (.) when something happens.=.hh (0.2) Ya.
155 Sim Patient : (TSK) ((Alveolar tongue click))
156 Med Student : So for now we just put you under observation °la°-
157 |((Sim Patient shakes head))
158 we just don't want that to get there.
159 (0.2)
160 And we- (0.2) Ya: we just don't want it to get to
161 such a bad point.
162 Sim Patient : Mm:[hm:..]
163 Med Student : [Hmm.]
164 (0.5)

Following Team I Student 2's delivery of the SP's condition in Excerpt 17, Excerpt 35 begins in Lines 117 to 118 and 120 with the SP displaying worry about her current state of health while referencing the student's citation of her low platelet count, which was earlier done to impress upon the SP the seriousness of her condition. Towards these anxious enquiries about the treatment plan (Lines 120 – 123 & 126), the student affirms the SP's emotions, "Can see you are very worried." (Line 129), as a broad smile spreads across her face, perhaps in delight at the ephemeral 'success' of her persuasion efforts (Line 130). When the SP recapitulates her point of apprehension (Line 131), the student reassures her with the quality of the medical team (Line 133), before prefacing the discussion of the treatment plan with a signpost (Line 135). Her next utterance, however, appears jarringly contradictory. Having just declared that a course of 'action' will be taken, she now proclaims, "Uh::m (0.3) so normally we don't- >we don't< give you anything." (Lines 137 – 138), before backing it up with qualifying statements (Lines 140 – 142 & 145 – 146), which the SP acknowledges with a nod (Line 147). She then carries on explaining the supportive treatment for dengue as being non-interventionistic until the appearance of further symptoms (Lines 149 – 150 & 152 – 154).

At this instant, the SP overtly displays displeasure regarding the student's explanation for the first time with an alveolar tongue click (Line 155), followed by profuse shaking of her head (Line 157) while the student continues stating that she will just be kept under observation for the time being (Line 161) to prevent her condition from deteriorating to an advanced stage (Lines 162 & 164 – 165). Prior to this, the SP has been listening without interruption, only minimally acknowledging the student's points during a couple of transition relevant places (TRPs) in Lines 134, 139, 144 and 151 in between adjacent turn constructional units (TCUs). Thus for most of the sequence, the SP has given the student leeway to complete her explanation, thereby allowing her to be more assertive in her attempt

to convince. Only after she has spoken about the supportive management plan and made it clear that no active intervention will be done until the situation worsens did the SP voice her disdain. The next excerpt further reveals the SP's dissatisfaction with the proposed plan while the student attempts to dissuade her from getting discharged AMA, evidently proving that the student has revelled in her early 'triumph' (ref. Line 130) far too soon.

Excerpt 36. Station 1B/Team I Student 2: 03:35 Negotiation with SP

165 Sim Patient : ↑>I mean< you see like >what did you mention there
 166 is nothing much that you can do you know we just
 167 waiting and watching< right:?[So] I can go home::
 168 Med Student : [Hmm.]
 169 Sim Patient : and you=know update you with that something.=Can I
 170 can I do that?=""Because this is" (0.9) I sleep here
 171 you are not doing anything too: and .hh (0.3) you
 172 know it's really noisy and uncomfortable here.=
 173 Med Student : Oh ya I understand because a lot of doctors walk in
 174 and walk out [and nu:rses.]
 175 ((Waves left index finger back and forth))
 176 Sim Patient : [Yes (you know my)] (.) °my my next bed
 177 uh she not uh she she make a lot of noise she is
 178 very° ↑noisy.=""So (0.3)
 179 [>I cannot have a good< re]st.=
 180 Med Student : [<Oh no:.>]
 181 Sim Patient : ="So .hh I think I am more comfortable at ho:me.
 182 (0.4)
 183 Med Student : [Mm.]
 184 Sim Patient : [Ya.]
 185 (0.5)
 186 Sim Patient : [>()]< receiving any treatment here.
 187 Med Student : [()]
 188 (0.8)
 189 Med Student : Kay I- I can understand that [it looks like] we are=
 190 Sim Patient : [Hmm.]
 191 Med Student : ="not doing anything but actually we we- we are (.)
 192 putting our [very [(strength) and-].
 193 Sim Patient : [I- I only take] ↑Panadol.
 194 ((Raises and shakes upward-curved right palm with
 195 fingers held together))
 196 (0.2)
 197 Med Student : You only take Panadol 1a. ((Nodding))
 198 Sim Patient : >That's why it (doesn't seems make any take)
 199 Panadol<=""So (0.3) ↑I mean there is nothing to be
 200 done °so >why why why< should I stay here°.
 201 (0.4)

202 Med Student : The thing that what we are worried about right, is
203 that for example when you start bleeding your
204 condition could (0.2) go down very fast.
205 | ((Gestures downward motion
206 with curled right hand))
207 (0.5)
208 Sim Patient : [Hmm.]
209 Med Student : [Could] de-deter (.) riorate and worsen very fast.
210 ((Gestures downward motion with curled right hand
211 twice))
212 (0.3)
213 So we have we've- have had some patients.
214 Sim Patient : Mm hm.=
215 Med Student : =Uh:m.
216 (0.9)
217 Med Student : >Who: who:< who starts (0.5) bleeding and who start
218 (0.7)having their blood pressure drop very very
219 fast. ((Raises open left palm face-down, holds it in
220 mid-air and pushes it downwards))
221 Sim Patient : Mm hm.
222 Med Student : And then we've no choice but to put them in I-C-U.
223 (0.7)
224 Med Student : [So] when we will give them supportive management=
225 Sim Patient : [Hm.]
226 Med Student : =there.=We gave them platelets.
227 Sim Patient : Hmm hm.
228 Med Student : increase increase their platelets count so they stop
229 bleeding.
230 Sim Patient : Mm hm.
231 Med Student : Uh: we gave them (0.3) fluids, sa↑line, through a
232 drip.
233 (0.2)
234 Sim Patient : Mm hm.
235 (0.3)
236 Med Student : Ya.
237 (0.4)
238 Med Student : Such that uh:m to keep the blood pressure up and
239 then we will continue to (0.3) pump in their:
240 circulation [and] (0.3) uh profuse all their organs
241 Sim Patient : [Mm.]
242 Med Student : so that there=are bloods to all their organs.
243 (0.2)
244 Sim Patient : Mm::::. ((Smack lips)) .hh <Well I> I'm I'm not sure
245 if I'm going to get so serious because so far I
246 °mean-°you know I am having a fever [and °there°]=
247 Med Student : [Ya:.]
248 Sim Patient : =are some pain and things like that but (0.5) >you
249 know< so far I am still feeling alright.=I think
250 I can be discharge today.

251 (0.6)
 252 Sim Patient : Yea.=
 253 Med Student : =Kay:=
 254 Sim Patient : Hmm hm.
 255 Med Student : Kay.
 256 (0.3)
 257 Med Student : I: I agree that you are feeling well la:.=We just
 258 don't want that to happen la:.,
 259 (0.2)
 260 Sim Patient : Hmm hm.=
 261 Med Student : =Okay.
 262 (0.2)

Immediately after the student has finished her explanation of the treatment plan (Ex. 35), the start of Excerpt 36 shows the SP objecting to the proposition, characterising it as just “waiting and watching” and reverting to her original request for discharge from hospital (Lines 165 – 167). She counter-proposes updating the medical team on her condition from home instead (Lines 167 – 169), before citing the superfluous reason of an uncomfortable hospital ward (Lines 171 – 172 & 176 – 179) as additional ammunition. In response to her protests, the student attempts to empathise with the SP’s feelings by appending more details to the grating nature of the ward environment (Lines 173 – 175) as an affiliative display and recognising her point of view regarding the lack of observable treatment (Lines 189 & 191 – 191). In the midst of the latter sequence, the SP raises a new objection. She dismissively proclaims, “I- I only take ↑Panadol.” (Line 193) to highlight the lack of actual curative medication prescribed, while raising her upward-curved right palm with fingers held together and shaking it in an equally contemptuous action (see Figure 6 below), using this as a further justification for getting discharged (Lines 198 – 200).

Figure 6. Screenshot of Station 1B/Team I Student 2: SP expresses disdain for treatment plan with a dismissive hand gesture (raised and shaking upward-curved right palm with fingers held together).

After briefly acknowledging the SP's rant (Line 197), the student responds to her main complaint by explicating the medical reasoning behind keeping her warded in hospital. She paints a hypothetical picture of the SP starting to bleed (as in dengue haemorrhage fever) and explains that that could result in a rapidly deteriorating condition, amplifying her delivery with downward-motioning hand gestures as well (Lines 202 – 206 & 209 – 211). Next, she cites the case of suppositious patients who experienced such a situation (Line 213, 217 – 219 & 222). She goes on to outline the emergency treatment that has to be administered to these patients, i.e. platelet transfusion (Line 226) and intravenous fluid infusion (Lines 231 – 232), explaining the purpose of each respectively (Lines 228 – 229, 238 – 240 & 242). Despite this seemingly convincing line of argument, the SP nonetheless repudiates the idea that her condition will ever reach that stage of severity and reiterate her insistence on being discharged (Lines 244 – 246 & 248 – 250). The excerpt ends with a feeble attempt by the student to restate her point but in agreement with the SP, "I: I agree that you are feeling well la:.=We just don't want that to happen la:," (Lines 257 – 258), respecting the SP's somatic experience and orienting to her deontic right to clinical decision making. Subsequently, in

reference to an earlier part of the conversation, the student takes another shot at convincing the SP by asking if anyone can help take care of her family (not shown in excerpt), but this proved to be futile as well. The next excerpt shows the resolution of the ‘disagreement’ as the consultation ends in the SP’s favour.

Excerpt 37. Station 1B/Team 1 Student 2: 06:07 Deference to SP

302 Med Student : Okay >ya what ya< so the doctor has told me that
 303 actually we really discourage you (0.4) from going
 304 home.=This is normally how we: (.) how we: deal with
 305 dengue patient la .=We keep an- (0.4) uh:m (0.6) for
 306 patients that we think are at risk of developing
 307 these complications we keep them here (0.3).hh
 308 because we really really want to keep a close eye on
 309 you because we care about you don’t want anything to
 310 happen la.
 311 (0.7)
 312 Mm (.) but if (0.7) you really insist on going back
 313 (.) then I guess that can be arranged as well.
 314 Sim Patient : I: think that will be good.=Ya.
 315 Med Student : >[That will be] good uh<.=
 316 Sim Patient : [Uhh.]
 317 Sim Patient : =Yup.
 318 (0.2)
 319 Sim Patient : Ya.
 320 Med Student : Okay.
 321 Sim Patient : Mm hm.
 322 Med Student : Sure.
 323 (0.3)
 324 Med Student : Uh:: (0.3) do you have any other questions for me or
 325 anything that I could (0.3) try to convince you to
 326 stay?
 327 (0.2)
 328 Sim Patient : Mm:: no I think °I uh:m you know (0.4) since nothing
 329 much is done here I should go home ya°. =>I’m I’m<
 330 fine. I should be fine at home?=°ya°. =

 355 Med Student : Okay (.) is it okay if I get my doctor to come and
 356 talk to you in a bit?
 357 (0.2)
 358 Sim Patient : Regarding?
 359 (0.4)
 360 Med Student : Uh:: regarding the the same issue but I think he
 361 might have some (.) extra points.
 362 (0.4)
 363 Sim Patient : ↑Oh:.

364 Med Student : To:to:to share with me and talk to you:.
 365 (0.4)
 366 Sim Patient : Just let him know that let him know that I need to
 367 go home la. Since there is nothing much unless you
 368 know uh (0.4) ↓ya.
 369 (0.5)
 370 Like I mean if it is going to remain the ↑same then
 371 I think .hhh it's okay lor.=°Ya°.
 372 (0.3)
 373 I should go home?
 374 (0.6)
 375 Med Student : Okay [okay] hh sure.
 376 Sim Patient : [Mm.]
 377 (0.4)
 378 Okay.
 379 (0.2)
 380 Med Student : Nice talking to you Miss Tan.
 381 Sim Patient : Thank you very much.
 382 Med Student : Tha:nk you hhhhh.

After multiple unsuccessful attempts at convincing her to stay, the student finally accedes to the SP's request. Before abandoning the cause completely, she fortifies her retreat at the start of Excerpt 37 with a restatement of her stand, maintaining that under the doctor's instruction and in accordance with standard protocol for managing at-risk patients, she highly discourages the SP from discharge, "because we care about you don't want anything to happen la." (Lines 302 – 310). Finally, she concedes with reluctance, "Mm (.) but if (0.7) you really insist on going back (.) then I guess that can be arranged as well." (Lines 312 – 313), retreating to a patient-centred stance and acquiescing to the SP's demand. Having gotten her way at last, the SP promptly replies in delight, ">That will be good uh<.=)" (Line 315).

Unsatisfied with the impending outcome of her consultation, however, the student devises a flimsy comeback by plainly laying out her agenda, "Uh:: (0.3) do you have any other questions for me or anything that I could (0.3) try to convince you to stay?" (Lines 324 – 326). This invites a foreseeable rejection from the SP, who also reiterates her point that she should be released in the absence of active treatment and asserts that she will be alright at home (Lines 328 – 330). Following another weak bid at persuasion (lines omitted), the

student makes a last ditch attempt to salvage her cause by asking if she can have the doctor speak to the SP instead (Lines 355 – 357). Nonetheless, the SP assertively questions this proposition (Lines 358) and politely rejects it (Lines 366 – 368 & 370 – 371), pushing the envelope again in a seemingly permission-seeking format, “I should go home?” (Line 373). The consultation finally draws to a close with the student reaching her wits end and relenting unwillingly (Line 375), as illustrated by the multiple pauses in Lines 365, 369, 372, 374, 377 and 379.

In the case of Team I Student 2, an inverse relationship is plainly observed between the student’s clinician-assertiveness and patient-centredness, i.e. she pays less attention to the SP’s emotional responses when confidently presenting medically-sound arguments, and becomes more attuned to the SP’s negative emotions as the level of insistence on being discharged AMA increases. She approaches the task first attempting to exert her epistemic authority, but defers to the SP’s deontic authority once she meets with overwhelming resistance. In the next example featuring the same SP and scenario but a different student, the atmosphere gradually becomes less cordial as the two participants start a conversational tussle with each other. This continues until the time allocated is up and the facilitator has to stop the consultation prematurely. Excerpt 38 below outlines the beginning of their negotiation when the SP first protests against the student’s talk but with the discursive environment still remaining friendly.

Excerpt 38. Station 1B/Team III Student 4: 05:19 Negotiation with SP (Beginning)

321 Sim Patient : >You know (.) but then (0.6) you are not doing much
322 you see. [Since last] night until
323 Med Student : [Ya::.]
324 Sim Patient : [now I am= lying] on the be:d and (0.3)
325 Med Student : [right >that’s right<.]
326 Sim Patient : [the nurse] only uh give me Panadol:,
327 Med Student : [Alright.]
328 : Mm:.
329 (0.2)

330 Sim Patient : So: I mean I: don't see: why: should I continue
 331 [to stay] here so I'll pre[fer] to go home today.=
 332 Med Student : [<Ya:>.] [Mm.]
 333 Med Student : =Ya so (1.2) kay- cause your (0.2) like you pointed
 334 out actually most of what I do to be honest is: (.)
 335 <observation>.
 336 (0.4)
 337 So >it-it< you know you- you- feel like it's a bit
 338 wasting of your time right you want to go ho:me.
 339 ((Smiling))
 340 Sim Patient : Ye:s exact[ly.]
 341 Med Student : [Ya:..]
 342 Sim Patient : I mean u-unless you are doing more things.
 343 [Because there's nothing] much you see.
 344 Med Student : [Ya: I see I see.]
 345 Sim Patient : [It's] just take [Pana]dol I can also=
 346 [Yup.] [Yup.]
 347 Sim Patient : =take (.) Panadol at (0.2) home.= .hhh [So why]=
 348 Med Student : [Ya:..]
 349 Sim Patient : =should I be staying here and]=
 350 Med Student : =Ya:..
 351 (0.2)
 352 Sim Patient : wait:ing: for something to ha↑ppen [you know.=]
 353 Med Student : [Yes yes.=]
 354 Sim Patient : =[I hope not] touch ↑wood.
 355 Med Student : =[it's understandable.]
 356 Sim Patient : Ya.
 357 Med Student : Yea [yea yea.]
 358 Sim Patient : [(Ya lor).]
 359 (0.3)
 360 Med Student : Ya sure sure.= I mean like if I hh I am in >this
 361 situation I will feel very frustrated also<, [↑so]=
 362 Sim Patient : [Ya.]
 363 Med Student : =ya. .hhh

Prior to the excerpt, the student has just explained the different phases of dengue fever to the SP to justify the prolonged hospital stay, citing her current condition and the various problems that may occur if it worsens. At this point in time, the SP raises her first significant objection, claiming that nothing has been done since her admission except the prescription of Panadol (Lines 321 – 322, 324 & 326) and substantiating her request (Lines 330 – 331). The student responds in acknowledgement of her point, conceding that “=Ya so (1.2) kay- cause your (0.2) like you pointed out actually most of what I do to be honest is: (.) <observation>.”

(Lines 333 – 335), and empathising with her sentiments, “So >it-it< you know you- you- feel like it’s a bit wasting of your time right you want to go ho:me.” (Lines 337 – 339) while smiling broadly. Both parties appear to reach momentary consensus in this interval, with the SP exclaiming, “Ye:s exactly.” in overlap with the student’s agreement (Lines 340 – 341). She continues espousing her argument by contending that Panadol can equally be taken at home without having to be warded and that there is no point in “wait:ing: for something to ha↑ppen” (Lines 345, 347, 349 & 352). The student, on the other hand, remains relational and assumes the perspective of the SP in a bid to empathise with, or at least, project an empathic image to her (Lines 360 – 361 & 363), reflecting his propensity to be patient-centred.

However in Excerpt 39 (immediately following Ex. 38), the mood of the consultation shifts considerably as the SP reacts with heightened exasperation towards the student after he voices an implicit refusal in acceding to her request.

Excerpt 39. Station 1B/Team III Student 4: 06:02 Negotiation with SP (Escalation)

364 Med Student : >Alright so (0.2) like I said right (0.3) ya: (.) to
365 be honest uh: dengue doesn’t have any c:ure: you
366 know.=We can’t [give you a] medication to like just
367 Sim Patient : [Mm:.]
368 Med Student : kill the virus and that[’s it game over.]
369 Sim Patient : [Yes yea:.]
370 (0.2)
371 Med Student : Okay?
372 (0.4)
373 Med Student : So: (1.1) () (.) like I men- mentioned to you right
374 there’s a chance that you might go into (0.2)
375 <se:vere: phase> because you are >in [the cri]tical
376 Sim Patient : [Mm:.]
377 Med Student : mode<,
378 (0.5)
379 Med Student : Um: (0.4) so but (.) ya (0.2) so that’s why we are
380 observing you al↑righ[t:,] so (0.3) hopefully=right
381 Sim Patient : [Mm:.]
382 Med Student : (0.2) the best that can happen is (0.4) uh:m you
383 reach phase three w- which is what we called the
384 (0.2) recovery phase.
385 (0.2)
386 Sim Patient : Mm[:.]

387 Med Student : [Us]ually around (.) <day five to seven of your
388 dengue:>,
389 (0.2)
390 Sim Patient : Oh.
391 (0.2)
392 Sim Patient : [O:kay five to seven] uh uh:..
393 Med Student : [Around there okay?]
394 Mm: .hhh so when that happens right (0.3) your plate
395 (.) your body will start to recover your platelets
396 will start building up.
397 (0.2)
398 Sim Patient : Mm[:..]
399 Med Student : [T]he:n we can start talking about discharging
400 you alright?
401 (0.3)
402 Sim Patient : Af- (0.4) you mean I have to: stay another: (0.3)
403 two three days more?=
404 Med Student : =Mm:: (0.3) maybe a-around there I'll have to check
405 with [the doctor.]
406 Sim Patient : [So] many days: and [you are] not
407 Med Student : [Ya:.]
408 Sim Patient : doing anything you know [just] wasting my money
409 Med Student : [Ya:.]
410 Sim Patient : staying here,=a[nd] You know when I stay here it's
411 Med Student : [Mm:.] ((Lips sucked in))
412 very uncomfortable [you know] my neighbour is making
413 Med Student : [Ya ya.]
414 Sim Patient : a lot of noise [beside] (my) bed beside is ↑making a
415 Med Student : [Oh:.]
416 Sim Patient : lot of noi[se.]
417 Med Student : [Oh] dear.
418 Sim Patient : [So] last night I cannot sleep you [know.]
419 Med Student : [Okay okay.] [Oh]
420 dear. (0.2)
421 Sim Patient : And the environment is very different very ↑noisy
422 [so why] can't I go home and re:st.
423 Med Student : [Mm:.]
424 (0.2)
425 Med Student : I see I see.
426 (0.3)
427 Sim Patient : ↑Ya.
428 (0.4)
429 Med Student : Ya I understand like (.) >it-it< it definitely will
430 feel nicer to rest at home right?
431 (0.3)
432 Sim Patient : °Of° ↑course.
433 Med Student : [Ya man.]
434 Sim Patient : [(And)] you know my husband and my daughter alone
435 at home,

436 (0.2)
 437 Med Student : Mm[:.]
 438 Sim Patient : [So] I'm always with them.=So >you know< they are
 439 very uncomfortable that I'm away from ↑them.
 440 (0.9)
 441 Sim Patient : ↑Ya.
 442 Med Student : >Are- are- are-< they coping with it well?
 443 (0.2)
 444 Med Student : °(Any::)°
 445 (0.3)
 446 Sim Patient : Sorry?=
 447 Med Student : =Are they coping with it (.) it with it (.) [well?]
 448 Sim Patient : [My.]
 449 daughter keep messaging ↑me:.
 450 Med Student : Oh::.=
 451 Sim Patient : =That's why.<That's why I was thinking .hhh if you
 452 are not doing much then you should let me ↑go.=
 453 Med Student : =I see I see.
 454 (0.4)
 455 Sim Patient : Ya I can come back la::=I can com[e back] if=
 456 Med Student : [Mm:.]
 457 Sim Patient : =there's (1.2) [some] other things or what[ever:or]
 458 Med Student : [Ya.] [Mm::.]
 459 Sim Patient : like I get uncomfortable whatever [I can] come back.
 460 Med Student : [Mm:.]
 461 Sim Patient : Let me go home [now la]::=I mean for [now.]
 462 Med Student : [Ya:.] [I under]stand
 463 ya:.
 464 (0.6)

In Lines 364 to 366 and 368, the student openly admits that there is no medicinal cure for dengue fever that the doctor can prescribe. Drawing upon his epistemic authority, he next references the information that he presented earlier on and warns the SP that her condition can easily deteriorate from the critical phase to a severe mode (Lines 373 – 375 & 377), thereby accounting for the ward observation (Lines 379 – 380). He carries on with the same line of medical reasoning by describing the recovery phase (Lines 382 – 384 & 394 – 396) and its occurrence along the clinical course as “Usually around (.) <day five to seven of your dengue:>,” (Lines 387 – 388), which the SP repeats in a display of understanding without noticing its potential implication for her agenda (Line 392).

At this juncture, the student utters, “The:n we can start talking about discharging you alright?” (Lines 399 – 400), a seemingly natural closure to his logical supposition but which unwittingly draws fire from the SP. Having noticed his implied rejection of her request, the SP protests in disbelief, “Af- (0.4) you mean I have to: stay another: (0.3) two three days more?=” (Lines 402 – 403), complete with a performative air of incredulity. The student backs down a little, claiming that he needs to check with the doctor on the exact number of days she has to remain under observation (Line 404 – 405). Before the student even completes his utterance, the SP flares up instantaneously, remonstrating “So many days: and you are not doing anything you know just wasting my money staying here,” (Lines 406, 408 & 410). She continues ranting about the uncondusive environment of the hospital ward (Lines 410 – 411, 413, 415, 417 & 420 – 421). Visibly disconcerted, the student could only produce multiple tokens of agreement to acknowledge her reckoning (Lines 407, 409, 411, 413, 415, 417, 419 – 420, 423 & 425), at one point in time sucking in his lips (Line 411). To defuse the situation, he reformulates her point as a question expressly agreeing with her sentiment (Lines 429 – 430), using a design that is syntactically interrogative (in form) but semantically exclamatory (in function).⁷ After concurring unequivocally in a disparaging tone (Line 432), the SP initiates a new sequence about her family’s reliance on her at home (Lines 434 – 435 & 438 – 439) and uses it as a charge to argue for her ‘release’ (Lines 451 – 452). At the end of Excerpt 39, she contends that she can always return to the hospital if any health trouble arises (Lines 455, 457 & 459) and implores the student to let her go home (Line 461).

⁷ I hesitate to describe the student’s utterance as a rhetorical question (RQ) despite it fulfilling the dictionary definition of “a statement made in the form of a question with no expectation of an answer” (Cambridge University Press 2009). The presence of a second pair part “°Of° ↑course.” (Line 432) is not the issue at hand, for an RQ can equally invite a response from the hearer. Rather, because the student is soliciting an agreement from the SP to show that he is “on her side”, his action features neither the *negative polarity licensing* nor *semantic incompatibility* identified by some authors as characteristic of RQs (Rexach 1998; Špago 2016), which accounts for its well-recognised pragmatic functions of strengthening assertions or expressing sarcasm. Indeed, as Frank (1990) contends, a unified theory to explain the definitional and explanatory problems regarding RQs has yet to emerge.

The next excerpt (continuing immediately from Ex. 39), consists of three segments that depict the final leg of the consultation where the student and the SP reach an interactional gridlock in which no party is willing to yield to the other (at least within the time allowed).

Excerpt 40. Station 1B/Team III Student 4: 06:02 Negotiation with SP (Impasse)

465 Med Student : I mean like I would also wish that you know >you-
466 you-you-< could go back.=Cause of course you know
467 stay- staying at home is obviously better uh.=
468 ((Smiling))
469 Sim Patient : =Ya.
470 Med Student : Ya alright (0.2) but like I said because (0.3) whe:n
471 (0.3) if really touch wood uh (.) [really] really
472 Sim Patient : [Mm.]
473 Med Student : you get severe dengue fever right, [it can] (.)
474 Sim Patient : [Mm.]
475 Med Student : it can spiral out of control q:uite quickly. Okay?
476 (0.2) [So like] (0.5) I- (0.2) <I don't mean to
477 Sim Patient : [Mm:.]
478 Med Student : scare you> but (.) there are cases where it really
479 happens and >you know< (0.3) patients (.) their:
480 major organs start getting damaged.= I mean (.) like
481 I said is not hu:ndred percent but we want to >make
482 sure that< (0.6) when(0.2) >you [know]<
483 Sim Patient : [It's] not hundred
484 percent then I can go la. I mean <I'm not that sick
485 now what>.
486 Med Student : Mm:..
487 (0.7)
488 Mm.
489 (1.0)
490 Sim Patient : Correct or not?
491 (1.2)
492 Med Student : .hhh uh::m no >I-I-I< honest to be hh honest I I
493 cannot like sick validate like >I-I-I< cannot (cor)
494 say that you are <not that> sick you know because
495 (0.2) sometimes (.) <it can strike without warning>.
496 (0.3) So even though now you-you you know you are
497 like (.) quite (0.4) you seem quite healthy you can
498 talk to me, have a conversation it doesn't mean that
499 .hhh maybe twenty four hours later: (0.2) >you know<
500 (.) nothing will happen.
501 (0.3)
...
527 Sim Patient : =You jus:t uh just help me arranged for me to
528 discharge today. (0.3) (No[thing so much.])
529 Med Student : [To:day:-]

530 no uh >I'm I'm< I'm so sorry but ya >we we we<-
531 |((Raises right palm)) |((Raises right palm
532 and briefly holds it in mid-air))
533 (0.3)
534 Sim Patient : I mean you will understand my
535 si[tuation here right],
536 Med Student : [Ya: I understand la]. But (0.5) >I I need to let
537 you know that you know< observation ya it- it may
538 seem quite useless uh: but but is really (0.3) we
539 just want to make sure <nothing happens to you>.
540 (0.4) >You- you< know what I mean?
541 (2.5)
542 Sim Patient : ((Scrunches face and opens both palms outwards))
543 () [you're n]ot doing much to help me.
544 Med Student : [A bit hard.]
545 (0.4)
546 Mm:. (0.3) Ya I mean like (.) unfortunately (.) we
547 cannot uh:: (0.5) to (0.3) to help you the best we
548 can right, we cannot let- let you be discharged we
549 really want to make sure there's NO: complications
550 at all.
551 (0.6)
... ..
568 Med Student : =(>I mean<) is is there <anything else you would>
569 (0.4) We- we can do for you besides uh:: (.)
570 discharge. (0.3) [Which] unfortunately we:
571 Sim Patient : [I] (0.2) I-I-I don't know what
572 else you can do [for m]e:.=Uh [be]cause so far it's
573 Med Student : [Yea:.] [Ya.]
574 Sim Patient : only Panadol. I mean I seriously have no idea what
575 else you can do for me,=.hhh maybe you can let me
576 <go home:> you know like I say or I will let you
577 know if there's anything wrong with me or I feel any
578 different or whatever °yea°.
579 (0.6)
580 Med Student : Mm:.
581 (1.3)
582 Med Student : Okay but (.) ya >I-I< think you already have a idea
583 of like (.) why: we are (0.2) >you know< (0.5)
584 continuing to (0.3) observe you la.=
585 Sim Patient : =Ya.=
586 Med Student : =And (0.3) you feel that you know you (0.5) you are
587 you are confident that you know if you go home: you
588 can (0.8) you can like monitor yourself right?
589 Sim Patient : Ya because I I don't feel <that sick> you see.
590 [I mean ya] I'm a bit uncom[fortable this and]=
591 Med Student : [Ya ya.] [Correct correct.]
592 Sim Patient : =that but [.hh is] uh more or less the same=
593 Med Student : [Correct.]

594 Sim Patient : =<past few days la>.
 595 (0.3)
 596 Med Student : [Mm:..]
 597 Sim Patient : [Ya.]
 598 (0.8)
 599 Med Student : Okay (.) I see.
 600 (0.6)
 601 Med Student : Ya okay >I-I-I< I understand what you are talking
 602 about la ok[ay.]=But (0.6) I-I think right now we==
 603 Sim Patient : [Mm:..]
 604 Med Student : =we cannot see eye to eye on the value of: uh: (0.2)
 605 observation right,=because >you-you< feel that >you
 606 know< observation you can like just: (0.6) monitor
 607 yourself then (0.7) you will come back when there's
 608 a need to right?=
 609 Sim Patient : =Mm.
 610 (0.5)
 611 Med Student : Mm.
 612 (0.5)
 613 Med Student : Alright.
 614 (0.5)
 615 Med Student : Okay why don't=
 616 Facilitator 1 : =Okay: I'm gonna stop you guys.

In response to the SP's proposal of returning to hospital if the need arises (Ex. 29 Lines 455, 457 & 459), the student maintains his relational approach at the start of Excerpt 30 (Line 465 – 466). Yet this was done only as a preface to his actual message that severe dengue fever can “spiral out of control” rapidly (Lines 473 & 475). He then attempts to alarm the SP into conforming by stating that there have been cases of major organ damage due to dengue (Lines 478 – 480), despite proclaiming, “<I don't mean to scare you>” (Lines 476 & 478). His cautious disclaimer that this outcome “is not hundred percent” (Line 481), was however picked up by the SP as a logical loophole in his argument. Latching onto it before the student could complete his utterance, she uses the detail to her advantage in asking to be let go (Lines 483 – 485) and bolsters her assertion by defiantly questioning him, “Correct or not?” (Line 490). Momentarily stumped (Line 491), the student avoids falling into the ‘trap’ of agreeing with her, instead producing a dispreferred response to cover his base, “.hhh uh::m no >I-I-I< honest to be hh honest I I cannot like sick validate like >I-I-I< cannot (cor) say that

you are <not that> sick you know because (0.2) sometimes (.) <it can strike without warning>.” (Lines 492 – 495). The inter-turn gap of 1.2 second and turn-initial delay marked by “.hhh” (in-breathing) and “uh::m” nonetheless shows an orientation to the conversational preference for agreement (see Sacks 1987; Sidnell 2010). He then substantiates his defence by citing the unpredictable nature of her condition although she appears well enough at present (Lines 496 – 500).

Frustrated with the student’s unaccommodating responses, the SP issues an ‘ultimate’ directive point-blank, “You jus:t uh just help me arranged for me to discharge today.” (Lines 527 – 528). This was met with an even stronger refusal from him, “To:day:- no uh >I’m I’m< I’m so sorry but ya >we we we<” (Lines 529 – 530), uttered while raising his right palm twice in negation (see Figure 7 below). This assertion of authority represents a departure from the patient-centred approach he has maintained so far in ensuring that medical decision making is guided by patient preferences (see Section 1.1.3). In reply, the SP takes a step back and appeals to his goodwill by soliciting for empathy, “I mean you will understand my situation here right,” (Lines 534 – 535), formulated as a “yes”-biased polar question with an affirmative underlying proposition (see Lee 2013). In light of the question’s recipient design, the student downgrades his stance on the issue, first avowing his knowledge of her situation (Line 536) before conveying a softer, more empathic message (Line 537 – 539). He then seeks validation regarding the SP’s degree of concurrence with his position, adopting a question design similar to that just used by her, “>You- you< know what I mean?” (Line 540). Other than functioning as a checkpoint for gauging how much he has convinced his interlocutor, the utterance also alludes to his underlying policy of non-compromise. The SP appears to have understood the fundamental implication of his presupposed concern. Following an extended pause of 2.2 seconds (Line 541), she produces a scrunched up facial expression ostensibly conveying disgust and disdain for his explanation and opens up both of

her palms outwards in a fully-embodied display of resignation and exasperation (see Figure 8 below), before uninhibitedly complaining, “you’re not doing much to help me.” (Line 543). With this escalation, the student upgrades his stance correspondingly and informs her straightforwardly, “we cannot let- let you be discharged we really want to make sure there’s NO: complications at all.” (Lines 548 – 550).

Figure 7. Screenshot of Station 1B/Team III Student 4: Student refuses SP’s directive with a raised right palm briefly held in mid-air.

Figure 8. Screenshot of Station 1B/Team III Student 4: SP displays resignation and exasperation with both palms opened outwards. Her scrunched up facial expression cannot be seen, however, due to the anonymisation. Notice also that the student has his hands clasped together earnestly.

Having reached an impasse in the final leg of the consultation, the student decides to skirt the issue and find an alternative solution to hospital discharge (Lines 568 – 570). The SP promptly dismisses this suggestion, citing the lack of any effectual medicine for treating her (Lines 571 – 572 & 574). Given that the hospital can afford to provide no other treatment option apart from supportive management, the offer may have indeed appeared incredulous to her. She verbally lunges at him with an upgraded repetition in an irritated tone (Lines 574 – 575), restating her request and proposal to update the medical team if something goes awry (Lines 575 – 578). At this point, the student finally comes to the realisation that the SP will not be convinced by all which he has delivered. He begins prefacing a closure of the consultation with a summary of the situation (Lines 582 – 584)—to which the SP agrees immediately in the next turn—as well as a reconfirmation of her intention and ability to execute her plan (Lines 586 – 588). After she affirms his assessment (Lines 589 – 590, 592 & 594), the student formulates his closing by acknowledging her point of view and recognising their difference in opinion (Lines 601 – 602 & 604 – 605). Wrapping up, he confirms her position as grounded in a belief that clinical observation can be self-directed (Lines 605 – 608), so as to devise his concluding proposition (Line 615). This is however stopped by the facilitator before completion (Line 616). While his final motion will never be known, the design of the student’s final turn, “Okay why don’t=” suggests that he feels compelled to respect the SP’s deontic rights at the end of the day.

This student’s approach to dissuading the SP is markedly distinct from the previous student in that his level of assertiveness does not simply vary in the opposite direction as a function of the SP’s own aggressiveness and the corresponding attention he pays to patient-centredness. While he orients to her emotional displays empathically and attempts to assuage her concerns accordingly, he refuses to change his stance on disallowing her to be discharged AMA, even as the SP upgrades the claims to her deontic rights over the matter. Nonetheless,

in light of the SP's continuous assertions, he recognises the limits of his epistemic authority and seeks to reach a settlement with her eventually after the protracted 'power struggle', albeit never achieving it eventually due to the lack of time.

Looking at the lengthy treatise on the performances of Team I Student 2 (Ex. 35 – 37) and Team III Student 4 (Ex. 38 – 40), it is evident that while the former student is unable to get the SP to follow medical advice, her execution of the consultation is interactionally and arguably as a whole, superior to the latter student. On the other hand, although the latter does indeed stall the SP temporarily in attaining her agenda, his paternalistic approach proved to be unsuccessful in leading to a satisfactory outcome for either party. Instead, his insistence on compliance with medical advice led to a prolonged stalemate which is far from a final resolution—whatever that may be—whilst incurring extra time and effort in the process. In an actual clinical setting, this may be detrimental not only to the hospital's daily operations, but more importantly, to the patient's mental and physical wellbeing. With a patient-centric model of care, students need to recognise that they have to exercise their epistemic authority with care and discretion, while respecting the deontic authority of patients in deciding what sort of treatment ought to be pursued. In the case of Station 1B, it may be wiser for students to allow the SP to make her own decision after clearly explaining the medical reasoning behind the management plan of supportive treatment for dengue fever and the potential consequences of not observing the medical advice. More importantly, students should also be mindful of the SP's feelings throughout the consultation and refrain from invalidating or arguing with her regardless of the circumstances. Achieving a good balance between clinician-assertiveness based on sound medical judgment and patient-centredness based on respect for a person's autonomy is an ability that they need to acquire and hone as they progress along in their future career.

Clinical persuasion skills are of course, not limited to use with patients. In the medical field, the ability to convince fellow colleagues, particularly senior ones, is also critical given the hierarchical nature of the hospital environment. Station 2B, which involves a simulated phone call to a senior doctor rather than a consultation per se, represents an opportunity for students to gain experience in handling such interactions. Being a clinical encounter between a medical professional and doctors-to-be, however, the requirements expected of students performing this scenario are greatly different from that of the other stations. As the overall trajectory of the 'phone call' did not differ much across the three students assigned Station 2B, I have selected excerpts mainly from one student's 'consultation' to depict the manner in which students accomplish the task, with extracts from the other two chosen only to illustrate differing practices or situations. Note that because the interaction is designated as a phone call, especially one supposedly happening in the wee hours of the night, the facilitator had purposefully kept these 'consultations' short, with the mean duration of the three being only 3 minutes and 55 seconds.

Excerpt 41. Station 2B/Team I Student 4: 00:20 Opening Statement of Intent

1	Med Student	:	Uh hello,=
2	Facilitator	:	=[Yes,]
3	Med Student	:	[Hello, hi.] Am I speaking [to Doctor Tan.]
4	Facilitator	:	Yeah, speaking, hi=
5	Med Student	:	=Uh yah sorry to disturb. my name is uh: XXX I'm a
6			medical student with the surgical on-call team.
7	Facilitator	:	Mm HMM,
8	Med Student	:	Yeah. I'm call [↑] ing (.) to ask (.) uh: .hh >cause we
9			have this< uh: (0.5) uh thirty year old [lady-]
10	Facilitator	:	[You've] got
11			five minutes.
12	Med Student	:	Oh: kay (>see ah<) so- there's this thirty year old
13			lady uh Susan Tan and .hh she came in with a: r- (.)
14			a: migratory right iliac fossa pain query (.) uh:
15			appendicitis [and] we'd like to arrange a c- (.)
16	Facilitator	:	[Mmhmm,]
17	Med Student	:	a urgent C-T (.) A-P for her to confirm the
18			diagnosis.

Excerpt 42. Station 2B/Team II Student 2: 00:08 Opening Statement of Intent

1 Med Student : Good morning, uh: is this <Doctor Tan,>
2 (1.3)
3 Facilitator : Uh yes. Hi. Hi. This is Doctor [Tan-]=
4 Med Student : [Hi] Doctor Tan(h),
5 Uh I'm XXX >I'm medical< student with the surgical
6 team on-call, .hh I'm sorry for disturbing you at
7 this time but [uh ()-]
8 Facilitator : [Yeah thanks.] °Ya°=
9 Med Student : =I have a urgent case, (0.3) uh: so uh this patient
10 Miss Susan Tan, .h uh: she's a thirty year old lady
11 she came in with right (.) iliac fossa pain,=
12 Facilitator : =You've got FIVE minutes.
13 Med Student : Okay UH- so currently what we're suspecting is uh:
14 uh: (0.4) possible appendicitis .h and I'd like to
15 (.) get a (.) C-T for her- ↑C-T abdomen pelvis for
16 her, (0.4) uh:

Excerpt 43. Station 2B/Team III Student 6: 00:04 Opening Statement of Intent

1 Med Student : Hi good (1.1) good morning uh: am I speaking to
2 Doctor Tan?
3 Facilitator : Yes this is Doctor Tan, hi who's this?
4 Med Student : Okay I'm (.) XXX one of the uh medical students with
5 the surgical team on call:,
6 (0.3)
7 Facilitator : Hi [XXX.]
8 Med Student : [I'm] calling: (0.2) uh is it a convenient time
9 to talk now?
10 Facilitator : Yeah go ahead two A-M in the night.
11 I'm very sure it's convenient. ((Jokingly))
12 Med Student : hhhh Okay sorry to disturb you uh I have this
13 patient Miss Susan Tan thirty year old year- (0.3)
14 thirty year old lady from the E-D who has .hh right
15 iliac fossa pain (0.5) and uh:: we suspect uh::
16 appendici↑tis.
17 (1.1)
18 So (1.0) uh I'll like to (0.7) call for approval for
19 urgent C-T-A-P.

Excerpts 41, 42 and 43 all start with the standard opening sequence of a phone call, complete with greetings and verification of each other's identity by both parties (Ex. 41 Lines 1 – 6; Ex. 42 1 – 6; Ex. 43 Lines 1 – 5). In addition to this, the students in Excerpts 41 and 42 append an apology of the form, “Sorry to disturb” in their opening lines. Curiously however,

Team I Student 4 chooses to do this before he introduces himself to the recipient (Lines 5 – 6), whereas Team II Student 2 places it after her self-introduction in an extended formulation, “I’m sorry for disturbing you at this time but uh ()-” (Lines 6 – 7). Given its sequential placement, it is arguable that Team I Student 4’s utterance is a *token apology*, typically used to convey politeness perfunctorily. Conversely, Team II Student 2’s utterance is not merely a statement of courtesy, but carries more substantive ‘regret’ for ‘calling’ ‘in the middle of the night’. On the other hand, instead of simply using this construction, the third student employs yet another strategy. In Excerpt 43 Lines 8 – 9, Team III Student 6 enquires, “uh is it a convenient time to talk now?” She receives a response from the facilitator, “Yeah go ahead two A-M in the night. I’m very sure it’s convenient.” (Lines 10 – 11), which was expressed not with sarcasm, but has a teasing, jocular quality to it.⁸ At this point in time, the reader might ask: Are the differences in formulation consequential? The answer may lie just ahead as we continue down the lines.

In all three cases, the students proceed to convey the purpose of their calls after the self-introduction and apologetic sequences (whichever comes first). Team I Student 4 begins with “Yeah. I’m cal↑ling (.) to ask (.) uh: .hh >cause we have this< uh: (0.5) uh thirty year old lady-” (Ex. 41 Lines 8 – 9). Before he could finish his utterance, the facilitator interrupts with pretended impatience, “You’ve got five minutes.” (Ex. 41 Lines 10 – 11). The student thus has to restart his account of the patient’s case (Ex. 41 Lines 12 – 15) before pronouncing his request (Ex. 41 Lines 15 & 17 – 18) at the end of his new turn. For Team II Student 2, following a cynical interjection by the facilitator towards the end of her apology (Ex. 42 Line 8), she produces a succinct statement, “=I have a urgent case,” (Ex. 42 Line 9) that does not communicate the intention of her call directly, but would be conceivably understood by the facilitator acting as a radiologist. She then delves immediately into a description of the

⁸ This property is unfortunately beyond the reach of either written (transcript) or pictorial (screenshot) representation, and can only be gleaned directly from the video.

patient's symptoms (Ex. 42 Lines 9 – 11). Here, the facilitator cuts her off in the same way and format as he does to the first student but with greater intensity (Ex. 42 Line 12). However, unlike in the previous student's situation, her narrative was not impeded as she has basically completed her delivery. She then carries on stating her request, "Okay UH- so currently what we're suspecting is uh: uh: (0.4) possible appendicitis .h and I'd like to (.) get a (.) C-T for her- ↑C-T abdomen pelvis for her, (0.4) uh:" (Ex. 42 Lines 13 – 16).

In the case of Team III Student 6, after the facilitator admonishes the student jokingly, she apologises for her call, "hhhh Okay sorry to disturb you" (Ex. 43 Line 12). Notice that the laughter at the start of her turn shows her recognition of the facilitator's utterance as a tease not to be taken seriously. At the same time, while the form of her apology is principally identical to that of the other two students, it was produced not as a pre-emptive measure but as a second pair part to the facilitator's statement, thus constituting a different type of action: a po-faced response to a tease even when recognition of the humour is evident (Drew 1987).⁹ Thereafter, the student continues with the reason for her call using the description in the 'case notes' (vignette) in essentially the same manner as the others, stating "I have this patient Miss Susan Tan thirty year old year- (0.3) thirty year old lady from the E-D who has .hh right iliac fossa pain (0.5) and uh:: we suspect uh:: appendici↑tis." (Ex. 43 Lines 12 – 16), followed by expressing her intent, "So (1.0) uh I'll like to (0.7) call for approval for urgent C-T-A-P." (Lines 18 – 19). Throughout this entire process, the facilitator does not intrude upon her talk and attempt to unsettle her. While there could be multiple factors at play, with the limited data available, it appears that checking the recipient's availability right after giving the self-introduction may be an effective strategy at nullifying potential hostility when making a call during odd hours of the day.

⁹ According to Drew (1987), po-faced receipts exists along a continuum ranging from humorously going along with the tease (free of seriousness) to interactionally ignoring it (entirely serious). In this instance, the student's response would correspond to a "laughing acceptance, followed by serious rejection of the proposal in the tease" (p. 225) in Drew's typology.

Throughout the rest of the subsection, I trace the development of Team III Student 6's consultation as she navigates the questions posed by the facilitator and successfully convinces him in the end to conduct the diagnostic test, starting first with her delivery of the patient findings (medical history and physical examination). Contrastive examples with comparable excerpts from Team I Student 4's performance are also presented to highlight cases in point.

Excerpt 44. Station 2B/Team III Student 6: 00:39 Delivery of Patient Findings

20 Facilitator : Why ↑°why° why is that so?
 21 (0.5)
 22 Med Student : Okay so uh: because uh (0.3) we are suspecting uh
 23 (0.2) appendicitis so we need to .h confirm the
 24 diagnosis to °move on with her management°.=
 25 Facilitator : =What's (so) urgency (in that) (0.4) Why is it so
 26 urgent.
 27 (0.7)
 28 Med Student : Because uh: there's a: (.) possible (0.9) chance
 29 that the: (0.4) appendix may perforate and then
 30 it'll cause >.hh peritonitis< which is .hhhh very::
 31 uh severe.=
 32 Facilitator : =Can you tell me something (on) the history of
 33 this patient?
 34 (0.3)
 35 Med Student : °Yeah° okay so she has .hhhhh uh: she came in::
 36 <this morning> with pain over her suprapubic region
 37 that migrated to the .hh right iliac fossa .hhhh
 38 this (.)uh: (0.6) some nausea but no vomiting (0.4)
 39 and no urinary symptoms so her vital=signs were
 40 (0.8) she has a fever thirty eight point two
 41 degrees: (0.4) her blood pressure is (0.4) low
 42 [hundred and] ten.
 43 Facilitator : [O↑kay.]
 44 Med Student : Over sixty two.
 45 Facilitator : O↑kay.=
 46 Med Student : =>Tachycardic hundred< and ten.=
 47 Facilitator : =Mmhmm.=
 48 Med Student : =°Heart rate° .hhh S-P-O-2 ninety five percent on
 49 room air.
 50 .hh so our examination (0.2) we: uh so:: she has no
 51 other past medical histree.=.hhhhh when we examine
 52 her (0.5) sh- there was (0.3) uh: >right iliac fossa
 53 tenderness< with (0.3) localised guarding no rebound
 54 tenderness. (0.7) And (0.4) uh:: (0.6) pr and per-
 55 vaginal examinations were normal.
 56 (0.3)

After Team III Student 6 has stated her request (Ex. 43 Lines 18 – 19) in the previous excerpt, the facilitator asks for an explanation at the start of Excerpt 44 (Line 20), to which she explains that because the surgical team suspects a case of appendicitis, they need a CT scan to confirm the diagnosis before proceeding with treatment (Lines 22 – 24). At this point, the facilitator questions the need for an immediate scan (Lines 25 – 26). In reply, the student gives a concise but medically-sound explanation, “Because uh: there’s a: (.) possible (0.9) chance that the: (0.4) appendix may perforate and then it’ll cause >.hh peritonitis< which is .hhhh very:: uh severe.=” (Lines 28 – 31). This simple account of a probable critical prognosis appears to be a sufficient reason for the facilitator, who moves on to his next question about the medical history of the patient (Lines 32 – 33). While her answer seems straightforward enough, the other two students face significant challenge justifying the urgent request in their own consultations, a matter which will be highlighted with the next excerpt. In the subsequent lines, the student goes ahead to deliver the patient’s symptomatic presentation and vital signs in reply to the facilitator (Lines 35 – 42, 44, 46 & 48 – 49). Lastly, she reports no past medical history for the patient and describes the results of the physical examination (Lines 50 – 55). Her entire commentary thus proceeded smoothly across a single extended turn with minimal acknowledgement from the facilitator in Lines 43, 45 and 47.

Excerpt 45. Station 2B/Team I Student 4: 00:49 Delivery of Patient Findings

19	Facilitator	:	<u>Why</u> you want a C-T scan.
20	Med Student	:	Yeah Uh: okay. ↑so (.) um: her symptoms (0.4) uh:
21			sounds suggestive of uh: acute appendicitis and
22			technically [there's-]
23	Facilitator	:	[<u>What</u>] symptoms.
24			(0.4)
25	Med Student	:	Uh: she has um .hh uh: (0.6) >sa- suprapubic reg-<
26			uh: pain which subsequently migrated to the right
27			iliac fossa [()] (0.3)
28	Facilitator	:	[Mhmm.]
29	Med Student	:	and is of intermittent and sharp quality
30			[and she also] had some nausea but currently no:- no
31	Facilitator	:	[Mhmm.]

32 Med Student : vomiting uh .hh
33 Facilitator : Mm.=
34 Med Student : =AND- there's no other urinary symptoms so it's- .hh
35 uh unlikely to be any kind of colic .h urinary colic
36 (0.5) yeah. and uh on examination we noted that
37 she's febrile .hh an:d there's also some uh: .hh
38 uh >right iliac fossa tenderness and guarding< (0.5)
39 so: uh: (0.4) we al[↑]so did a: blood test for her and
40 she currently has a high total whites lah. .h so:
41 (0.5) her: (0.5) h- her'm: menstrual score is uh:
42 .hh uh <suggestive> of uh appendicitis but we're not
43 entirely sure (.) that's why we wa[nt to-]
44 Facilitator : [Operate lah::!]
45 Med Student : |((Smiles sheepishly with bemusement))
46 Facilitator : This one you tell your team lah! Operate lah! why
47 you want to C-T scan lah:: (0.8) for: what!
48 (0.8)
49 Med Student : Uh be[↑]cause uh although it's: suggestive but .hh
50 it's not enough for us to: .hh to be sure.
51 (0.5)
52 Facilitator : Sure of what.
53 (0.5)
54 Med Student : That DAH: that the: (.) um: .hh (tsk) (.) >that the<
55 diagnosis is appendi°citis°.

Excerpt 45 represents a contrastive example to Excerpt 44 on the difficulty faced by the student in delivering the patient findings to present a convincing case for his request. Following his statement of intent (Ex. 41 Lines 15 & 17 – 18), the facilitator asks Team I Student 4 the reason for requesting the CT scan (Line 19), just as in Team III Student 6's case (Ex. 44 Line 2), to which the student replies that the patient's symptoms are suggestive of appendicitis (Lines 20 – 22). However, before he could complete his utterance, the facilitator abruptly probes, “What symptoms.” (Line 23). The student therefore launches immediately into a description of the patient's symptoms as specified in the vignette (Lines 25 – 27, 28 – 29, 32 & 34), thereby concluding that it is unlikely to be another condition (Lines 34 – 35). He continues by stating the physical examination findings (Lines 36 – 38) and investigative results (Lines 39 – 42), before attempting to connect these details to the purpose of his call by pronouncing, “but we're not entirely sure (.) that's why we want to-” (Lines 42 – 43). At this

juncture, the facilitator interjects again, voicing his dissent in a “cool, calm and collected” but disputing fashion, “Operate lah::! This one you tell your team lah! Operate lah! why you want to C-T scan lah:: (0.8) for: what!” (Lines 44 & 46 – 47).⁸ As he produces this performative utterance, the student displays a sheepish smile characterised by bemusement (Line 45).⁶ He replies the facilitator with a restatement of his previous point, “Uh be↑cause uh although it’s: suggestive but .hh it’s not enough for us to: .hh to be sure.” (Lines 49 – 50). The facilitator prods further, “Sure of what.” (Line 52), to which the student clarifies his referent as the diagnosis of appendicitis (Lines 54 – 55).

It appears that the facilitator repeatedly challenges Team I Student 4 here because he cannot produce a satisfactory justification for his request. Unlike Team III Student 6, who manages to verbalise the danger that a delayed diagnosis and treatment would pose to the patient (Ex. 44 Lines 28 – 31), he is either unable to conceive of this explanation, or has not found an opening to convey it. In any case, simply stating that the purpose of the CT scan is to confirm the diagnosis proves to be insufficiently convincing for the facilitator. We shall see later that this problem becomes exacerbated further down his consultation due to a lack of knowledge on the other possible causes of the patient’s presentation, which the scan would conclusively eliminate if she indeed has appendicitis. For now, the next excerpt shows Team III Student 6’s approach in addressing this very issue known as differential diagnosis.

Excerpt 46. Station 2B/Team III Student 6: 00:39 Ruling out Differentials

57	Facilitator	: So you think it’s appendicitis right?
58	Med Student	: Ye:s:.
59	Facilitator	: Then why don’t you just go and operate why you want
60		me to do a C-T scan in the middle of the night.
61		(0.4)
62	Med Student	: Uh because we need to (0.2) confirm the diagnosis
63		and [rule out other differentials.]
64	Facilitator	: [What are whu whu whu yeah] rule out <u>what</u> ?
65		(0.5)
66	Med Student	: Okay so uh (.) since as she’s a- lady: we might
67		also: suspect uh pelvic inflammatory disease.

68 (0.6)
69 Facilitator : ↑Mm[↓hmm.]
70 Med Student : [Yeah] so [we]
71 Facilitator : [What] else?
72 (0.9)
73 Med Student : °Uh° there could also be a diverticulitis °even
74 though-° (0.2) but that's (0.2) less likely (0.5)
75 bec[ause sh] of her age.
76 Facilitator : [°Okay°.]
77 (0.4)
78 Med Student : [But we need] to rule out other differentials so=
79 Facilitator : [°Okay°.]
80 Med Student : =that we don't do the wrong surgery.
81 (1.0)
82 Facilitator : O:↑kay. But then uhm (0.5) are you trying to say
83 that if I do a C-T scan now:, and I give you a
84 result (0.5) you'll actually operate in the middle
85 of the night?
86 (1.1)
87 Med Student : Yea::h um (0.3) so: >after the C-T scan then we'll
88 know the diagnosis and then we can< (0.6) if it is
89 appendicitis then we'll do an emergency surgery
90 (0.2) to remove the appendix.
91 (0.3)
92 Facilitator : So mean to say you'll operate now? (0.2) >In the
93 middle of the night<?
94 Med Student : Uh:m not sure whether the surgeon is available that
95 one I have to discuss with the team, (0.6) have to
96 find out from the team. (0.4) But they will
97 definitely operate as soon as possible it, (0.5)
98 because it's an emergency.
99 (0.6)

Based on the patient findings Team III Student 6 has presented (Ex. 45), the facilitator questions the need to do a CT scan given that the surgical team on call already believes it to be an appendicitis case, and flippantly proposes, “Then why don’t you just go and operate why you want me to do a C-T scan in the middle of the night.” (Line 59 – 60). The student then counters, “Uh because we need to (0.2) confirm the diagnosis and rule out other differentials.” (Lines 62 – 63). As alluded to above, differential diagnosis is “the application of a systematic diagnostic method to distinguish on disease or condition from multiple candidate conditions, presenting with similar sign and symptoms” (Volpe 2015:384). To

enact the right treatment plan for the patient, ruling out the possibility of other diseases is crucial. The CT scan is requested precisely because of its capability to derive a differential diagnosis for the patient's multitude of symptoms. As such, the crux of the scenario lies in the ability of the student to convince the radiologist of the importance and urgency of excluding the other probable differentials. After the student raises this pertinent topic, the facilitator pursues it further by asking what other conditions need to be ruled out (Line 64). Given that the effective application of clinical content is equally emphasised alongside communication skills in the third-year CCP, students are expected to make use of their medical knowledge as and when needed during the consultation. For Station 2B, it is in fact explicitly stated in the vignette for the 'actor' (as termed since the facilitator is involved rather than an SP), "*You expect the team (and hence the student) to have done their due diligence to rule out other obvious causes of RIF (right iliac fossa) pain.*" Appearing to be adequately prepared for this question, the student lists out two such differentials, "Okay so uh (.) since as she's a- lady: we might also: suspect uh pelvic inflammatory disease." (Lines 66 – 67), and "°Uh° there could also be a diverticulitis °even though-° (0.2) but that's (0.2) less likely (0.5) because sh of her age." (Lines 73 – 75).¹⁰ She then appends to her latter example an additional explanation, "But we need to rule out other differentials so that we don't do the wrong surgery." (Lines 78 & 80) to avoid being grilled for citing an unlikely condition.

Seemingly contented with her answers, the facilitator throws another spanner in the works with regard to the urgency of the situation, questioning the student whether she will proceed with surgery at this hour if he does the CT scan (Lines 82 – 85). She replies that the scan will (dis)confirm the diagnosis and if it indeed is appendicitis, the team will carry out the emergency operation on the patient (Lines 87 – 90), evidently skirting the issue. Clearly

¹⁰ Note that diverticulitis is also cited by Team II Student 2 as a possible differential, but unlike in Team III Student 6's consultation, the facilitator questions her for doing so because she does not give a disclaimer that the likelihood of the patient having this age-related condition is low. Due to the lack of a good fit with the present analysis, this point and the corresponding transcript is not included in the main text.

dissatisfied this time, he presses her for a definitive answer (Lines 92 – 93). Being unable to avert the question any longer, the student skilfully gives a noncommittal response, claiming that she will have to discuss with the team regarding the availability of the surgeon, “But they will definitely operate as soon as possible it, (0.5) because it’s an emergency.” (Lines 94 – 98). In the ensuing feedback discussion, the facilitator later describes his question as a ‘bait’ to ‘tempt’ her with, and is pleased with the way she handled it.

In comparison, the performance of Team I Student 4 with regard to quoting possible differential diagnoses contrasts starkly with that observed above, as he struggles with the task when explicitly called by the facilitator to do so in Excerpt 47.

Excerpt 47. Station 2B/Team I Student 4: 01:58 Ruling out Differentials

56	Facilitator	: 'Kay, [so:] what do you think the C-T scan will
57	Med Student	[Yeah.]
58	Facilitator	: find for this patient,
59		(0.3)
60	Med Student	: Uh: we just wanna=
61	Facilitator	: =>other than< an inflamed appendix.
62	Med Student	: .hh >We just want< uh: (0.3) make sure that we rule
63		out all the other: differentials for her.
64	Facilitator	: Such as,
65	Med Student	: Such as u::m .hh such as ↓u:h any:: (0.4) uh (0.5)
66		maybe uh (1.2) uh: (1.4) other kinds of uh G-I
67		pathology.
68		[()]
69	Facilitator	: [>↓You're going] to tell me by today right,
70	Med Student	: Hmm?
71	Facilitator	: You're going to tell me by today right,
72	Med Student	: The: C-T scan by today.
73	Facilitator	: No you're going to tell me <u>what</u> other things you
74		want to do now by today right,
75	Med Student	: Uh yes yes (0.4) yeah. so >really< just want to
76		exclude the other G-I pathologies.=
77	Facilitator	: =Such as,
78	Med Student	: Uh like terminal ileitis (0.6) or lik- (0.7) like
79		any kind of uh: (0.3) .hhh. uh (0.5) uh:: .hh or
80		any- (0.7) uh: female uh urin- uh:: geni- (0.6) >or
81		any other< female reproductive (0.5) uh:: °systems°.
82		(0.9) °Pathology yes°.
83	Facilitator	: Such as,
84	Med Student	: °Such as:° (0.7) °uh::° uh: like uh: like any

85 ovarian (0.9) uh: s:: (0.7) ovarian (1.3) <cyst
86 rupture> uh- (2.2) or:: (0.3) torsion (0.6) °of the°
87 t- the fallopian tubes. Yeah, just gonna exclude
88 those.
89 (1.5)
90 Facilitator : <Oh kay,>=
91 Med Student : =°Mm [yes.°]
92 Facilitator : [You] think (.) she's having torsion is it,
93 Med Student : UH no it- it's unlikely that she is::.
94 Facilitator : Oh kay.

Following Team I Student 4's reiteration of his reason for requesting the CT scan (Ex. 45 Lines 49 – 50 & 54 – 55), the facilitator continues questioning its necessity by asking him what possible findings can be obtained apart from a confirmation of the appendicitis (Lines 56, 58 & 61), orienting and steering the conversation to a discussion on differential diagnosis. Picking up on the topic without initially giving any candidate responses (Lines 62 – 63), the student struggles to cite other medical conditions after being prompted by the facilitator with the answer-seeking formulation “Such as,” (Line 64), managing only to give a generic reply of “maybe uh (1.2) uh: (1.4) other kinds of uh G-I pathology.” in an utterance peppered with multiple hesitation tokens, “um” and “uh” (Lines 65 – 67). The unsatisfactory content and wavering delivery clearly reflects his unpreparedness in considering differential diagnosis as an essential component of the station, and more broadly, in convincing a senior colleague to adopt a diagnostic plan.

At this moment, the facilitator overtly displays his discontentment with the answer given by cynically saying, “[>↓You're going] to tell me by today right,” (Line 69), alluding to the fact that the student has been “hemming and hawing” all this while rather than giving a clear line of medical reasoning. When the student persists in giving the same non-specific rejoinder (Lines 75 – 76) after a clarifying side sequence regarding Line 69 (Lines 70 – 74), the facilitator carries on with the same probing question (Line 77). This finally elicits from the student an exact disease, terminal ileitis, as well as “other female reproductive

pathologies” to be differentiated from appendicitis, albeit the latter being yet another general category (Lines 78 – 82). Still dissatisfied with the (un)specificity of the last reply, the facilitator repeats his question again (Line 83), this time garnering two other plausible medical conditions, ovarian cyst rupture and torsion of the fallopian tubes, to be excluded from consideration (Lines 84 – 88). At last, the facilitator acknowledges the student’s points (Lines 90 & 94) and seems sufficiently convinced of his case following a short clarification sequence (Lines 92 – 94). While there is no more trouble in the subsequent talk (not shown) since both parties have now reached a consensus, the overall exchange has been fraught with difficulties as a result of the student’s inability here to properly rationalise the basis for his request according to the accepted clinical decision making model of differential diagnosis.

The next and last excerpt of this subsection shows the final portion of Team III Student 6’s successful consultation, starting from the point where the facilitator displays the first sign of willingness to consider her request, after her adequate presentation earlier in delineating the possible differentials and handling the question on scheduling of the operation.

Excerpt 48. Station 2B/Team III Student 6: 02:51 Facilitator’s Deference to Student

100	Facilitator	: O↑kay o↑kay and you tell me are there any
101		contraindications to do the C-T scan for this
102		patient?
103	Med Student	: Uhm so she is (0.4) not (0.5) pregnan:t uh there’s
104		no:=
105	Facilitator	: =Why do you say she’s not pregnant?
106	Med Student	: That they did a: pregnancy test=
107		=[she’s not pregnant.]
108	Facilitator	: [Oh and she’s negative] is it?= 109 Med Student : =Yes[:.] ((Nods once))
110	Facilitator	: [Oh]↑kay [fine what else?]
111	Med Student	: [And then] uhm (.) she has no
112		>past medical history so no asthma< no uh no kidney
113		disease. (0.3) Uh: no known drug allergy ()
114		(0.7) contras <u>t</u> so::] yeah there’s no=
115	Facilitator	: [Mm↑hmm.]
116	Med Student	: =contraindi[cations.]
117	Facilitator	: [>Is the patient] diabetic<?
118		(0.6)

119 Med Student : Uh: no.
 120 (0.4)
 121 Facilitator : So no Metformin right?=
 122 Med Student : =Eh no. (0.3) No not on any medication. (0.7)
 123 [Yeah.]
 124 Facilitator : [Okay.]
 125 (0.6)
 126 Med Student : And the (0.6) they have already uhm told the patient
 127 the (0.5) the plan and they're (0.2) already told
 128 her to b:e >nil-by-mouth<, (0.7) °Yeah.° (0.3)
 129 So she should be quite ready for the scan.
 130 (0.7)
 131 Facilitator : °Okay.°
 132 (0.3)
 133 Med Student : °Yeap.°
 134 Facilitator : I'll give the C-T scan only this one time okay next
 135 time don't call me.
 136 (0.3)
 137 Med Student : O:kay: thank you very much.
 138 Facilitator : Thanks.

Satisfied with the way the student handled his question on the operation scheduling, the facilitator acknowledges it with “O↑kay o↑kay” in Excerpt 48 Line 100, followed by a next enquiry on whether there are any contraindications in doing the CT scan for the patient (Lines 100 – 102). In considering the factors that may affect the execution or feasibility of the procedure, this question represents a subtle shift in his disposition, for it signals that he is no longer focused on resisting her request but is now orienting towards performing the scan. She replies stating that the patient is “not (0.5) pregnan:t” (Line 103), which led to a short exchange to ascertain the information (Lines 105 – 108); and has “no >past medical history so no asthma< no uh no kidney disease.”, “no known drug allergy” and consequently “no contraindications.” (Lines 111 – 114 & 116). A Q&A sequence follows, arising from the facilitator’s clarification question regarding whether the patient is on a diabetes medicine (Lines 117 – 124). By this time, it is recognisable, at least to the analyst, that he is amenable to performing the scan. Likely realising this as well, the student provides additional details that the patient has already been notified of the plan and kept NBM (Lines 126 – 128),

interpreting the information as “So she should be quite ready for the scan.” (Line 129). With this concluding supposition, the facilitator finally relents. Perhaps as a face-saving measure to account for the reversal of his stance, he pronounces his compliance with a snide remark, “I’ll give the C-T scan only this one time okay next time don’t call me.” (Lines 134 – 135).

A close examination of Team III Student 6’s consultation reveals that sound medical reasoning is the driving force behind her successful persuasion of the facilitator in acceding to her request. By substantiating it with the right arguments, ensuring that the logic between her points is watertight, as well as pre-empting certain foreseeable questions and objections (both content and context-driven) she is able to avert some of the interactional problems that the other students faced. Note that the student does not exhibit any particularly outstanding behaviour and in fact displays a lack of confidence that is evidenced by her slow pace of delivery and mildly shaky voice, an issue which the facilitator also brings up during the feedback discussion. However, the strength of her cohesive reasoning brings her through this call with an ostensibly irritated doctor without being the subject of backlash. While it may not be the case that this approach would work for every other clinical conversation with a senior colleague, it is certainly a fundamental premise of the interactional work that students in the field have to deal with on a daily basis.

3.2 Delivery Features

While each simulated consultation proceeded in a slightly different manner depending on the needs of the scenario in question and the students’ approach to handling the task (the conversational trajectories of which I have traced in Section 3.1), similarities were observed across the board as well. Taking into account the task requirements at hand, I discuss some overarching features observed from a number of these consultations that can be said to reflect the common predispositions of medical students in this study.

3.2.1 Orientation to Information Sharing over Empathic Understanding

One particular characteristic of the consultations, in general, is that the students often pay greatest attention to the delivery of information to the SPs as spelt out in the vignettes. This is unsurprising given that key objectives of the Year 3 CCP are to learn information sharing as the next skill after information gathering (or history-taking), and transit to predominantly clinical exposure in that year of study. Besides, as illustrated in the previous subsection, providing patients with information about their diagnoses or state-of-being, along with presenting the diagnostic and treatment options available, are key components of the medical consultation that doctors have to be proficient in delivering as part of their daily routine. Given the crucial role that information sharing plays in medical decision making, it is no wonder that many people—healthcare professionals and laypersons alike—believe in the pervasive assumption, “the more the better”. Indeed, some researchers claimed that doctors often underestimate their patients’ desire for information and ought to provide more of it during the consultation (e.g. Waitzkin 1985; Orsino et al. 2003). Conversely, other studies have also demonstrated the opposite adage, “less is more”, in view of factors such as the mode of information delivery and patients’ memory of it (e.g. Kessels 2003; Long and Curtis 2015; see Tuckett and Williams 1984 for an early review).

Rather than weigh in on the debate from the perspective of which or who is right, however, I consider the topic in relation to another important aspect of healthcare delivery — empathic understanding of the patient. Note that in accordance with the fundamental spirit of ‘unmotivated examination/observation’ in CA (Schegloff 1996, 1999), the two matters were derived vis-à-vis each other not from predetermined selection but had instead emerged naturally from the data in an overwhelmingly recurring manner. As a working definition, I have chosen American humanistic psychologist, Carl Roger’s early conceptualisation of

empathy. According to Rogers (1959), “The state of empathy,¹¹ or being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the “as if” condition.” (p. 210 – 211).¹² This means that doctors need to understand and feel what patients are experiencing from their point of view while keeping in mind that these cognitive and affective states are those of the patients and not themselves. In this subsection, instances of students’ orientation to information transfer over and above the need to be empathic are presented from across a number of scenarios and situations, but primarily with particularly illuminating examples from Station 3A.

Excerpt 49. Station 3A/Team III Student 1: 00:36 Orientation to Information Sharing

25	Med Student	:	Yah so- um maybe can I [just ask-	]
26	Sim Relative	:	[>But- but< is it] (.)	
27			Is he okay now?	
28	Med Student	:	Mm! Okay ↑so basically your- your father was treated	
29			for this heart attack?=-	
30	Sim Relative	:	=Okay.	
31	Med Student	:	So um (0.4) °uh° >just to tell you now< it was	
32			successful and now [he's in the gene]=[=ral ward,]	
33	Sim Relative	:	[Okay. (.)] [>Okay.]	
34			(.) Okay.	
35	Med Student	:	↑So uh- maybe I <u>jus</u> : uh: ask you- do you know what	
36			a heart attack is and what's your understanding	
37			[about it.]	

Prior to Excerpt 49, the student has just delivered the diagnosis, confirming the SR’s query of whether what she has been told as ‘acute myocardial infarction’ is the same as heart attack. Just as the student tries to establish the SR’s existing knowledge of the medical condition (Line 25 with reference to Lines 35 – 37), the SR anxiously enquires, “>But- but< is it] (.) Is he okay now?” (Lines 26 – 27). Instead of answering the question directly, i.e.

¹¹ Decades later, Rogers updated his idea of empathy in a paper dedicated to the topic, stating that “I would no longer be terming it a “state of empathy”, because I believe it to be a process, rather than a state” (Rogers 1975:4). He did not propose another definition, however, but provided a discursive description of its various facets and supplemented that with operational definitions from other contemporary researchers.

¹² According to Rogers (1959), “If this “as if” quality is lost, then the state is one of identification” (p. 211), a notion suggested by the Austrian psychoanalyst, Sigmund Freud (Laplanche and Pontalis 1967/2018).

relating the patient's physical condition, the student gives a brief summary of the hospital's actions since the incident and reports the final outcome as "successful" and that "he's in the general ward," (Lines 28 – 29 & 31 – 32). Following that, she returns to her original agenda of establishing prior knowledge and asks, "↑So uh- maybe I jus: uh: ask you- do you know what a heart attack is and what's your understanding about it." (Lines 35 – 37). Evidently, the SR's expression of concern for her father's condition is treated by the student not as an opportunity to display empathy, but as a chance to deliver a narrative of what happened and general knowledge about the condition. This represents two facets of information sharing that I have observed in the data: (1) patient updates, in terms of (a) the diagnosis/condition and its symptomatic presentation, as well as (b) the diagnostic/treatment procedures administered or pending; along with (2) knowledge transfer, with respect to the medical content knowledge that students provide to explain Point 1.¹³ Note that this is a delineation of conversational content and does not imply innate differences in categories of talk. The next few excerpts are extracted from different consultations that reflect these various aspects of information sharing.

Excerpt 50. Station 3A/Team 1 Student 5: 01:01 Orientation to Information Sharing

42	Med Student	: Okay? So (.) is- maybe- mmm >you could tell me< do
43		you- uh (.) what do you >actually< know about heart
44		attacks.
45	Sim Relative	: My grandfather passed away from that.
46	Med Student	: OH: okay, °yah°. So:: (.) do you know what it- it-
47		it's due to?
48		((pen clicks)) (0.4)
49	Sim Relative	: Uh:: [N°o::..°]
50	Med Student	: [Not really] °ah↓°. Okay, no worries °uh°. So
51		a ↑heart attack happens: when your heart doesn't get
52		enough blood to pump. (.) Um- um- m- m- m- it does
53		not get enough um blood supply >it needs< so that
54		it can [pump the blood].
55	Sim Relative	: [Bu- But how is] my father's condition <u>now</u> ?
56	Med Student	: ↑Oh okay. Yah, [so currently]-

¹³ In unpublished work presented at two academic conferences, I have used the terms "information sharing" and "knowledge transfer" interchangeably for one paper, as well as "knowledge transfer" and "medical narrative" differently for another (Ng, Ler, et al. 2018; Ng, Tierney, et al. 2018). My nomenclature has now been updated in this thesis to reflect a more nuanced and hopefully accurate understanding of the data.

57 Sim Relative : [Because they] told me: he was in
58 the C-C-U.
59 Med Student : Ah:: yes yes yes I understand. So >currently< your
60 uh- what was done for your father- so what happened
61 was that >he came in< with thi:s (.) uh=
62 Sim Relative : =Mmm.=
63 Med Student : =<chest pain> °right°.=
64 Sim Relative : =Mmm.
65 Med Student : So we put- (.)so he was sent to the <A and E> and
66 we: um: <did an E-C-G> (.) >which is actually< um
67 electro- uh- uh- it's a machine that actually
68 records: .hh um: your heart <activity>.
69 Sim Relative : Okay [okay.]
70 Med Student : [Yes.] And we found that he actually had what
71 we call uh °uh uh° S-T elevation (.) >myocardial
72 infarction.< Basically it's a >heart attack< [that]=
73 Sim Relative : [Mmm.]
74 Med Student : =re[quires]=
75 Sim Relative : [Mmm.]
76 Med Student : =<e:mergency treatment>.

At the beginning of Excerpt 50 (a shortened version of Ex. 26), the student seeks to establish the SR's background knowledge of heart attacks after delivering the diagnosis (Lines 42 – 44) to initiate information transfer, just like in the previous example. However, instead of giving an account of what she knows (or do not know) about it, which would give the student a carte blanche to provide her with the appropriate facts, the SR reports that her grandfather passed away from it (Line 45). At this juncture, the student could have oriented to this as an empathic opportunity to address the underlying concern of heredity in the family, or even used this to elicit further information for history-taking. Instead, any such attempt seems to have been aborted for the agenda of knowledge transfer. In Lines 46 – 47, he attends to the grandfather's cause of death in reference to his initial sequence to find out what the SR knows about heart attacks, to which she claims ignorance (Line 49). The student then goes back to his 'project' and supplies her with the 'relevant' medical knowledge (Lines 50 – 54).

However, before he completes his delivery, the SR impetuously asks, “Bu- But how is my father's condition now?” (Line 55), incrementing it with a clausal glue-on, “Because they

told me: he was in the C-C-U.” (Lines 57 – 58).¹⁴ This indicates that the information just delivered by the student is circumstantially of lesser import, at least at that very moment, than her primary concern for the patient’s current state of health. This time, he orients to her question as a call for more information on the emergency treatment administered, rather than as a request for an update on her father’s present health status. He launches into a procedural account of the events that transpired since the patient’s admission to hospital and the process of diagnosis (Lines 59 – 61, 63, 65 – 68, 70 – 72, 74 & 76), despite her unmistakable use of the word “condition” in her question. Clearly, if the student had actually listened to the SR empathically and sought to understand the question from her perspective of an anxious daughter, the mismatch in information given would not have occurred.

The next excerpt, featuring the remaining student assigned Station 3A, shows a case where a preoccupation towards delivering the medical narrative causes the student to lose sight of the other issues the SR has in mind.

Excerpt 51. Station 3A/Team II Student 3: 03:50 Orientation to Information Sharing

162 Med Student : Okay? Ya. So:: um (.) >a-at a- at< a::- at >this
 163 point in time< do you have any other questions
 164 about.
 165 (0.6)
 166 Sim Relative : >Uh I- I< still have many things that I want to
 167 <↓know:>.
 168 Med Student : >Okay. okay.< [So.]
 169 Sim Relative : [°Yah°]
 170 Med Student : >I- I< just <continue> first? ↑Okay. so↑ (1.1) uh:
 171 from there then we:: gave him some oxygen? (.) to
 172 breathe? .hh (.) and:: and we gave him some
 173 medications: to:: uh >thin the blood<.
 174 (0.7)

¹⁴ CCU refers to the Coronary Care Unit, a hospital ward for heart conditions that require continuous monitoring and treatment. A separate consultation (Team II Student 3) involving the same scenario and SR reveals that she has misunderstood the “CC” in CCU to mean “critical condition”. However, there is no difference in implication because a CCU is in fact an Intensive Care Unit (ICU) for the critical care of cardiac patients in recent times (Katz and Becker 2010).

Before Excerpt 51, the student has just delivered an extensive medical narrative fraught with problems (to be addressed in the next subsection) that includes both procedural details of the emergency treatment and relevant medical knowledge. Halfway through (after explaining how a heart attack occurs), she pauses to ask, “Okay? Ya. So:: um (.) >a-at a- at< a:::- at >this point in time< do you have any other questions about.” (Lines 162 – 164). Rather than being an opening for the SR to clarify all her doubts freely, the student’s offer was made with respect to her preceding delivery. This is evidenced not only by the sequential order in which the utterance is placed, but also her positioning of “about” at the end of the turn, albeit not explicating the referent predicate. Indeed, it even appears not to be an offer to answer any question at all, contrary to its face content. Instead, the sequential environment in which it occurs suggests that it is a token question designed to elicit a continuer from the SR, such that the student can legitimately progress with her information sharing agenda without having to account for a dominating monologue.

However, the SR seems to have taken the question as a genuine and general offer by the student to raise other overriding concerns, proclaiming in the next turn, “>Uh I- I< still have many things that I want to <↓know:>.” (Lines 166 – 167). Yet rather than orienting to her needs with empathy, the student brushes off the SR’s request with “>Okay. okay.<” (Line 168), ironically, and proceeds to complete her sharing of the treatment procedure (Lines 170 – 173). Even though she asks, “I just continue first?” (Line 170) before resuming, seemingly seeking permission from the SR to carry on, it was done hastily without any opening for the SR to voice any disagreement. In explicitly denying the SR of the opportunity to clarify her questions precisely after offering to do so, the student has demonstrated an overwhelming preoccupation with information sharing that has impeded her ability to consider the sensitivities of the SR and the needs of the interaction adequately.

In the next two excerpts, I show that this orientation to information sharing over adopting a being of empathic understanding cuts across other stations in the CCP, i.e. it occurs not as a function of the scenario design.

Excerpt 52. Station 2A/Team I Student 3: 02:49 Orientation to Information Sharing

107	Sim Patient	:	<SUR[gery]> so serious ↓ah?
108	Med Student	:	[°Mmhmm.°]
109			↑Okay. so um: (.) so what this surgery is? is that
110			(0.3) uh it's called an <appendecto[my:??>]
111	Sim Patient	:	[mmm.]
112	Med Student	:	So what is going on is that the surgeon is going to
113			remov- um: to: (.) help you to remove your appendix.
114	Sim Patient	:	°Mmm.°=
115	Med Student	:	=Um: the reason why we do this is (.) um: .hh (0.2)
116			while appendis- (.) while appendicitis itself↓ (0.2)
117			um: >is not< (.) is not very serious, the main thing
118			is that we are afraid that the appendis- (.) the
119			appendix will bu:rst? When it burst then all the
120			<germs:> (.) all the dirty things inside will go to
121			the rest of your <belly:>. So >we do-< we don- >we
122			don't want that< okay?=
123	Sim Patient	:	=°Orh:..°

Excerpt 53. Station 1A/Team III Student 3: 02:12 Orientation to Information Sharing

93	Sim Patient	:	=S-so is it I'm I'mm-in a very <u>serious</u> condition
94			↑now?
95	Med Student	:	Okay so ↑like basically like dengue: (0.3) can
96			present in people different ways.
97	Sim Patient	:	Uh-↓huh.
98	Med Student	:	So sometimes it can be like quite mild in people
99			like, >you can have a< dengue (0.2) like, (0.2) >you
100			can have a dengue< infection but you might not be
101			very unwell but [with some people they- (0.2) they
102	Sim Patient	:	[°Mmm::..°]
103	Med Student	:	just tend to get more sick with it.
104	Sim Patient	:	Uh::: so so (0.3) um ↑mine i:s:: what kind of, (2.0)
105			so what is it going on with me no[w so I'm (oh)]
106	Med Student	:	[Oh kay.]
107	Sim Patient	:	I mean because you did mention some is mild, some
108			is not so so what about me?
109	Med Student	:	Okay so [for <u>you</u> :] (0.2) we noticed that your fever
110	Sim Patient	:	[Uh huh.]
111	Med Student	:	is pretty ↑high?=
112	Sim Patient	:	=Mmhmm.=

113 Med Student : As well as like you have- (0.3) your heart rate is
 114 quite (.) ↑fasst [so] there's some things that
 115 Sim Patient : [↑Okay.<]
 116 Med Student : like we're concerned about [tha]t's why we (.) we're
 117 Sim Patient : [Mm.]
 118 Med Student : admitting you as well like- >°because° we'd like to<
 119 monitor you (0.4) [like ju]st check on you as you
 120 Sim Patient : [°Oh.°]
 121 Med Student : like- (0.2) yeah as you recover.

Excerpt 52 (a fragment of Ex. 29) is an example we have seen previously in Section 3.1.2. After the student mentions the need for surgery (see Ex. 29 Lines 105 – 106), the SP exclaims in a performative manner where the excerpt begins, “<SURgery> so serious ↓ah?” (Line 107), clearly conveying her apprehension towards the treatment plan. Yet other than minimally acknowledging her concern with “°Mmhhh.°” (Line 108) and “↑Okay.” (Line 109), the student replies with an explanation of the surgery, citing its name (Line 110) and describing it procedurally (Lines 112 – 113), before providing a rationale for the operation from Lines 115 to 122 (refer to analysis on Page 62). Here the student appears to believe that an objection to a medical procedure ought to be handled by providing more information about it, rather than resolving the matter by seeking to understand the SP's underlying concern.

For Excerpt 53 (a fragment of Ex. 25), which has also been discussed earlier, the SP asks, “=S-so is it I'm I'mm-in a very serious condition ↑now?” (Lines 93 – 94) as a display of concern for her present state of health. Seemingly avoiding the question, perhaps because the prognosis for dengue fever is often unclear, the student instead provides information on the possible progression of dengue, “So sometimes it can be like quite mild in people like, >you can have a< dengue (0.2) like, (0.2) >you can have a dengue< infection but you might not be very unwell but with some people they- (0.2) they just tend to get more sick with it.” (Lines 95 – 96, 98 – 101 & 103). As noted in the previous analysis (see Section 3.1.1 Pg. 50 – 51), this answer is clearly unsatisfactory to the SP, who pursues the question further with an upgraded design (Lines 104 – 105 & 107 – 108). Only with this does the student respond

sufficiently with information about SP's condition (Lines 109, 111 & 103 – 104). If she had adequately considered the SP's emotional state and needs, instead of focusing on her own agenda of 'dispensing' all the 'required' information to complete the task, the SP's follow-up question, and her accompanying anxiety, would have been obviated much earlier.

As illustrated by the examples above, students are first and foremost preoccupied with information sharing during their consultations—be it about patient updates or the supporting medical knowledge—rather than being concerned with the interactional needs of the SP/SR. Indeed, translation of medically-relevant information, most of which is procedurally-focused or content-based in nature, is attended to with such single-mindedness and intensity that the students' vernacular or laic ability to detect and recognise their interlocutors' emotional displays appears to be significantly compromised. There are therefore missed opportunities to demonstrate empathic understanding at appropriate moments that could lead to trouble or even potential breakdowns in communication. While information giving remains crucial to the medical consultation, students need to be made more aware of the other side of the task to be able to navigate between the medical and emotional discourses with greater finesse and confidence. Even where information is warranted, assuming an empathic orientation will allow students to identify the right information to deliver in the face of a request, instead of simply being driven by their own agenda or dictated by the task requirements at hand.

3.2.2 Inadequacy in Calibrating the Use of Language

Another common feature of the students' consultations, as seen in a number of cases, is the ineffective choice of vocabulary while talking to the SP/SRs, who do not have the same background training as them. Indeed, doctors are often criticised for using medical jargon that patients do not understand. Much research has shown that patients frequently misunderstand medical terminology and doctors consistently overestimate patients' understanding of their language (Koch-Weser, DeJong, and Rudd 2009; Blackman and Sahebjalal 2014). There

have also been calls from professional bodies like the Royal College of General Practitioners in the UK and the AAMC in the US for doctors to avoid jargon and adopt plain language during their communication with patients (Rowlands et al. 2014; Jablow 2016).

In the subsection, I present some cases where the words used by students hindered the SP/SR's understanding and led to communication problems. The first excerpt below contains three segments of the same consultation, each of which has one site of lexical trouble that eventually led to significant disturbance for both parties.

Excerpt 54. Station 3A/Team II Student 3: 01:01 Inadequate Calibration of Language Use

34	Sim Relative	: [>HOW-] HOW is he <u>now</u> ?<
35	Med Student	: Currently he's <stable>? he's
36		[in the <general ward>?]
37	Sim Relative	: [Okay but I- I heard] that he was in the CCU
38		°is it°?
	...	...
94	Med Student	: ↑So okay. so this: (0.7) um:: (.) his uh: heart- his
95		heart attack? (.) <u>he::</u> (.) >when- when< he came to
96		the:: emergency department? So we did some <u>tests</u> ?
97		Like (.) we did a E-C-G? =
98	Sim Relative	: =°Mm hmm.°°=
99	Med Student	: =The one where you stick the stickers:? (.) °Like-°
100		to check the electrical: (0.5) um (0.6) .hh (.) cir-
101		(0.2) <currents> of the uh- (.) <u>chest</u> .
102		((Gestures with right hand in circular motion in
103		front of her own chest))
104	Sim Relative	: °>You mean there is electrical current on his
105		chest?<° ((Looks bewildered))
106	Med Student	: In- inside the heart. >cause that's< <u>how</u> the heart
107		beats. °Some::°
108	Sim Relative	: °I-° >I don't understand<, ((Shakes head))
109		you mean there is <u>electric current</u> in his heart?
110		((Looks even more bewildered))
111		(3.0) ((Student smiles exasperatedly at audience))
112	Med Student	: °Um:° (0.4) >it- it< is:: (.) because HOW the heart
113		<u>BEATS</u> ? it's- it needs some electrical st-
114		< <u>stimulation</u> >? ((Smiles awkwardly at "stimulation"))
115		(1.3)
116	Sim Relative	: Okay (.) so- >[so what] exactly is this (.) I- I=
117	Med Student	: [Yah::]
118	Sim Relative	: =really don't °understand.°< ((Shakes head))
	...	...
127	Med Student	: So (.) after this <u>E-C-G</u> , .hhh uh we found tha:t (.)

128 um there was <a (.) portion-> >a< part of his heart?
129 .hhh <Tha::t u::m> was injured.
130 (1.2)
131 Sim Relative : °°Part of his heart [is injured.°°]=
132 Med Student : [Ya.]=>one ↑part of
133 his heart was injured.<
134 Sim Relative : You mean like. (.) >wh- why< is it injured.
135 Med Student : Oh >because< (1.1) the:: (.) >that-< portion of the
136 heart did not receive enough <oxygen>?
137 (0.7)
138 Sim Relative : O:kay?
139 Med Student : Yah (.) <so this is due to?>=
140 Sim Relative : =But when you [mean] injured meaning: he had a fall=
141 Med Student : [Mmm.]
142 Sim Relative : =>and all this thing< and >he hurt his heart< or:.=

In Excerpt 54, following a procedural account of the events since the patient entered the hospital (not shown), the SR anxiously enquires about her father's condition, "[>HOW-] HOW is he now?<" (Line 34). In response, the student announces that "Currently he's <stable>? he's in the <general ward>?" (Lines 35 – 36), to which the SR asks a further question about his previous stay in the coronary care unit. While the exchange is itself not problematic, the student's choice of the term "stable" may not be particularly illuminating to laypeople.¹⁵ This is because it merely implies that no immediate change in the patient's condition is anticipated, but is not mutually exclusive with either "critical" or "serious", i.e. a person can be both "critical" and "stable". Nonetheless, it appears that the SR has accepted the use of the word to mean that her father is 'fine'.

However, the student's subsequent inadequate choice of vocabulary leads to her getting into 'trouble' with the SR. She begins her delivery of the medical procedures that were performed on the patient by first describing the use of an electrocardiogram (ECG) to diagnose the heart attack (Lines 94 – 97 & 99 – 101). In her depiction, she mentions the use of "stickers" to "check the electrical: (0.5) um (0.6) .hh (.) cir- (0.2) <currents> of the uh- (.)

¹⁵ "Stable" is also used in an imprecise manner in the medical field, and "does not reliably indicate normal observations or variations in observations within physiological limits" (Scott, Vijayan, and Male 2011:d7504).

chest.” (Lines 99 – 101). Unexpectedly, the SR latches onto this utterance and questions with a bewildered look, “°>You mean there is electrical current on his chest?<°” (Lines 104 – 105). The student promptly replies that it exists inside the heart and is the way which the heart beats (Lines 106 – 107). With a look of greater bewilderment, the SR repeats her question, “°I-° >I don’t understand<, you mean there is electric current in his heart?” (Lines 108 – 109), effectively upgrading her personal stance using the first TCU while shaking her head at the same time.⁶ Apparently baffled by the SR’s utterance, and possibly distracted by another student’s exaggerated reaction (the bed view camera shows a male student placing his hands flatly on each side of his face during the SR’s turn, in a manner similar to Norwegian artist Edvard Munch’s famous painting, *The Scream*), the student turns her sight towards the audience smiling exasperatedly during a silence of 3 seconds. She then turns towards the SR and reformulates her previous reply by explaining that the heart needs electrical stimulation to beat, producing an awkward smile while uttering the last word “<stimulation>” (Lines 112 – 114). Still, the SR remains perplexed and seeks further clarification by asking, “Okay (.) so->so what exactly is this (.) I- I really don’t °understand.°<” while shaking her head (Line 116 & 118). Although the confusion quickly got resolved in the omitted lines, the issue surfaced because of the student’s indiscriminate use of the term “electrical current” caused the SR to be alarmed. Notwithstanding the layperson’s lack of awareness about the normal, necessary presence of electricity in the heart, her use of the expression easily conjures up the image of a strong and deadly electrical flux, which would understandably worry the SR when mentioned in relation to her father’s health. In this case, the problem could have been averted easily by excluding the detailed description from the start, or more generally, through the avoidance of potentially troubling terminology in the medical consultation.

Last but not least, the student uses another word whilst reporting the ECG results that undermined referent understanding for the SR, shortly after straightening out the previous

one. She informs the SR, “So (.) after this E-C-G, .hhh uh we found tha:t (.) um there was <a (.) portion-> >a< part of his heart?.hhh <Tha::t u::m> was *injured*.” (Lines 127 – 129). After a major pause of 1.2 seconds, the SR repeats the last part of the student’s utterance almost inaudibly with a slight reconstruction, “°°Part of his heart is injured.°°” (Line 131). Oblivious to the SR’s display of bemusement, the student affirms the SR’s expression by restating her own point (Lines 132 – 133). At this juncture, the SR voices her concern, “You mean like. (.) >wh- why< is it injured.” in Line 134. Yet the student remains unaware that her word has once again created a breakdown in intersubjectivity. She answers the question by stating that the injury stems from a lack of oxygen to a particular portion of the heart (Lines 135 – 136). This however was obviously unsatisfactory for the SR, who acknowledges the student minimally after a 0.7 second pause (Lines 137 – 138), and follows up on her question before the student could elaborate further (Line 139) by asking, “But when you mean injured meaning: he had a fall =>and all this thing< and >he hurt his heart< or:.” (Lines 140 & 142). This statement shows that her understanding of an “injury” is limited to a bodily wound dealt by a physical blow, and differs from the medical sense which may include tissue damage with a disease aetiology that occurs without an external force.¹⁶ Indeed, as Ong et al. (1995) noted, there is a distinction between medical and everyday language vocabularies. Doctors are ‘bilingual’ in everyday and medical language, whereas patients are typically unfamiliar with the latter and only speak the former. Common terms like “injury”, “appear to have both a clinical and a lay meaning, constituting a basis for misunderstanding” (p. 910).

The next excerpt shows a case from Station 1B where instead of a single word that diverges in professional and laic denotation, the student uses a medical term that has a slightly different connotation in everyday language and in an actual medical setting, which nonetheless affected the SP’s understanding and led to some alarm.

¹⁶ There is apparently no agreed upon definition even in medicine either. According to Langley and Brenner (2004), “The theoretical definition of injury is problematic since there is no basic scientific distinction between disease and injury.” (p. 69).

Excerpt 55. Station 1B/Team III Student 4: 03:02 Inadequate Calibration of Language Use

191 Med Student : =So (0.3) what happen is that when you lose a lot of
192 platelets,
193 Sim Patient : ↑Mm hm.
194 Med Student : Your blood. (0.2) >You know youss goinst have a bit
195 of internal bleeding here and there right?
196 (0.5)
197 Sim Patient : ↑WHAT? ((Leans forward))
198 (0.4)
199 Med Student : Like (0.3) >you you'll< start bleeding a bit more.
200 (1.3)
201 Sim Patient : I will start- ((shaking head))
202 (1.0)
203 Med Student : Like (0.4) okay ↑so what what happens is that
204 [right ss:: (0.4) within your body=
205 Sim Patient : [↑Mmhm.
206 Med Student : =you (.)because there is no platelets your blood
207 is a bit th:inner right?
208 Sim Patient : ↑Mmhm.
209 (0.3)
210 Med Student : >You you< might start (0.2) bleeding more la. <I
211 mean (.) it >it's not something that you can see.=
212 It's not like orh you are going to start vomiting
213 out blood or what but it's all happening within your
214 blood< (0.2) <your: body>.
215 (0.4)
216 Sim Patient : Oh::[oh:]o↓kay:↑.=
217 Med Student : [Yea,]
218 Med Student : =Okay?
219 (0.3)

In explaining severe dengue fever, the student states at the start of the excerpt that when the body loses a lot of platelets, internal bleeding will occur. He shares the information in a question format with an underlying assumption that the addressee knows about it, “>You know youss goinst have a bit of internal bleeding here and there right?” (Line 194 – 195). This proves to be problematic for the SP, who, following a 0.5 second pause (Line 196) questions the student’s statement in an accentuated exclamation, “↑WHAT?” (Line 197), complete with an upward-rising intonation contour and increased speech volume, as she leans forward in her chair. The student then reformulates his description as “Like (0.3) >you you’ll< start bleeding a bit more.” (Line 199), but the SP continues to show astonishment, as

exemplified by an even longer pause of 1.3 second (Line 200) and her partial repeat of his statement, “I will start-” while shaking her head in disapprobation (Line 201), as if it is morally implicative. Only in the student’s ensuing explanation where he clarifies that the bleeding is not manifestly visible that she seems reassured (Lines 206 – 207 & 210 – 214).

Yet this does not address the root cause of the problem, which actually stems from his use of the term “internal bleeding”. Though descriptively accurate in both everyday and medical language, its everyday usage tends to confer the implication of a serious, even fatal emergency; whereas in actuality, its extent of severity can range widely. Also, in claiming that there will be “*a bit* of internal bleeding *here and there*” the student’s construction elevates the seriousness of the situation considerably, while the use of “*youss* goinst have” implicates the SP directly. In this instance, if mentioning this symptom is deemed necessary, it is probably better for the student to downgrade his stance to avoid alarming the SP of a probable situation that may not happen, by delivering it in a non-judgemental formulation (statement rather than question with assumption) that contains minimal subjective comments. For example, a candidate design could be, “There may be some internal bleeding if your body loses too many platelets”, which presents the information neutrally without over-insinuating that it will be the SP’s definite consequence.

The last excerpt involves a somewhat antithetical example to my analysis thus far of student’s inappropriate language use, which has centred on their orientation to “medical talk”. Contrary to the previous examples, Excerpt 56 shows that students may at times use overly everyday language in communicating with patients.

Excerpt 56. Station 2A/Team II Student 1: 03:34 Inadequate Calibration of Language Use

132 Med Student : Um: (0.6) Okay so: that’s first step. Next step is:
 133 IF: we confirm is appendicitis[s,] there’s some
 134 Sim Patient : [Mmm.]
 135 Med Student : possibility it’s not but we think it’s very likely:..
 136 .hh um then (0.3) um then: (0.7) t’urm (0.4) the

137		likely- (0.9) the <u>best</u> way to get rid of a aflamed
138		appendix is to take it <u>out</u> .
139		(1.1)
140	Sim Patient	: ↑Orh[:.] (0.8) Take out that means operation la.
141	Med Student	: [°Mmm.°]
142		°Uh:.° (0.9) So uh: we call this an appendectomy,
143		which means taking out your appendix.

In Excerpt 56, a truncated version of Excerpt 28, the student explains the treatment option of surgery to the SP as “the best way to get rid of a aflamed appendix is to take it out.” (Lines 137 – 138). However, her usage of the laic expression “take it out” becomes a source of trouble for the SP. After a pause of 1.1 seconds (Line 139), the SP realises that the student was referring to surgery and exclaims, “↑Orh:. (0.8) *Take out* that means operation la.” (Line 140). Despite this, the student persists on using her ambiguous expression in the next turn when giving the name of the surgery, “°Uh:.° (0.9) So uh: we call this an appendectomy, which means *taking out* your appendix.” (refer to Section 3.1.2 Pg. 55 for a more complete analysis). This puzzling phenomenon of reverting to and insisting on using a laic term may be explained by the student’s desire to obey the general principle of using plain language when communicating with patients. Paradoxically, the expression “taking out” proved to be even more confusing to the SP, who prefers the medical term “operation” instead. Students thus have to recognise that there is some medical terminology that has found its way into people’s everyday language and have been adopted in favour of a more generic expression because of its greater precision, as per the reason for its usage in medicine. Also ironic is the student’s decision to highlight the clinical name of the operation, “appendectomy” in precisely the same turn, just as she opts for the supposedly common expression of “take out”.

As seen from the examples above, the students are very much inadequate in adopting the right choice of words in their interactions with the SP/SRs. Despite only having been in medical school for less than three years, it appears that they have acquired medical language to such a great extent that their ability to use everyday language with others outside the field

has been considerably compromised. Not only are they simply attuned to purely professional talk either, as the last excerpt shows. It is clear that imposing a universal principle of using simple vocabulary does not work, because students may have lost touch as to what constitutes medical language that are now commonly and overwhelmingly used as part of the everyday lexicon. The question then, is not “How do we get students to use less jargon?”, but “How do we get students to *calibrate* their language use appropriately according to the situation?”, as the title of this subsection suggests.

CHAPTER FOUR: THE FEEDBACK DISCUSSION

4.1 Overall Framework

For medical students to learn clinical communication effectively, practicing their skills in simulated consultations with the help of SPs is just the beginning. The next critical step is to obtain feedback for their performance that would consolidate the learning and inform their delivery of future consultations, allowing them to bridge the gap between actual and desired outcomes (Cantillon and Sargeant 2008).

The model of feedback giving adopted for use in the CCP is known as “Pendleton’s rules”, first drafted by British business psychologist David Pendleton and colleagues (though not labelled as such). These rules, as first written, specified that feedback should: (1) clarify matters of fact; (2) encourage the learner to go first; (3) consider what has been done well first; and (4) make recommendations rather than state weaknesses (Pendleton et al. 1984:75). According to the authors, in a revised version of the book two decades later, the rules were originally designed to create a safe learning environment for students in response to the antiquated practice of teaching through humiliation in the medical field that was commonplace in bygone times (Pendleton et al. 2003). In its actual implementation, one way that the feedback session can advance is to begin with a clarification of any point-of-fact questions. Next, the learner shares what he/she thinks was done well, followed by the teacher sharing what he/she think was done well. The learner then indicates what he/she thinks was not done so well and could be improved on, after which the teacher indicates what he/she thinks was not done so well and finally suggests possible improvements (Launer 2016).

In this section, I discuss the various stages of the feedback discussion as executed in the CCP. Given that Pendleton’s rules has evolved to become more prescriptive in actual practice over the years, the CCP feedback discussions also appears more rigidly enacted than

specified in the original rules, instead resembling more contemporary versions of the model revised by others, particularly that which is described in McKimm and Swanwick (2012:7):

- (1) Check the learner wants and is ready for feedback
- (2) Let the learner give comments/background to the material that is being assessed
- (3) The learner states what was done well
- (4) The observer(s) state what was done well
- (5) The learner states what could be improved
- (6) The observer(s) state how it could be improved
- (7) An action plan for improvement is made

Although generally following the guidelines laid out in (Pendleton et al. 1984) and structured in a similar manner as the organisation delineated above, it is clear that there is nonetheless considerable structural variation across the data, and no two discussions are ever entirely the same. Still, there are four clearly identifiable components common to all (except Station 2B, where there is no SP): (1) student's reflection; (2) audience's feedback; (3) SP's feedback; and (4) facilitator's feedback.

While most of the discussions proceeded in that overall order, other than at the start where the supposed specific sequence is: Students' positive self-appraisal > Audience's positive feedback > Students' negative self-appraisal > Audience's negative feedback; facilitators often vary the sequence as the interaction unfolds, and include other elements of their own (e.g. questions to all students). Nonetheless, to facilitate comparison of the data between cases, this section has been organised according to these broad divisions. At the same time, I have chosen one student's feedback discussion to feature as a common denominator across each subsection, in the hope of maintaining a sense of congruity for the reader. Team III Student 2 is selected to illustrate the different components of the feedback discussion due to the facilitators' rather strict adherence to Pendleton's rules in his case.

4.1.1 Student's Reflection

With the exception of Station 1, whose facilitators began the feedback discussions requesting a student from the audience to summarise the preceding simulated consultation, all other sessions started with a self-appraisal by the student in the hot seat. The general format corresponds to Steps 3 and 5 of the abovementioned structure described in McKimm and Swanwick (2012). The next few excerpts demonstrate how this is done.

Excerpt 57. Station 3B/Team III Student 2: 14:26 Student's Reflection (What was Done Well)

493 Facilitator 1 : Okay. .hh XXX. So (0.3) uh: what do you think you
 494 (.) <did well> [in this] scenario let's talk about
 495 Med Student : [Ur:m::.]
 496 Facilitator 1 : the- (0.7) the positive things first.=
 497 Med Student : =Ur:m:: (0.7) I think I tried to-uh: address his:
 498 um: concerns a::nd I tried to like (0.9) >do what I
 499 was supposed to do lah< like give him the: (0.3) the
 500 <advice> a:nd=
 501 Facilitator 1 : Oka:y,
 502 (0.6)
 503 Med Student : Like >counselling< him on his medication and
 504 [stuff.]
 505 Facilitator 1 : [Mmhmm.] Hmm.
 506 Med Student : ↓<Yea::h.>
 507 (0.6)
 508 Facilitator 1 : So addressing his==
 509 Med Student : =>Addressing his con[cerns.< Yea yea yea.<]
 510 Facilitator 1 : [His conce:rns. Okay.] And the:
 511 wh- what other things you- you said that you felt
 512 that (0.3) you:: (0.3) were able to: (0.3) make him
 513 feel <ca:lm> and all that lah. °(But-what)° HOW did
 514 you feel (.) that he took that well.
 515 Med Student : °Uh make him feel calm lah (I think)° Uh: (0.3) I
 516 THINK (1.1) I think I tried to: (0.6) °uh° (0.8)
 517 listen: (back) like (0.3) understand why he did-
 518 like why he smokes and (.) why: um °why'd- like°
 519 (0.6) his reason behind smoking all these .hh like
 520 not- and not just like jump to conclusions: ↓like
 521 why like he smokes because he >what what< like try
 522 to listen to him.
 523 Facilitator 1 : <So listen to [his concerns.> Okay
 524 Med Student : [Yeah mainly listening to his
 525 Facilitator 1 : okay.]
 526 Med Student : concerns] °actually.°=

The facilitator starts the discussion by first asking the student, “what do you think you (.) <did well> in this scenario let’s talk about the- (0.7) the positive things first.” (Lines 496 & 498). The student replies as a positive aspect of his consultation that he tried to address the SP’s concerns and advise him on medication (Lines 497 – 500 & 503 – 504). After affirming what the student said (Lines 508 – 509), the facilitator then follows up on his response by enquiring the actions taken by him to ensure that the SP felt calm (Lines 510 – 514), to which the student said that he tried to understand the reason behind the SP’s habit of smoking without judgment. The opening sequence ends with the facilitator restating his answer in summary. As noted above, this is a formulaic way of commencing the feedback discussion, one constructive feature of which is it elicits a desired response from the student in introspectively acknowledging the areas of good performance. The next excerpt shows how the facilitator elicits the same student’s negative self-appraisal down the lines, after asking for positive feedback from the audience in between.

Excerpt 58. Station 3B/Team III Student 2: 18:16 Student’s Reflection (What Could be Improved)

625	Facilitator 1	:	°Okay. So apart from the: (0.9) from the: good
626			things° Let’s talk about (.) something that you felt
627			you could improve on.
628			(0.5)
629	Med Student	:	URM: (.) ((Clears throat)) I think I- (1.4) not sure
630			if my content was enough la. Like >I-I< I don’t know
631			if I- =>like I tried to< address his concerns but
632			.hh I’m not sure they were <u>addressed</u> like
633			adequately: (0.6) [enough:..]
634	Facilitator 1	:	[What-] (0.5) What do you
635			think. What do you feel was not (.) not enough?
636			(1.0)
637	Med Student	:	Like< (0.4) in like- (0.3) >especially regarding<
638			the <u>medications</u> : like (.) like he ask me oh >do I-do
639			I< have to take it for life >that kind of thing I
640			said uh: I actually I not< sure: uh maybe just ask-
641			=we can ask the docto:r about it. [.hh] Then he
642	Facilitator 1	:	[°Okay.°]
643	Med Student	:	ask me >why I must why I must take longer (I say-)<
644			just like try to give like some .hh [(maybe)] like

645 Facilitator 1 : [hh]

646 Med Student : (.) generic reason like oh: >you have to take it
647 long term 'cause it prevents the heart attack that
648 : kind.<

649 Facilitator 1 : Mhm.

650 Med Student : >SO I'M NOT SURE LIKE-< (0.2) like if I gave him a
651 (0.2) like a GOOD reason enough to actually take the
652 medications.

653 Facilitator 1 : Mhm.=

654 Med Student : =That kind of thing.

655 Facilitator 1 : Mm[hm.]

656 Med Student : [Yea.]
657 (0.9)

658 Facilitator 1 : °Okay:..° But you did< °e-° (0.4) SAY that you were
659 not sure[:].

660 Med Student : [↓Yah]:

661 Facilitator 1 : And that you::- y'know you said you are not sure but
662 you'll find out more.

663 Med Student : Yea.=

664 Facilitator 1 : =So: (0.3) ->a-a-a< at least show him that (0.7) you
665 knew that (0.4) you were not very sure about it uh:
666 °you'll go and find out more lah.°

667 Med Student : And like I (expect) like that smoking part I'm not-
668 I'm not sure .like if I was s- SUPPOSE to actually
669 counsel him on .hh like smoking cessation. (0.4)
670 'cause I think like that's like (0.2) another like
671 huge topic.
672 (0.4)

673 Facilitator 1 : But I think that was a- (0.1) good [sugg]estion,
674 ((Looks towards Facilitator 2))

675 Facilitator 2 : [Yea.]

676 Facilitator 1 : [Yes. Mm.]

677 Med Student : [Yeah so] like >I-I-I< just >I don't know whether
678 it's appropriate to just go [oh]< I just refer you
679 Facilitator 1 : [°Mm.°]

680 Med Student : to: [to the-]

681 Facilitator 2 : [But that] was a appropriate [(suggestion)]

682 Facilitator 1 : [Yes.]

683 °Mm.°=

684 Facilitator 2 : =°Yea.°

685 Facilitator 1 : Mm. Because in a real-life scenario you would also:
686 the- [patients] would also ask you the same

687 Facilitator 2 : [°Mm.°]

688 Facilitator 1 : questions. [(.)] And you would also say that-that

689 Facilitator 2 : [Mhm.]

690 Facilitator 1 : that you will refer them (0.4) for-for that. So I
691 think that was quite yah. (0.5) Uh: anything else
692 that you felt .hh
693 (1.1)

694 Med Student : Uh:: (0.8) I- I stuttered here and there:: that kind
695 (.) like (.) .hh at some POINT >then I was like< I
696 quite- I quite didn't know what to say.
697 Facilitator 1 : °Mhm.°
698 Med Student : So >I-I< I stuttered here and there >and then then
699 like< I-I'm not sure if I came across like a bit
700 like (0.4) <nervous> and unsure of what to say .hh
701 (0.4) [°(then I-)°]
702 Facilitator 1 : [↑Okay-] (.) That's interesting. >I-I-
703 I'll< .h I'm gonna check with the rest what they
704 felt °uh° before I come back to that [because] >I-I-
705 Med Student : [°Sure. °]
706 Facilitator 1 : I< can give you some feedback about that. .hh
707 (1.4)

In Excerpt 58, the facilitator formulates her question to elicit the negative self-appraisal with “°Okay. So apart from the: (0.9) from the: good things° Let's talk about (.) something that you felt you could improve on.” (Lines 625 – 627). The student replies that he is not sure whether the information he has supplied adequately addressed the SP's concerns (Lines 629 – 633). When thrown back the question and asked to elaborate on what he thinks is insufficient (Lines 634 – 635), he explains that he is doubtful if he has properly answered a query from the SP about whether and why the medication has to be taken for the long term (Lines 637 – 641, 643 – 644 & 646 – 648), surmising that he is unsure if he had given the SP enough reason to take them (Lines 650 – 652). In response to this lack of confidence and self-denunciation, the facilitator reassures the student by stating *thrice* in various reformulations that he did acknowledge his uncertainty in front of the SP and promised to find out more information at the very least (Lines 658 – 659, 661 – 662 & 664 – 666). She recognises that the student may have been overly critical of himself, and tries to nullify its negative consequences by pointing out a mitigating factor in his delivery. Indeed, given that students may be affected by the experience of sharing in front of their peers the mistakes they perceive themselves to have made, facilitators have an important role to play in steering the discussion away from (self-) criticism and towards constructive learning.

After the facilitator has addressed this point, the student mentions another occasion where he was unsure about his content delivery. This uncertainty concerns whether he was right in counselling the SP on smoking cessation when the issue of smoking was brought up (Lines 667 – 671), to which a second facilitator affirms its appropriateness (Lines 681). The first facilitator concurs with her assessment and states the congruency of his action with what would have been done in a real-life situation (Lines 685 – 686, 688 & 690 – 691), before asking him if he would like to bring up any other point (691 – 692). In this case, rather than pointing out solutions to the student’s self-declared problems, which would correspond to the last point of the original Pendleton’s rules in making recommendations rather than stating weaknesses, the facilitators here do not find his approach problematic and turns to assuaging him instead. The student then raises a last concern about stuttering (Lines 688 – 701), to which the first facilitator states that she will allow the other students to contribute first because she has some personal feedback on the issue to add later (Lines 702 – 704 & 706).

The two excerpts above show how a strict adherence to the prevailing adaptation of Pendleton’s rules have been used to draw out the learning from within the student with regard to both positive and negative aspects of his consultation. However, the data shows that more often than not, facilitators employ a less rigorous, or more flexible (depending on perspective) approach to applying the model in their discussions. Excerpt 59 depicts a more prevalent type of opening formulation found in five of the 18 feedback discussions reviewed.

Excerpt 59. Station 2A/Team II Student 1: 09:17 Student’s Reflection (How Did You Feel)

284	Facilitator	:	You okay? Okay? how do <u>you</u> - how do you feel, (0.3)
285			How did it go (.) for you.
286			(0.5)
287	Med Student	:	°Uh[:°.]
288	Facilitator	:	[You] had a rough ↑time, Did you sweat it ↑ou::t,
289	Med Student	:	Hehehehe.
290	Facilitator	:	How did you feel.
291			(0.5)
292	Med Student	:	.hh I think Miss Tan was very nice >so it was like<

293 she didn't put me in any hard positions.=
 294 Facilitator : =°Uh huh.°
 295 Med Student : Um: .hh (0.5) I guess I wasn't- I was a bit unsure
 296 throughout: [(0.4)] [the thing?] [cause I]
 297 Facilitator : [°Mm hmm.°] [°Mm hmm.°]
 298 Med Student : didn't know what (1.0) she wanted to know::
 299 (.) or[::] how much detail to give her and
 300 Facilitator : [Mm hmm.]
 301 Med Student : [stuff.]
 302 Facilitator : [Mm.] Mm hmm.=
 303 Med Student : =>So it's like< [(0.8)] trying to avoid jargon (.)
 304 Facilitator : Mm.=
 305 =>so there were a lot< of uh::s.
 306 (0.8)

At the beginning of Excerpt 59, the facilitator asks, “Yah? You okay? Okay? how do you- how do you feel, (0.3) How did it go (.) for you.”, “You had a rough ↑time, Did you sweat it ↑ou::t,”¹⁷ and again “How did you feel.” (Lines 284 – 286, 289 & 290), displaying concern for the student while simultaneously engaging her in commencing the feedback discussion. In reply, she comments that the SP was very nice and did not put her in a spot (Lines 292 – 293), before disclosing that she was unsure about the information sharing aspect (Lines 295 – 296, 298 – 299 & 301). She then brings up her difficulty in avoiding jargon that leads to plenty of hesitation tokens, “uh” (Line 303 & 305). Notice here that unlike in Excerpt 56, the facilitator does not begin the discussion by adhering to the ‘rule’ of asking “what was done well” as the first question, but instead enquires about the student’s feelings. This results in her offering information regarding the problems she faced instead. Indeed, when the facilitators casually formulate their initial prompt as an open question, in four out of the five cases, students displayed an overwhelming propensity in orienting to their own shortcomings, effectively answering the “what could be improved” question instead. We shall see in the next two excerpts from the same student how the facilitator deals with this.

¹⁷ The first TCU in this utterance is a question produced with upward intonation despite its declarative look in written form, with the entire turn said in a sing-song manner. It therefore is clear from the video that Line 288 is a display of concern by the facilitator and not an attempt to specifically elicit negative self-appraisal from the student. Furthermore, the student was not primed by it to begin with something undesirable either, given that she initially started off with a positive commentary (Lines 292 – 293) in response to “How did you feel.” (Line 290).

Excerpt 60. Station 2A/Team II Student 1: 09:48 Student's Reflection (What was Done Well)

307 Facilitator : °Okay°, so:: what did you (.) think you did well.
308 (1.7) ((Med Student looks downwards, then at
309 vignette))
310 Med Student : I guess I tried to address her <con:cerns>,
311 Facilitator : =Okay, what [else.]
312 Med Student : [Um::] (0.5)
313 and to ex[plain things-]
314 Facilitator : [So did you think] you did a good job in
315 addressing her personal °()°?
316 (1.8)
317 Med Student : I answered [all the] <questions> (.)=
318 Facilitator : [Okay.]
319 Facilitator : =Okay.
320 Med Student : She brought [up at] least [yea.]
321 Facilitator : [Good.] (.) [That's] good okay what
322 else?
323 Med Student : Uh::m.
324 (1.0)
325 Med Student : I tried to explain things in terms sh- I thought
326 she might understand (.) cause >[so sometimes] it's
327 Facilitator : [°Yes.°]
328 Med Student : a little [hard like-]
329 Facilitator : [So simple-] simple terminology which
330 patients (.) can understand:: not those .hh very
331 difficult terminology which we- which we usually
332 talk [and also] simple jargon [°y'know°?] °okay°
333 Med Student : [Yeah.] [Mmm.]
334 Facilitator : no- no- no unnecessary words and- ↑°o(h)kay° very
335 good I agree too↑. >Anything else.<
336 (1.0)
337 Facilitator : >Nothing that's all you do well?<
338 Med Student : °Yes.° Heheh.

As Line 307 shows, the facilitator steers the focus “back on track” to positive self-assessment by asking, “°Okay°, so:: what did you (.) think you did well.”, to avoid having the student continue expounding on her weaknesses. This indicates that he has to redirect the conversation in accordance with Pendleton’s rules when the open questions used previously (Ex. 59 Lines 285 & 290) did not work. After looking downwards and momentarily at the vignette for 1.7 seconds (Line 308) seemingly in brief thought, the student replies, “I guess I tried to address her <con:cerns>,” (Line 308 – 309). The facilitator then prompts her further,

posing a question on whether she thinks that she addressed all the SP's concerns (Lines 310 & 312 – 313), to which she answers affirmatively (Lines 317 & 320). When prodded again for another point, she cites her use of simple terminology with the SP (Lines 325 – 326 & 328), which the facilitator readily agrees (Lines 327, 329 – 332 & 334 – 335). He tries again to elicit another answer from her (Line 335), this time to no avail (Lines 336 – 338), before moving on to the next question in Excerpt 61 below.

Excerpt 61. Station 2A/Team II Student 1: 10:31 Student's Reflection (What Could be Improved)

339	Facilitator	: Uh:: I'm supposed to ask you what (.) could you have
340		done better.
341	Med Student	: .hhh Umm >I think I could have< been more:: (0.6)
342		I think I was a bit unsure >so I think some of that<
343		came across:.
344		(0.8)
345	Facilitator	: Okay, but you <u>are</u> a medical student in that sense
346		you are not a (.) the scenario doesn't give you:-
347		doesn't empower you as a .hhh [registrar] or a=
348	Med Student	: [Yeah yeah.]
349	Facilitator	: =resident [or] a consultant.=
350	Med Student	: [Mmm.]
351		=Mmm.
352	Facilitator	: It does empower you as a student and that bit of
353		unsureness .hh would be <u>there</u> when you start off
354		so:: th- that- >because it's-< (0.3) it's just the
355		exposure you're not being exposed that much
356		[so] I <u>wouldn't</u> take that against you.=
357	Med Student	: [°Yeah:°]
358	Facilitator	: =°Ah what else.°
359		(0.9)
360	Med Student	: Um-=
361	Facilitator	: =Or you shouldn't (.) be <u>harsh</u> (.) on yourself
362		[about that.] (.)=
363	Med Student	: [Hehehe.]
364	Student 6	: [hhh hhh]
365	Med Student	: [Hehehe.]
366	Facilitator	: =[Let's put it like that]=You shouldn't be harsh
367		on yourself about that.
368	Med Student	: Mmm.
369	Facilitator	: What else?
370		(2.0)
371	Med Student	: Uh:: (0.7) I think I mentioned (.) surgery too early
372		then she got a bit (0.5) °sho'k-° like startled a
373		bit so maybe I could've done that slowly:: and

374 introduced it later.

375 Facilitator : Yup. (.) the:: that's true I mean uhh:: (.) you
376 could have start off- (0.4) uh:: just given the
377 start off uh::=

378 Med Student : =Yeah.

379 Facilitator : That you had an x-ray and you have so many blood
380 investigations and .hh from that the team has (0.4)
381 thought that you (were) appendicitis possibly you
382 said that?

383 Med Student : Mmm.

384 Facilitator : Uh:: and uh we are sort of pending investigations
385 [right] now, (0.4)

386 Med Student : [Mmm.]

387 Facilitator : And the:: investigation show that then maybe we'll
388 consider °surgery° =>because< .hh right now you
389 don't know [which] way it's going to go (.)=

390 Med Student : [Yeah.]

391 =Mmm.

392 Facilitator : So yah, but- but I think (0.5) her initial: this
393 (0.9) you- (1.0) when she was surprised, she was a
394 lil' bit anxious (.) but you took on that well
395 thereafter=You realised that I:: think- you took on
396 the- so you did well on that part °I think°.

397 (0.6)

398 Facilitator : °Yeah.° Is there any strong points you want to say?
399 (0.6) ((Student shakes head))

400 Facilitator : No? ↑°okay.°

In accordance with Pendleton's rules, the facilitator moves on to the question about what she could have done better in, which the student has actually began her sharing on right from the start. Interesting, he formulates his question as "Uh:: I'm supposed to ask you what (.) could you have done better." (Lines 339 – 340), perhaps orienting to the fact that the topic has already been broached before he asks. The student replies stating that she thinks some of her uncertainty came across to the SP (Lines 341 – 343), to which the facilitator tries to reassure her by stating that because the scenario empowers her with the epistemic status of a medical student rather than that of a more senior doctor, she is allowed to possess greater uncertainty (Lines 345 – 347, 349 & 352 – 356). In particular, he comforts her by personally asserting, "I wouldn't take that against you" (Line 356), and advising her twice not to be harsh on herself (Lines 361 – 362 & 366 – 367).

The facilitator then nudges her for another area of improvement (Line 369). After a 2.0-second musing (Line 370), she raises the point about her having mentioned surgery to the SP too early in the consultation (Lines 371 – 372).¹⁸ Concurring with her assessment this time (Lines 375 – 377), the facilitator recommends that she could have explained the results of the blood test and X-ray as indicative of appendicitis instead, and said that investigations are pending to determine if surgery is necessary in the SP's case (Lines 379 – 382, 384 – 385 & 387 – 389). As encouragement, he affirms her subsequent corrective action with the SP as a job well done (Lines 392 – 396). Winding up this portion of the discussion, he reverts to asking her the previous question again, “°Yeah.° Is there any strong points you want to say?” (Line 398), to which she declines by shaking her head (Line 399). While the facilitator may have wanted to end the student's reflection component on a positive note so as to defray her negative self-criticism, he inadvertently ‘flaunts’ the rules he is supposed to follow, at least in its present-day incarnation. Having students strictly reflect on what was done well before what could be improved may thus be a shortcoming of the current model of Pendleton's rules.

The examples above reflect the two primary question designs which the facilitators employ to get students to begin reflecting upon their consultations before receiving feedback from the rest. When facilitators formulate their questions in an open format such as “how do you feel” (Team II Student 1 & Team III Student 1), “how did it go” (Team I Student 3), or “what do you think” (Team I Student 4), it appears that students tend to be self-critical and orient to the negative aspects of their delivery. On the other hand, when facilitators follow Pendleton's rules strictly, students are ‘forced’ to consider the positive side of things before the areas for improvement, just as the creators have hoped for. This is however, not to say that a strict adherence to the rules is necessary good, for it also seems from Excerpt 59 (and the self-appraisals of other students) that students face difficulty recognising the strengths of

¹⁸ Refer to Chapter 3.1.2 Ex. 27 Pg. 53 – 56 for the corresponding excerpt of her consultation and the analysis.

their consultations even when explicitly asked to do so. At the same time, a freer approach may allow for more in-depth discussion of targeted issues without having to artificially identify good or bad points that are not central to the student's improvement. I shall continue to consider this issue in the subsequent subsections.

4.1.2 Audience's Feedback

In strictly adopting Pendleton's rules in a stage-like manner, the next step after asking students to identify what was done well is to open the same topic to the floor for feedback from the audience, which in this case would be the rest of the students who have been observing the student in the hot seat giving the consultation. For this component, the different facilitators have their own preferences in the selection of speakers. As briefly noted earlier, the two facilitators of Station 1 begin the discussions chaired by them not with the student giving his or her reflections, but by requesting one member of the audience to first summarise the consultation proceedings before inviting the rest to comment on the student's performance. In contrast, while most other facilitators do structure the overall discussion generally according to Pendleton's rules, some of them prefer to solicit the audience's feedback collectively while others favour calling upon students individually. Practices could also differ equally as a function of interactional dynamics, rather than personal preferences. Given the variation that exists, examples of feedback from discussions that contrast markedly in their patterns of audience engagement are presented in this subsection with respect to the two questions of "what was done well" and "what could be improved" so as to showcase the diversity in the data.

Excerpt 62. Station 3B/Team III Student 2: 15:28 Audience's Feedback (What was Done Well)

527	Facilitator 1	:	=Okay, that's that's good. Okay SO in terms of (.)
528			°um:° you guys, what do you think he (0.3) did well,
529			(0.4)
530	Student 5	:	I think he like- (.) his composure was actually
531			quite (0.3) [impressive] because this is actually a

532 Facilitator 1 : [Mm hmm.]

533 Student 5 : difficult topic like there are so: many things to

534 cover in such a short time =>you need< to talk about

535 the <lifestyles> his [.hh] medica[tion] how it

536 Facilitator 1 : [Mm hmm.] [Yeah,]

537 Student 5 : happen whatever .h whatever rubbish and like he: .hh

538 h- he actually like covered v- very adequate ground

539 like in such a short amount of time. And he did it

540 well =his- >he didn't< like rush through the

541 patient. [hh] Yeah he was very pa- (0.3) Ye:ah.

542 Facilitator 1 : [Mm hmm,]

543 Student 5 : H-he listen. He address the concern so (0.4) yeah

544 quite impressive actually.=

545 Facilitator 1 : =Okay so as a lay person you could actually <feel

546 that> .hh °uh° he was taking the ti:me to explain

547 everything [to] the patient.=

548 Student 5 : [Yes.]

549 =Yes.

550 Facilitator 1 : ↑Okay, (1.7) What about: (0.7) °XXX YYY°?

551 ((Student 2 and 3's names uttered consecutively))

552 (2.5) ((Student 2 looks at Student 3, who turns away

553 slightly))

554 Student 2 : [.hh-] ((Turns head back to the front))

555 Student 3 : [(° °)] ((Looks at Student 2))

556 °Oh° [nh: you can go first.] ((Pats Student 2's

557 right shoulder with left hand))

558 Student 2 : [(You can go first.)] ((Looks at Student 3))

559 Uh- I just think that um maybe: (0.7) °um-° his:- (.)

560 >so like two things< I think his <tone> a:nd (.)

561 body language were (0.4) quite good because like-

562 (.) >I think it< (0.3) °in-° (.) it made the- (.)

563 p:atient's tone looks like more nervous at the start

564 (0.3) but after a while I noticed that the patient's

565 tone: changed [(and he started-)] s:- there was like

566 Facilitator 1 : [Mm hmm:.]

567 Student 2 : less anxiety in his voice can tell.

568 Facilitator 1 : Mm hmm.=

569 Student 2 : =So I think there's 'cause like your voice like- you

570 have good composure.

571 Facilitator 1 : °Mm hmm.°

572 Student 2 : [The:n-]

573 Facilitator 2 : [How-] how did you pick up on anxiety when someone

574 is speaking.

575 Student 2 : ↑Like-=

576 Facilitator 2 : =You have a point. But how.

577 Student 2 : Like I felt like- if-a-a:t the start the (.)

578 patient's voice was like <softe:r> he was a little

579 bit more .hh reluctant to volunteer [infor]mation.=

580 Facilitator 2 : [Mm.]

581 =More reserved.

582 Student 2 : And like more of uh like °(attri-)° voice will
583 tremble a bit [more.]
584 Facilitator 2 : [°Mm] mm.°
585 Student 2 : But after a while his voice jus:’ (0.2) sounded more
586 like steady: and a little [louder] (0.6)
587 Facilitator 2 : [Mm mm.]
588 Student 2 : [Ya. Then] .hh I also felt that um: what I like was
589 Facilitator 2 : [(Oh kay).]
590 Student 2 : that he: did a >small road map< (0.3) or lik- some
591 things that you were gonna:=discuss. Then- (.) I
592 guess >different things were brought up to the
593 discussion ‘cause the patient will ask questions<
594 but he tried: to .hh gave some sort of structure.
595 (0.5)
596 Student 3 : Mm[hm.]
597 Student 2 : [↑Ya] ya I like that. (0.8) Mmhm.
598 (0.6) ((Student 2 looks and gestures at Student 3,
599 who gives her a sideways glance in return))
600 Student 3 : °Oh° (0.3) uh: actually I was gonna say all those
601 also. .hh ((Gestures at Student 2))
602 Student 2 : [Oh:.] |((High-fives with Student 3))
603 Student 3 : [Then] just to add on I-I- (.) I think you match the
604 tone of voice with the patient’s la. ↑So: .hh I
605 think that kinda >contributed to the rapport<. =So
606 he talk- he talk like softer so you also talk
607 softer: (°I th’nk it’s good lah.°)
608 (0.8)
609 Facilitator 1 : °Okay° but it’s very interesting right, that uh:
610 (0.8) almost everybody in the room sort of picked up
611 on the same: (.) [same:] same thing which is
612 Med Student : [Mm:.]
613 Facilitator 1 : important because when you: when-when other people
614 ar:e: (around-) are getting your message across and
615 you are picking up on the cues that .h uh his: he’s
616 relaying. (0.4) So: I mean-in °e-° (0.4) for example
617 I think you’s:- >first of all< you sat and then
618 you: .hh °uh:° (0.5) sit (down and to) explain: this
619 to him °(yah I hope that Mr Tay) is everything okay
620 >are you feeling okay<° So you are trying to set the
621 <scene:> a:nd try and make him feel comfortable so
622 °(that-that’s that’s uh) I- I think°>I think
623 everyone< felt that that was: something that was
624 quite use:ful and uh: °they picked up on that.

Excerpt 62 (which immediately succeeds Ex. 57 and precedes Ex. 58) exemplifies a prototypical positive audience feedback component of the entire discussion that proceeded in strict observance of the rules, while containing both means of feedback solicitation. After the

student has completed his reflection on what was done well (Ex. 57), one of the facilitators opens up the question to the audience (Lines 527 – 528). The first to volunteer his feedback is Student 5 of this particular session (see Figure 9 below for the audience’s sitting positions). He proclaims that the student in the hot seat (henceforth SHS in this subsection and where necessary to avoid confusion between the students) was impressively composed and empathic in spite of the difficult scenario and did it without rushing through his delivery (Lines 530 – 531, 533 – 535, 537 – 541 & 543 – 544). Interestingly, in describing the information needed to be shared with the SP, he characterised it as “whatever rubbish” after listing out some of these topics (Lines 534 – 535 & 537), revealing much about his underlying attitude towards them. To acknowledge his contribution, the facilitator affirms her understanding of Student 5’s comments (Lines 545 – 547), to which he agrees (Lines 548 – 549).

Next, she turns her attention to two other students, Students 2 and 3 and selects them as next speakers by asking, “↑Okay, (1.7) What about: (0.7) °XXX YYY°?” from Lines 550 to 551 (with the cipher characters being the two students’ names mentioned in succession). Ostensibly caught “off guard”, a 2.5-second interval ensued where Student 2 looks at Student 3 while the latter first remained silent in perceptible thought and then turned her head slightly away from Student 2 and the facilitator (Line 552 – 553), in a visible display of reluctance to be the first to respond. At this juncture, Student 2 was about to say something when Student 3 produces an inaudible utterance in overlap (Lines 554 & 555). The two next attempts to give each other the floor at the same time, both declaring, “You can go first” (Lines 556 & 558), but with Student 3 patting Student 2 on the right shoulder using her left hand in a stronger display of willingness to have her take the turn (see Figure 9 below for the embodied action). Student 2 then proceeds to comment that the SHS’s tone of delivery and body language had helped the SP to be less anxious gradually (Lines 559 – 565 & 567), ending her commentary by concluding that the SHS had good composure (Lines 569 – 570). Given its similar content

with Student 5's proximate feedback, alongside the fact that it is spontaneously prompted, Student 2's response is clearly parasitically derived without actual substantial contribution.

Figure 9. Screenshot of Station 3B/Team III Student 2: Student 3 pats Student 2 on the right shoulder using her left hand in a stronger display of willingness to have her take the turn. (In anticlockwise direction from the right: Facilitator 1, Facilitator 2, Student 1, Student 2, Student 3, Student 4, Student 5, SP and SHS.)

Just as Student 2 completes her turn, the second facilitator asks in clarification, “How- how did you pick up on anxiety when someone is speaking.” (Lines 573 – 574). In response, Student 2 first states that the SP’s was more reluctant to volunteer information at the start of the consultation, but his soft voice became steadier and louder from an initial trembling state (Lines 577 – 579, 582 – 583 & 585 – 586). She then offers a second point that the SHS “did a >small road map<” of items for discussion, which gave structure to the consultation despite the likelihood of questions from the SP that may derail his delivery (Lines 588 & 590 – 594). Winding up her observations with an affirmative remark (Line 597), Student 2 turns her head towards Student 3, who looks up and transiently gives her a sideways glance (side-eye) with an unamused look of displeasure for reselecting her as the next speaker (Lines 598 – 599).⁶ Left with no option but to speak, Student 3 unabashedly claims with an accompanying gesture in reference to Student 2 that she was about to bring up the same points (Lines 600 – 601).

Student 2 reacts with an acknowledgement token, “Oh:.” and enthusiastically gives Student 3 a high five that was received with less fervour (see Figure 10 below). While this is happening, Student 3 offers her own point about the SHS’s matching of the SP’s speech volume as contributing to the building of rapport (Lines 603 – 607). Finally, Facilitator 1 wraps up this part of the discussion with her own feedback, remarking that “it’s very interesting” how “almost everybody in the room” identified the same matter of picking up cues from the SP to “set the <scene:> a:nd try and make him feel comfortable” (Lines 609 – 611 & 613 – 624).

Figure 10. Screenshot of Station 3B/Team III Student 2: Student 2 enthusiastically gives Student 3 a high five that was received with less fervour.

In closely analysing Excerpt 62, it is not difficult to notice that both Students 2 and 3 are unprepared to contribute to the discussion at hand, with Student 3 being the most unready and reluctant to share. Having been ‘arrowed’ by the facilitator out of the blue, however, they are faced with no other choice but to ‘manufacture’ some discussion points synthetically. Corroborating the content of their utterances against each other and with the rest of the excerpt, it is evident that Student 2’s comments about tone and body language are at least in part derived from Student 5’s overall assessment of the SHS’s demeanour as confident yet empathic, while Student 3 has in turn utilised Student 2’s points when she describes the

SHS's delivery as appropriately pegged to the SP's loudness of voice. Interestingly, the facilitators seem unaware of their 'hogwash' or are unwilling to expose it, congratulating them instead on the commonality of their observations. At the same time, Student 2 also appears largely oblivious to Student 3's attempt to avoid selection by the facilitator as well as her subtle display of irritation exhibited when being chosen as the next speaker, ironically giving her a high five instead when she claims to have wanted to present the same points. From the rich material embedded in this single excerpt, it is reasonable to conclude that the most fruitful discussion is one where participants organically offer their own points rather than being forced to do so. Therefore, facilitators should first allow all students to volunteer their responses, and only resort to 'volunteering' people in the absence or lack of replies. In this case, while the facilitator has constructed her question openly to the audience and elicited voluntary feedback from Student 5, she decides to select Students 2 and 3 as the next speakers—who happen to be ill-prepared at the moment—instead of allowing the floor to remain continually open. Not only does this result in unnecessary distress for these students, the rest of the audience have also been denied the chance of speaking at that very opening, which may not be available subsequently especially in light of the rigid discussion format.

The next excerpt shows an example from Station 1A, where the facilitators guide the discussion with a different structure as previously described.¹⁹ There is therefore no clear delineation between the two questions. Instead, apart from the beginning where a student is specifically elected to give his feedback, the rest of the audience feedback contains a more 'organic' mixture of both positive and negative elements. On the flipside, this departure from the rules may predispose the discussion to a lack of focused attention on the part of the audience, as the following analysis suggests.

¹⁹ Note that Facilitator 2 does not make an appearance in this excerpt.

Excerpt 63. Station 1A/Team II Student 5: 26:29 Audience's Feedback (What was Done Well & What Could be Improved)

238 Facilitator : Okay can. You have two minutes to reflect °on° (1.3)
 239 whatever has happened,
 240 Sim Patient : Hhh hhh.
 241 Facilitator 1 : and get your friend to give a summary of (.)
 242 Student 2 : Okay so [uh:] (1.0) so regarding uh: have to
 243 Facilitator 1 : [Your case.]
 244 Student 2 : explain the diagnosis of dengue to Missus Tan
 245 [so um] I just jump straight to what the well done
 246 Facilitator 1 : [Okay,]
 247 Student 2 : and improvement part. Is that okay? (0.9)
 248 Facilitator 1 : | ((Nods head))
 249 Student 2 : So um I think uh he use the 'SPIKE' so um
 250 ? : [°Hhh hhh.°]
 251 Student 2 : ['SPIKE' treatment] to: explain this diagnosis (0.7)
 252 uh of dengue the:=
 253 Facilitator 1 : =So is that appropriate.=
 254 ((Signals Student 2 with his right hand to pause))
 255 Med Student : =That's not appropriate. No.
 256 Student 2 : That is uh::=
 257 Student 6 : =Bad news ah.
 258 Student 2 : >Yeah that is for bad news lah but it depends lah.
 259 Med Student : >Maybe maybe dengue is bad ne[ws.]
 260 Student 2 : [Maybe it's] bad news
 261 to a person.=
 262 Student 5 : ='Cause she think she can [die what.]
 263 Student 2 : [()] FOR ME I think
 264 that it's a framework that you can use but you need
 265 to adapt it to the [severity of] situation.
 266 Facilitator 1 : [(°Okay.°)] ((Nods head))
 267 (0.8)
 268 Student 2 : So in this case like he emphasised more on the:
 269 (0.8) the- ↓uh perception part. (0.5) Then like
 270 invitation he asked (the dee one) to (know). So that
 271 is (0.5) not very relevant in this case.=
 272 Facilitator 1 : =And then.
 273 Student 2 : And uh knowledge was whatever [he:] he gave
 274 Med Student : [Reflects.]
 275 Student 2 : lah. So- like I said (.) uh it's a good framework to
 276 start with but the thing he need to modify it as
 277 per situation.
 278 Facilitator 1 : Okay,
 279 Student 2 : Oh yes. He addressed the I-C-Es of the patients so
 280 it's quite obvious he asked for any ideas concerns
 281 [and] literally expectations
 282 Sim Patient : [.hh]
 283 Student 2 : [(.) for for the patient.]=
 284 Sim Patient : [.hhhhhhhh]=O(h)kay. .hhh
 285 Student 2 : Um so when he started off he explained the purpose

286 of why is he there, why he's there: and and uh:
 287 >like reveal the ()<
 288 So that he gives us a clear understanding of (0.8)
 289 uh give the patient a clear understanding of what
 290 he's there for. (0.7) Then he: ↓uh >SO what he does
 291 is that he explain the treatment plan (0.4) clearly.
 292 (0.8) Um: but I think some part of the treatment
 293 plan I'm not sure about the accuracy of it.=
 294 Med Student : =I also not very sure of the [accuracy. .hhh]
 295 Student 2 : [So like the ()]
 296 (.) pplatelet transfusion part [uh::.]
 297 Facilitator 1 : [Okay.] (0.6)
 298 We will: go through that in a while,
 299 Student 2 : Okay then uh another thing that is well done was
 300 that he introduced patient education on uh about
 301 dengue [so] °the five mozzie wipeout.°
 302 Facilitator 1 : [Okay.]
 303 Student 2 : So improvements um (0.7) ↓uh: I mentioned before
 304 it's the framework to adapt to (0.5) situation (0.4)
 305 the treatment plan part with the knowledge gap and
 306 the use of jargons °ah°.°
 307 Facilitator 1 : °Mm hmm° ((Nods head))
 308 (1.4)
 309 ? °Yah.°
 310 'Kay. the rest any comments, (1.2) do you think you
 311 may: have done differently, or you think was good
 312 that you would have done the same,
 313 (3.6)
 314 Student 5 : Actually I think the patient was quite um satisfied
 315 °um° (.) with the consultation.=
 316 Student 6 : °°She's not.°° (Smiles broadly, shakes head and
 317 points at Sim Patient with right index finger))
 318 Student 5 : She's not ah.= ((Sees the rest begin smiling and
 319 looks at them bewilderedly))
 320 All : =hhh hhh hhh hhh hhh hhh hhh hhh
 321 Student 6 : She's unsatisfied.
 322 Student 5 : OH okay but it's like I thought she was like smiling
 323 lah yes yes, at least uh I know that something will
 324 be done 'cause you know what's happening.
 325 Facilitator 1 : O↑kay?
 326 Student 5 : But it seems that [I'm wr↑(h)ong ()]
 327 All : [hhh hhh hhh hhh hhh hhh hhh hhh
 328 Student 5 : I won't say anymore >I won't say anymore<.]
 329 All : hhh hhh hhh hhh hhh hhh hhh hhh
 330 Facilitator 1 : But but what do you all think what do the rest
 331 think. Do y'all think:.
 332 (1.6)
 333 Student 6 : I thought it was okay. ((Smiles frivolously))
 334 Facilitator 1 : <You think: I think (1.1) It was not::>
 335 Student 1 : She's just a bit like uptight because um (0.6) she

336 doesn't know (0.5) what has been done so far.
337 Facilitator : Okay,
338 Student 1 : Yah. And um: (0.3) she needs she just I think she
339 just needs reassurance that- uh- um since her
340 admission (0.3) um (0.3) what the doctors has done
341 is [to] investigate. Instead of just leaving her
342 Facilitator 1 : [Mm.]
343 Student 1 : there not giving her a (plug) or anything.
344 Facilitator 1 : Okay! (.) °(You did that.)°
345 ((Turns briefly to Med Student))
346 Med Student : Oh I did ah. (Thank you.)
347 ((Pats self on the left arm with right hand))

Excerpt 63 begins with the facilitator telling the SHS that he has two minutes of reflection time, while another student summarises his delivery (Lines 238 – 239, 241 & 243). Student 2, the one assigned the task, begins by asking permission to talk about what the SHS had done well and what could be improved without summarising the consultation (Lines 242, 244 – 245 & 247), which the facilitator permits (Line 248). He begins by stating in Lines 249 and 251 that the SHS used the SPIKES model to explain the diagnosis, a six-step protocol designed for delivering bad news (Baile et al. 2000). Before he could carry on, the facilitator signals him to pause and asks if it is the appropriate framework to use (Lines 253 – 254). At this moment, the SHS himself answers that it is not appropriate (Line 255). Initially hesitant, Student 2 replies the facilitator that the model is for delivering bad news (Lines 256 & 258) after Student 6 first volunteers the answer (Line 257). In enacted defence, the SHS contends that dengue may be considered bad news (Line 259), to which Student 2 agrees in restatement (Lines 260 – 261) and Student 5 supplies a justification (Line 262). In a bid to pre-empt the facilitator's latent disagreement, Student 2 downgrades his claim to a more nuanced position, pronouncing that it is usable but needs to be situationally modified (Lines 263 – 265). The facilitator accepts this proposition (Line 266), and Student 2 proceeds to elaborate on the SHS's performance with regard to some of the steps in SPIKES and reiterating his assertion on the circumstantial adaptability of the framework (Lines 268 – 271, 273 & 275 – 277).

Next, Student 2 mentions that the SHS “addressed the I-C-Es of the patients” and that “it’s quite obvious he asked for any ideas concerns and literally expectations (.) for for the patient.” (Lines 279 – 281 & 283). In clear disagreement with his assessment, the SP begins sniggering during the latter part of his delivery, uttering “O(h)kay.” with some laughter after his completion (Lines 282 – 284). Student 2, however, pays no attention to her and continues substantiating his claim, giving mostly positive feedback from his own observations (Lines 285 – 293 & 296). This shows that even when engaged in the same simulated consultation, participants may develop vastly different perspectives from each other. After the facilitator comments that they will discuss the accuracy of the SHS’s treatment plan later (Lines 297 – 298), following Student 2’s single expression of uncertainty about it (Line 296), Student 2 raises another area that he perceives the SHS as having done well in: educating the SP about the government’s “five-step mozzie wipeout” dengue prevention campaign (Lines 299 – 301). Lastly, he ends his report by stating what the SHS could improve on, namely adapting the SPIKE framework to the scenario, re-examining his treatment plan, as well as his gap in knowledge and use of jargons (Lines 303 – 306). Using this approach, the facilitator elicits extended feedback from a single member of the audience on the SHS’s performance.

After Student 2 has given his personal account of the strengths and weaknesses of the SHS’s consultation, the facilitator opens up the floor for feedback from the audience with a formulation that includes both questions from Pendleton’s rules asked simultaneously, ““Kay. the rest any comments, (1.2) do you think you may: have done differently, or you think was good that you would have done the same,” (Lines 310 – 312). Student 5 starts the ball rolling by claiming that the patient was quite satisfied with the consultation (Lines 314 – 315). Upon hearing this, Student 6 to her left promptly corrects her saying, ““She’s not.”” (Line 316), shaking his head with a broad smile while pointing to the SP, who has quietly looked up from the feedback form that she is filling up (see Figure 11 below). At this juncture, everyone in

the audience excerpt for Student 5 begins smiling, while Student 5 produces the utterance, “She’s not ah.” with a look of bewilderment on her face in sudden realisation that she may have been wrong (Lines 318 – 319).⁶ The whole room then erupts with laughter at Student 5’s ignorance of the situation, including the facilitator and SP (Line 320), while Student 6 spells out clearly to Student 5 that “She’s unsatisfied.” (Line 321). After a futile attempt at explaining herself (Lines 322 – 324), Student 5 accepts her judgment error (Lines 326 & 328) while laughing along with the rest, who have started their laughter again (Lines 327 & 329) in response to her utterance.

Figure 11. Screenshot of Station 1A/Team II Student 5: Student 6 points at SP with right index finger in correction of Student 5. In clockwise direction from the left: SP, Student 1, Student 2, Student 3, Student 4, Student 5, Student 6, Facilitator 1, Facilitator 2 (SHS not in view).

With this side sequence having ended, the facilitator swiftly steers the discussion back to the topic by asking, “But but what do you all think what do the rest think. Do y’all think.” (Lines 330 – 331). While being more open and flexible as compared to separately eliciting feedback for what the SHS had done well and what he could have improved, the imprecise design of this question led to a vague response from the rest of the audience. After a silence of 1.6 second (Line 332) from the floor, Student 6 replies with a frivolous smile that he

thought it was “okay” (Line 333), to which the facilitator voices his disagreement with in a flatly elongated utterance (Line 334). Student 1 then offers a candidate explanation for why the SHS’s performance may have not met the facilitator’s expectations, stating that the SP might have been uptight because she was unaware of what had been done, and therefore just needs reassurance that the doctors have carried out the relevant investigative work (Lines 335 – 336, 338 – 341 & 343). Strictly speaking, this is not a feedback to the SHS. However, the facilitator turns it into a positive point by briefly commenting that he had done that in the consultation (Line 344 – 345), to which he performatively acknowledges by thanking the facilitator and giving himself a pat on the left arm (Lines 346 – 347).

From Student 2’s delivery at the start, we can see that the students are well-aware of Pendleton’s rules and the supposed requirement to give feedback on both the positive and negative aspects of the SHS’s consultation. He does so in a comprehensive manner without unnecessarily restricting himself to first talking about what was done well before commenting on what could be improved. However, as compared to the previous example, in which the audience’s feedback proceeded methodically according to the rules, the same component here could be described as orderly only at the initial stage. What followed Student 2’s report are lengthy jocular exchanges that started due to Student 5’s error in judgment, which became an object of ridicule that unexpectedly derailed the elicitation of proper feedback from the audience. While keeping things light-hearted may be conducive to learning, the flippant attitude of some students also limited the potential that audience feedback could bring to the discussion. Perhaps when the progress is thwarted by unforeseen circumstances and student behaviour, facilitators ought to adopt a more structured approach to direct the conversational trajectory back on track. In the case of this excerpt, the facilitator tries to refocus the students’ attention back to the SHS’s performance by asking, “But but what do you all think what do the rest think. Do ya’ll think,” (Lines 330 – 331), which is even less precise than his original

question, ““Kay. the rest any comments, (1.2) do you think you may: have done differently, or you think was good that you would have done the same,” (Lines 310 – 312). The lacklustre feedback received at the end of Excerpt 63 suggests that the audience did not orient to the later formulation in the same way that the earlier is likely to have prompted.

4.1.3 *Simulated Patient’s Feedback*

In the medical school’s adaptation of Pendleton’s rules, the next step after having the student and audience discuss what was done well and what could be improved is to obtain feedback from the SP with respect to these same two questions. Interestingly, what turns up consistently is that SPs *always* answer the questions in this very order despite *always* given free rein by the facilitators in structuring their feedback when asked for it (except when they only have positive feedback to give, as in Excerpt 64). More importantly, the facilitators and students appear to orient to the SP’s feedback as reflecting the absolute truth of the simulated consultation, though differences in uptake certainly exists in the data. In spite of their highly formulaic sequential organisation, three examples of the SP’s feedback are presented to showcase its variations in receipt by facilitators and students.

Excerpt 64. Station 3A/Team III Student 1: 19:01 SP’s Feedback (Wholly Accepted)

696	Facilitator 1	:	XXX. ((Gestures at Sim Relative)) (0.3) What is the
697			experience (0.3) uh communicating with this young
698			doc[tor].
699	Sim Relative	:	[°O]kay° (0.3) YYY.
700	Med Student	:	Hi.
701	Sim Relative	:	Hi. .hh So urm:: (1.0) Initially I was very
702			nervous:: an:d and uh anxious about my: dad’s
703			condition, .hh so:when <u>you</u> :: spoke to me in <a very:
704			uh: <u>calm</u> > .hh an:d uh:: (1.1) um I would say a very
705			calm < <u>voice</u> > and also you provided me with uh .hh
706			comfortable:: uh pauses in between .hh it makes it-
707			it helps to calm me down =>and it also< provided me
708			time to <u>think</u> about uh what are the questions that I
709			want to ask you after you’ve shared with me so much
710			information. [.hh] So: .h it-
711	Med Student	:	[Mm.]
712	Sim Relative	:	uh: (enter) um:: so in between .hh uh:: (0.5) I feel

713 more less anxious lah it allows me to share more
714 this with you.

715 Med Student : Mm.

716 Sim Relative : Then also um: (0.4) .hh th- (0.3) I was very clear
717 after the consultation, um: because um:: of ↓the::
718 of your explanation=y- uh you used jargon but you
719 actually explained it immediately after so I was
720 clear .h okay this is the things my dad is
721 experiencing, .hh an::d .h uh this is u::m ↓wa'did
722 call it↓ the medical TERM >and then<- of- >in
723 simpler term you explained it to me so you make me
724 feel the connection: between you and me .h so I
725 didn't feel< that you were actually talking down to
726 me [.h] it feels that you're trying to match at my

727 Med Student : [Mm.]

728 Sim Relative : level [(.) uh]

729 Med Student : [°Thank you.°]

730 Sim Relative : s- for someone who doesn't understand and what all
731 these things about. .hh And then um: .hh I: I feel
732 listened- I- I felt very listened to, and I also
733 feel that you ↓wou- (.) you were with me at the same
734 level you've uh you were empathetic and-
735 understanding of WHAT I'm going through .hh because
736 you actually allow me opportunity to:: to act- um
737 .hh to listen uh to:-to ask you questions. .hh
738 >So you asked me okay do you have< any concerns and
739 .h when I do have a concern you try to address it
740 .hh and also uh try to give me a:: ↓uh: >alternative
741 like okay< .h if this happened what- what- what- uh:
742 what can I do [.hh] and ↓uh:: I- you also offer

743 Med Student : [Mm.]

744 Sim Relative : your::- your comfort to me .h like said okay uh I do
745 understand that you are going through a very
746 difficult time. .h So it does help to calm me down
747 too.
748 (0.3)

749 Med Student : Okay=

750 Sim Relative : =Okay.

751 Med Student : Thank you.=

752 Facilitator 1 : =Okay great. Doctor [()]

753 ? : [Mm.]

754 Facilitator 1 : ((Gestures at Facilitator 2))

755 Facilitator 2 : So YYY. (.) I just gonna echo on what XXX mentioned
756 uh °earlier° I think duh- uh- I felt that you did
757 very very well in explaining exactly .hh uh what-
758 acute myocardial infarction was >and about the<
759 stenting 'cause everything was non-jargon and as a
760 LAY person I could y'know I felt I could °y'know I°
761 understand .hh on what you were saying, .hh

Excerpt 64 begins with one of two facilitators in the session inviting the SR to share her “experience (0.3) uh communicating with this young doctor.” (Lines 696 – 698), designed as an open question for the SR to freely give her feedback. Taking the cue, the SR exchanges greetings with the student (Lines 699 – 700) and launches into an extended sequence about how the student’s “calm voice” and “comfortable pauses” soothed her from a state of anxiety and provided her time to formulate her questions after receiving information from the student, allowing her to share more as well (Lines 701 – 710 & 712 – 714). Next, the SR commends the student for immediately explaining the meaning of a medical term in lay terms after using the jargon, which gave her the sense that the student was matching up to her level of medical knowledge rather than speaking from the vantage point of a professional, thereby leaving her with clarity of thought (Lines 716 – 726 & 728). She elaborates that she felt “very listened to” with empathy and understanding because the student gave her opportunities to ask questions and addressed her concerns by offering alternative solutions and comforting her (Lines 730 – 742 & 744 – 747).

After listening to the SR’s delivery, the student and facilitators ostensibly accepts her feedback without question (Lines 749 – 752). Facilitator 1 turns to Facilitator 2 for comments, who continues the discussion by first reiterating the SR’s stance stating, “I just gonna *echo* on what XXX mentioned uh °earlier°” (Lines 755 – 756), visibly orientating to the SR’s words as definitive and constructing her own view as being congruent with what was said. She highlights with greater specificity that the student’s explanation of AMI and its treatment was easy for a layperson to understand, before moving on to her own inputs on separate matters (not shown). This excerpt is therefore an example of how the SR’s feedback is taken ‘wholesale’ by all the other participants. The next excerpt shows a slightly different form of response from the facilitator towards the SP’s comments, where the former seeks to clarify how the latter felt about a certain aspect of the consultation.

Excerpt 65. Station 3B/Team III Student 2: 24:45 SP's Feedback (Clarified)

762 Facilitator 2 : So-so (.) so I'm gonna hand it over to uh: Mr Tay:
763 who was on the <re:ceiving> end of this session. And
764 [ask him] how he felt about it.
765 Med Student : [Alright.]
766 (2.7)

767 Sim Patient : Talk about the good thing first ah. (0.4) The good
768 thing is that the (0.3) °the° (0.7) the <detail> that
769 you (.) went through and explain to me what (0.5)
770 what I've went through: through that episode 1a.
771 (0.3) So that was a good thing and also the
772 medication that you explain to me. (0.7) I felt the
773 same thing like what you all felt also while sitting
774 here, .hh the introduction I think that you could
775 have spent some time on the introduction .hhh and uh
776 breaking the ice.

777 Facilitator 1 : °Mm.°=
778 Sim Patient : =Because was a (.) life and death threatening
779 situation then I just came out from the A and E
780 (0.6) and: and you ask me: (0.4) and: (.) and I also
781 not sure whether: (.) how should I react .hh in a
782 very awkward the first (0.8) (°I don't know°) three
783 or five seconds in the beginning.

784 Facilitator 1 : °Mm.°
785 Sim Patient : Maybe that- that area I'm also not sure whether
786 (1.1) how to improve that °1a° (0.8) [Maybe you]
787 Facilitator 1 : [()]
788 Sim Patient : should say whether [.hh] how are you today how was
789 Facilitator 1 : [°Mm.°]
790 Sim Patient : [your:] operation.
791 Facilitator 1 : [°Mm.°]
792 (0.7)

793 Facilitator 2 : I'm not quite sure: I felt it was quite ni:ce when
794 he ask you (.) before I start .h do you have any
795 pain: are you comfortable to continue:. .h [How-how]
796 Sim Patient : [Ya.]

797 Facilitator 2 : internally how did you respond to [that.]
798 Sim Patient : [I think] >that-
799 that-that<-that was good.
800 Facilitator 2 : That [was] nice ah.=
801 Sim Patient : [But-]
802 =Yeah but [the:] (.) the blending in of the (0.3)
803 Facilitator 2 : [Mm.]
804 Sim Patient : the (0.3) the: (0.4) meeting of the doctors [and]
805 Facilitator 2 : [Mm.]
806 Sim Patient : the patient, that portion was a little bit (0.2)
807 (TSK)
808 Facilitator 1 : Sorry I think I-I see [where you] mean it. =it was
809 Sim Patient : [awkward.]
810 Facilitator 1 : the beginning part [after] that he [was] a lot of

811 Sim Patient : [Ya.] [Ya.]
 812 Facilitator 2 : [Mm:.]
 813 Facilitator 1 : questions. [So] [I think] maybe SOMETHING that you
 814 Sim Patient : [Ya.]
 815 Facilitator 2 : [Mm.]
 816 Facilitator 1 : could think about.

Prior to Excerpt 65, Facilitator 2 was commenting on the student's choice to start his consultation asking the SP multiple questions right after introducing himself (not shown). At this point in time, she invites the SP to give his feedback and formulates the request as an announcement to the SP and a directive to the student (Lines 834 – 836). The SP begins by signposting, "Talk about the good thing first ah." (Line 839), after which he lists down the positive aspects of the delivery, stating that the student had taken the time to explain in detail the medical procedures that he had underwent in the scenario and done a good job explaining the medication (Lines 839 – 844). He then moves on to an area for improvement, stating that just as the facilitator has commented, the student could have spent more time on the introduction and ice-breaking (Lines 844 – 848). He explains that because he has just had a harrowing life-and-death experience and came out from the hospital's Accident and Emergency (A&E) department, he did not know how to react to the student's question on how he was feeling, leading to an awkward start to the consultation for the first few moments (Lines 850 – 855). In concluding his feedback, the SP offers an advice, claiming that while he does not know how the student can improve, asking about his day and how the operation went could be possible ways to establish rapport (Lines 857 – 858, 860 & 862).

After the SP has completed his delivery, Facilitator 2 engages him further based on his feedback and in relation to her own previous comments about the student's opening lines. She asks about his perspective on the student's opening display of concern, which she felt was nice but would like to know, "How-how internally how did you respond to that." (Lines 865 – 867 & 869). The SP replies saying that it was good (Line 870 – 871), but subsequent

efforts to establish the doctor–patient relationship were lacking and resulted in awkwardness (Lines 872, 874, 876 & 878). In response, Facilitator 1 displays recognitional reference of his input, acknowledging, “Sorry I think I-I see where you mean it. =it was the beginning part after that he was a lot of questions.” (Lines 880, 882 & 885), and highlights it to the student as “I think maybe SOMEthing that you could think about.” (Lines 885 & 888). This sequence shows that, at least in this discussion, facilitators do clarify the feedback garnered from the SP to make explicit areas where the student can possibly improve. Nonetheless, she still orients to the SP’s critique as valuable input. Thereafter, the two facilitators provided their own suggestions on how this could be done (not shown) before the discussion ends.

The last excerpt of this subsection depicts a case where, apart from agreeing with the SP wholeheartedly, the facilitator goes a step further in expounding on her delivery. Due to the voluminous length of the SP’s main feedback in this discussion,²⁰ only the facilitator’s additional exposition and a sequence of further inputs from the SP is included in the excerpt.

Excerpt 66. Station 3A/Team II Student 3: 21:55 SP’s Feedback (Expounded)

762	Facilitator 1	: °Okay° (0.7) XXX that is a excellent <feedback>.
763		((Addressing the Sim Relative))
764		Uh I think uh don’t- >I mean< you look very nervous
765		again. Hhh >d(h)on’t look so nervous<=
766		((Turns to Med Student))
767		=come closer come closer hhh hhh .hhh hhh .hhh
768		Gestures to Med Student
769		so we have this practical so that you know we can
770		all uh try and improve on (.)°you know° the
771		communication skills ah =so XXX actually (.)
772		what XXX was trying to explain was exactly how a
773		patient (.) ’s daughter would have felt in the
774		[whole scenario] so if you can just imagine you put
775	Med Student	: [Mm mm.]
776	Facilitator 1	: yourself in that entire scenario then you probably
777		would have felt the same way. But it’s not to say a
778		bad thing. I think we all know (.) that you were
779		very anxious you were just trying to- to find the

²⁰ The SR gave 67 lines of near uninterrupted commentary on the positive and negative aspects of the student’s consultation spanning almost two pages of transcript, in response to the multiple, major conversational problems that arose during the consultation.

829 you're <paiseh>²¹ and quiet it immediately shows. So
830 in a session in a s- in a situation when you need to
831 hold yourself ah, you have to watch all these (0.7)
832 <cue leaks> okay? So what is <leaking out> from you
833 that you're not aware is what people pick up on and
834 read and use that to interpret [you.]
835 Facilitator 1 : [Mm.]
836 Med Student : =Mm.

Just prior to Excerpt 66, the SR has just delivered a lengthy feedback, first stating as a positive point that the student's calm demeanour had helped to assuage her initially, before commencing an extensive report of what could be improved: the explanation of the treatment procedures her father had gone through, the student's focus on the vignette rather than the interaction at hand, which projected a lack of confidence and made her feel unacknowledged, and the student brushing aside her concern in favour of giving a procedural account of the treatment plan (refer to Chapter 3.2.1 Ex. 51 on Page 118); all of which she gives concrete suggestions for correction. Thereafter, where the excerpt begins, Facilitator 1 compliments the SR on her feedback (Line 762 – 763) and turns to addressing the student (Lines 765 – 768). In a bid to sum up the SR's comments without invalidating the student, she claims that the feedback represents what a patient's daughter would have felt in a real-life emergency, acknowledging the student's anxiety but reminding the student to remember and heed the SR's suggestions in the future (Lines 771 – 774, 776 – 781 & 783 – 785). Facilitator 2 also briefly offers comfort by stating that the simulated training is the best time for making mistakes (Line 787). While this focus on the student's emotional wellbeing and uptake of the SR's feedback squarely and rightly places the student at the centre of attention, the facilitators' blanket acceptance of the SR's advice nevertheless displays an underlying orientation to the veracity of her words.

²¹ "Paiseh" is a Hokkien Chinese term commonly used in Singapore for feeling embarrassed or shy.

At this juncture, the SR comes in with another input in overlap with Facilitator 2's turn. She comments that she was initially struck by the student's confidence and appearance, but the student's nervousness subsequently became an impediment to their interaction (Lines 789 – 795). The SR then claims that “if she- she be less nervous I- I actually would be able to click very well with her (.)” , a remark that does not appear very helpful to the student (Lines 795 – 797). In spite of this, Facilitator 2 responds in agreement with the SR's opinion as a whole and builds upon it, asserting that “you are being observed the moment you walk into the room.” (Lines 799 – 801). She recapitulates the SR's observation (Lines 803 – 804 & 806 – 810) and briefly assures the student that it is a learning experience for everyone (Lines 810 – 811 & 813 – 814) before expanding on the idea. From Lines 816 to 821, she underscores the importance of the initial moments of the consultation by warning that, as medical students in the hospital, patients sitting outside the clinic will be watching them from the get-go. In closing the topic and in relation to the SR's point, Facilitator 2 gives her own feedback that the student ought to be more aware of her unconscious affective displays, being someone whose emotions are immediately obvious to others. In this manner, apart from agreeing entirely with the SR's feedback, the facilitator rehashes and expound on it with her own input.

The examples above highlight the two phenomena introduced at the beginning of this subsection. Firstly, SPs are inclined to follow Pendleton's rules in starting their feedback with the positive side of the student's performance before commenting on the negative aspects. I surmise that several reasons may be possible: (1) they have received ‘standardised’ training to follow this order; (2) the format of the feedback form (to be completed immediately after the simulated consultation and before the feedback discussion, while the student is given time to reflect) predisposes them to it; and (3) the overarching implementation of Pendleton's rules by facilitators during the feedback discussion primes them to adopt the sequence. Secondly, it appears that facilitators and students overwhelmingly consider the SP's feedback to be the

absolute reality of the consultation—a holy grail of sorts—that must be respected and cannot be denied. The only courses of action which facilitators may undertake after the SP has spoken, as afforded by the data, are: (1) accept it in its entirety; (2) clarify what is meant, but agree nonetheless with the premise; and (3) agree and expound upon the view espoused. This phenomenon is unsurprising though, for being the interlocutor to the student and a layperson external to the medical system gives SPs a unique (and perhaps ironic) status in this simulated context that confers them epistemic authority over what views of the student’s performance may be considered valid — a right that they seem to lack in an actual clinical setting as real patients, where doctors orient to their deontic authority in accordance with the notion of patient-centred care, rather than their knowledge of human interaction as conversational partners in the consultation.

4.1.4 Facilitator’s Feedback

Unsurprisingly, this is the most ‘fluid’ part of the data, given that facilitators are the ones in control of the feedback discussions. As opposed to the other components which typically take place as standalone ‘silos’ within the discussion as dictated by Pendleton’s rules, the facilitator’s feedback may either occur also in a (self-)designated slot or emerge naturally alongside the rest of the feedback as a rejoinder to other comments. Nonetheless because facilitators have free reign over the session, even when their delivery is purposefully structured, the feedback is often provided in response to some preceding feedback from the rest of the participants. In the next excerpt, I present a truncated example of this case, where the facilitator gives her feedback in a fashion similar to the turn design of the other feedback components but does so in relation to the student’s self-reflection on what could be improved.

Excerpt 67. Station 1B/Team III Student 4: 18:20 Facilitator’s Feedback (Structured)

976 Facilitator 1 : I kinda think it started off ↓well: but (it’s to
977 going) introduction: you came across like very
978 confident: when you build rapport: (perfect). (0.2)

979 When you explain the phases of her illness to her
 980 <so she's (test) (0.2) she (knows) (0.4) that (0.3)
 981 OH this guy knows what he's talking about >you know<
 982 [unlike] some sh:abby: () to just talk to=
 983 Med Student : [Mm.]
 984 Facilitator 1 : =me.
 985 Med Student : Mm:.
 986 (0.2)
 987 Facilitator 1 : Yup=.hhh Uh:m:(0.2) so:: (0.7) what I didn't like
 988 that you kept referring to the sheet:.
 989 (0.6)
 990 Med Student : The (.) oh:..
 991 Facilitator 1 : Ya:..
 992 (0.2)
 993 Facilitator 1 : Uh cause you (kept like) (0.2) uh:: >your platelet
 994 then you< will uh:: (>something like that ah<).
 995 (0.2) (Don't la). (0.6) () (0.3) not didn't like
 996 is [↑that] la.
 997 Student 3 : [.hhhh]
 998 Facilitator 1 : Cause (0.2) in a: (u:sual) communication station
 999 (0.5) (the) u: (0.4) usually like >that not (papers)
 1000 in front of< you .hhhh so you can refer to it but
 1001 you shouldn't be like (0.8)
 1002 ((demonstrating the action)) uh: looking all around
 1003 for it [la.]
 1004 Med Student : [Okay.]
 1005 (0.2)

Prior to Excerpt 67, the student was mentioning that because the SP and he could not see eye to eye on the value of observational treatment for dengue, he was not sure how much he could force it. At this juncture, the facilitator starts giving her feedback to the student in an extended sequence of turns, stating that his consultation started off well with poise and good rapport established (Lines 976 – 978). She carries on talking about another positive point that he was able to explain the different phases of dengue with certainty, thereby giving the SP confidence that she is speaking with someone credible (Lines 979 – 978). Orienting to Pendleton's rules, the facilitator then moves on to what could be improved and pronounces that a shortcoming of the student's performance is that he kept referring to the vignette (Lines 987 – 988). By enacting the student's body movement in checking the SP's platelet count on the sheet, she explains that he was jumping back and forth between the vignette and the SP

far too much (Lines 993 – 996). She further expounds on it by describing with her hands the spatial orientation of a typical communication station and demonstrating with her body how the vignette should be placed so that the student does not have to search around for it (Lines 998 – 1003). Subsequent to the excerpt, she raises a number of other points for improvement before handing the time over to the SP for her feedback. Her structuring of the feedback, even in response to the student's own self-appraisal — an ad-hoc opening for giving her inputs, demonstrates a preponderant proclivity towards Pendleton's rules. Beyond simply organising her positive points ahead of the negative, her multimodal elaboration also illustrates the last step seen in McKimm and Swanwick (2012), i.e. formulating an action plan for improvement.

To contrast with this approach, Excerpt 68 below shows another form of facilitator feedback. Instead of providing the student with information and instructions on what to do, the facilitator here uses an inductive method of questioning instead as part of her feedback. The excerpt begins with the last part of the audience's feedback on areas for improvement, after which the facilitator prompts the students with open questions to scaffold their learning.

Excerpt 68. Station 3B/Team III Student 2: 21:00 Facilitator's Feedback (Scaffolded)

723 Student 4 : A:nd um: (0.9) I'm not sure- like on his just now he
724 also mention [tha:t] (0.3) he: (0.3) might not have
725 Facilitator 2 : [Mmhm.]
726 Student 4 : addressed the patient's concerns ade[quately.] .hh
727 Facilitator 2 : [Mmhm.]
728 Student 4 : <UR:M:> (0.5) DAT thing I also pick up because:
729 like- (0.3) the patient keep (.) talking about the
730 work being very: busy then (.) about whether >having
731 to take medication< long term .h so EVEN- (.) after
732 XXX tried to explain then he also h-`then the
733 patient ASK again and again. (0.3) So I'm not sure
734 whether: it has been adequately addressed or
735 [(I dunno).]
736 Facilitator 2 : [(So like to)] (.) I'm going to ask you °ah° both of
737 you are on to something ah. You- were-yu I think as
738 a hu:nch right you know: that (TSK) (0.2) maybe
739 something is not (.) mm quite resolved la ↑hor .hhh
740 I'm going to ask you to think back °about the
741 patient you encounter just now.° So let's say I'm
742 your consultant, (0.4) and then I say ↑okay so have

743 you spoken to Mr Ta:y ↑so how was he (0.3) So how
744 would you report back to me .h how would you report
745 ↑actually this patient I feel:: what would you say.
746 (1.2)
747 Med Student : Um: (3.0) like I would say that he's actually he's-
748 he's tryin- like (.) he seems to (.) to want to try
749 to actually (0.5) take appropriate steps towards
750 recovery. But (0.1) he does have some .hh (0.3) uh:
751 he seems to have some <concerns> which I've-I've not
752 like appropriately addressed
753 [with regards to his stress at work.]=
754 Facilitator 2 : [°And what do you think these concerns are?°]
755 Med Student : =and [how] um: (0.5) he might actually continue
756 stuff like <smoki:ng> and .hh >not taking
757 medication< because of that.
758 Facilitator 2 : °Mm.° So you suspect he: won't take his medications
759 la.
760 (0.3)
761 [°Okay.°]
762 Med Student : MAIN:-MAINLY the smoking part. [Uh:-uh] the
763 medications part <I'm not too sure.>
764 Facilitator 2 : Mm.=
765 Med Student : =Like with regards to the smoking part >cause he
766 says he very stress at work that's why he smokes.<
767 Facilitator 2 : Mm:.
768 Med Student : And:: Ya. Like (.) >'cause I didn't manage to
769 counsel him on that.<
770 Facilitator 2 : °Mmhm.°
771 Med Student : °So:° not >uh-uh< I-I-I wouldn't say that (0.3)=
772 Facilitator 2 : [Mm.]
773 Med Student : =[he] would stop working >jus 'cause I< told him
774 not to la.°
775 Facilitator 2 : <Mm: Okay.>=
776 Med Student : =And 'cause like work is quite stressful (0.7) °Yea.°
777 And is not something that (0.1) we can do anything
778 about ['cause] >it's li-like< a external factor la
779 Facilitator 2 : [Mm.]
780 Med Student : [which] we can't actually change.=
781 Facilitator 2 : [Mm.]
782 =Mm:: (1.3) okay. So- s- if you had time to go and
783 <re:visit> this. Let say you go and speak to him a
784 second time .hh What would you: (0.1) (expound) on,
785 (0.4)
786 Med Student : I think I would have expounded on the work part la
787 'cause I [think] that's the main cause of like all
788 Facilitator 2 : [Mm.]
789 Med Student : the problems like (0.5) the reason for his bad diet
790 and (0.5) the smoking >is actually all stem from<
791 the work (.) maybe I would have expounded a little
792 more on that.

793 (2.1)
794 ((Knocking on door))
795 Facilitator 2 : Okay:.
796 (2.3)

In Excerpt 68, Student 4 raises the same point for improvement that the SHS himself mentioned earlier in the student's reflection component regarding whether the SP's concerns were adequately addressed (Lines 723 – 724 & 726). He explains that this is because the SP continually mentioned about his work being busy and asked repeatedly if the medication has to be taken long term, despite the SHS having answered the same questions before (Lines 728 – 735). At this juncture, the facilitator remarks to the SHS and Student 4 that she is going to ask them a question because they are “on to something” with this “hunch” that “something is not (.) mm quite resolved” (Lines 736 – 739). She poses a hypothetical scenario where the consultant has enquired about the consultation with the SP and asks how they would convey the situation to him (Lines 740 – 745). In doing so, the facilitator gets the students to consider the scenario as situated in an actual hospital setting, where they as medical students are expected to report the outcomes of their consultations back to a senior doctor. To this end, it would necessary to accomplish certain goals with the patient. Compelled to contemplate this circumstance, the SHS says he would tell the consultant that the SP is actually trying to take the appropriate steps towards recovery, but has some concerns with regard to work stress that he has not appropriately addressed (Lines 747 – 753). When asked to elaborate (Line 754), the SHS cites smoking and not complying with medication intake as the main concerns, with the former being the primary issue because the SP claims that smoking helps to relieve work stress (Lines 762 – 763 & 765 – 766) but he did not manage to counsel the SP on that (Lines 768 – 769). He continues explaining that this is particularly worrying because it is an external factor that the medical team has no control over (Lines 776 – 778 & 780).

At this moment, the facilitator follows up with another question to the SHS, asking what he would have expounded on if given a second chance to speak with the SP (Lines 782 – 784). Intentionally designed to get the SHS and other students to reflect on the information he might have missed out or the loopholes in his delivery, this question encourages them to mentally construct a timeline of ‘deliverables’ to the SP from which they can retrospectively “work backwards” towards. In reply, the SHS states that he would have addressed the work stress further as it is the root cause behind the SP’s dietary and smoking habits (Lines 786 – 787 & 789 – 792), suggesting a heightened self-awareness of possible areas for improvement. In this manner, the facilitator provides her feedback in the form of question prompts at multiple junctures to stimulate the student’s thinking and reflection.

As mentioned at the start of Chapter 4.1, I have selected examples from Team III Student 2 throughout this section due to its prototypical fit with Pendleton’s rules. From Excerpt 68, however, it is interesting to note that the facilitators’ feedback is provided much more freely in this overall highly structured discussion. While vastly different in formulation and approach, the facilitator’s feedback in the excerpts selected from Team III Student II and Team III Student 4 were produced in relation to inputs from the other participants (the student’s reflection in Excerpt 67 and the audience’s feedback in Excerpt 68). Indeed, given the central role of the facilitators in coordinating the feedback session, it is important that they comment on and integrate the inputs from different parties into their own feedback to better enhance the learning that takes place. Because of the sheer volume of feedback garnered from all parties involved in the discussion, facilitators have a critical role to play in consolidating the points brought up into a succinct picture of the entire simulation exercise for students to pay attention to and draw key takeaways from. Although the unadulterated use of Pendleton’s rules in facilitation already provides significant support to students in making sense of the SP training, it appears that scaffolding questions may be employed alongside the

model in improving student learning through introspection, especially when considered in relation to the workings of a hospital. Perhaps, different pedagogical approaches to group-based teaching within and beyond that observed in the data ought to be explored to enhance the facilitated training of clinical communication skills in medical school.

This is of course not implying that Pendleton's rules are, by itself, an inadequate framework for the feedback discussion. What can be gleaned from the examples throughout this section is the observation that, for the rules to be effective, facilitators need to strike a balance between adhering to the structure rigidly and leaving room for manoeuvrability and interpretation. In fact, as highlighted at the beginning of the chapter, the original guidelines as conceived by Pendleton and colleagues were never meant to be prescriptive. Rather than enacting the discussion strictly in a stage-like fashion according to the present-day version, facilitators may benefit students better by instead understanding the spirit of the original rules. On the other hand, facilitators should also be mindful that they need to properly construct their feedback-soliciting questions when using Pendleton's rules. Adhering to the "what was done well/what could be improved" dichotomy—judiciously, not dogmatically—may confer structural benefits to the discussion by compelling participants to consider both merits and shortcomings of a given student's consultation with focused effort. As Excerpt 63 suggests, an unspecific question is likely to backfire and yield lacklustre results in the form of generic or less-than-helpful advice. Much remains to be done in identifying the interactional effects of Pendleton's rules on group facilitation, for instance, in other incarnations and across different contexts, or in conjunction with alternative paradigms and techniques.

CHAPTER FIVE: CONCLUSION

5.1 Summary

As stated in the introductory chapter, the main objective of this thesis is to examine the latest practices of clinical communication training in medical education to advance the state of research in this field. By identifying the various interactional practices in the present data from a conversation analytic perspective, it is hoped that my research can better inform the state of knowledge on the SP methodology and group-based learning in the literature as well as the training of medical students as a real-world application.

The research findings are primarily situated in Chapters 3 and 4, which respectively addresses the interactions present in the simulated consultation and feedback discussion segments of the third-year CCP in LKCMedicine. In Chapter 3, three key learning domains were identified as important skills that students have to acquire from the training. Firstly, delivering the diagnosis or condition of the patient is an area where interactional groundwork is heavily required before the task itself can be attempted. This includes explaining the purpose of the consultation, displaying concern for the patient and establishing the patient's prior knowledge as preparation for relating and explaining the diagnosis/condition. The actual delivery, apart from being contingent upon the preceding sequences, often consists of other elements such as clarification of the disease aetiology and its symptomatic expression. The next key area of learning is explaining the diagnostic or treatment plan. In this domain, the sequential order of information may be an important aspect of the delivery to ensure that patients are aware of the rationale behind a certain course of action. Content-wise, this may involve not just immediate or long-term prospective measures, but also retrospective events, as in the case of emergency treatment. The last major topic in the CCP, convincing the patient or a senior colleague, appears to entail contrasting skills; the former necessitating students to be sensitive to the emotional needs of the patient and the latter requiring them to project a

logical flow of argument. Apart from these learning themes, two general features of the students' delivery were identified. Students were found to orient to information sharing over and beyond empathic understanding, indicating a preoccupation with the task requirements rather than the interactional needs of the patient. At the same time, they seem inadequate in calibrating their use of medical and everyday language, frequently employing vocabulary that differs in denotation or connotation between professional and laic contexts, but sometimes using overly simplistic terms instead that nonetheless undermined the SP's understanding as well. Contrary to popular belief, the issue is not as straightforward as—or even about—having students and doctors use less jargon with patients.

In Chapter 4, I deconstruct the feedback discussion into four components according to the use of Pendleton's rules as an overarching framework. Depending on the facilitators' implementation, the first two components of students' reflection and audience's feedback in terms of "what was done well" and "what could be improved" may proceed separately or simultaneously, affecting the overall conversational trajectory. It appears that separating the two questions results in more focused responses from the SHSs and audience, whereas an open format of query may predispose the SHSs to consider only their weaknesses and elicit vague rejoinders from the audience that do not significantly contribute to learning. On the other hand, a strict adherence to the preordained structure may yield only mediocre results in keeping the feedback balanced, while subjecting all participants to rigidity in giving and receiving feedback. This may ironically be at odds with facilitators' efforts to protect the SHSs' self-esteem, as well as unnecessarily restrict the form of input that may arise naturally in free-flowing discussions. As compared to the variability seen in the first two components, SPs delivered their feedback in a consistent manner, beginning with the first question and then the second. Interesting, regardless of how the facilitators respond to it, they (along with the students) overwhelmingly orient to the SP's words as being factually legitimate. Finally,

facilitators may provide their feedback either in a structured or inductive manner with greater freedom than the rest, and mostly with respect to the other participants' inputs. This allows for flexibility while integrating the rest of the discussion together, but facilitators need to be adept at adapting Pendleton's rules appropriately for it to happen beneficially.

5.2 Recommendations

Apart from having analysed a number of simulated consultations and feedback discussions, hence giving rise to a greater understanding of their conversational trajectories and features of talk, the greatest significance of this research is its pedagogical relevance to the teaching and learning of clinical communication in medical education. Considering the various findings as earlier summarised, I present three broad recommendations that medical schools may adopt in overcoming some of the challenges highlighted in this thesis.

Firstly, because the purpose of any simulated activity is to approximate the real act, it is absolutely necessary for scenarios to be designed as close to real life as possible by having medical doctors on the clinical communication team assist in writing up the vignettes based on actual concerns on the ground. Coming from an insider's point of view, clinicians would be able to propose everyday situations that reflect apposite nuances in patient characteristics and the most pertinent of medical conditions for students at this (preclinical) stage of their career, precluding superfluous scenarios from finding their way into the CCP just for the sake of 'practice'. More importantly, because they have had first-hand experience of real-world emotions from patients and family members that inevitably arise during interaction, they are more likely to avoid coming up with vignette designs that elicit atypical reactions from SPs.

Nonetheless, a high-fidelity vignette does not insure against unrealistic portrayals of the role by SPs. For them to break away from mere 'acting' and improve the quality of their representations, their training can be enhanced with video recordings of actual doctor–patient interactions—preferably in a similar context as their role-play—where real patients naturally

voice their concerns to the doctor. Trainers can first highlight certain episodes or specific instances of patient behaviour from these videos, before conducting moment-to-moment analyses and re-enactment of selected scenes through repeated pausing and playback. The same strategy can also be used with students in their clinical communication training. On a more personal basis, SPs and students alike can have their simulated consultations recorded (just as in this study) and reviewed with guidance from their own trainers and facilitators after the exercise. This individual evaluation can even be conducted longitudinally, especially in the case of students, who can chart the development of their communicative competencies across their five years of study.

Next, facilitation of the feedback session can potentially be improved by better defining the role of the facilitator. Although the emphasis of the Year 3 CCP may be on the delivery of medical information, many facilitators appear to be more concerned with the students' informational inaccuracies than their interactional competencies, which remain the fundamental premise of clinical communication training. Aside from merely giving their own pointers, facilitators also need to be adept at bringing together the feedback from all parties in conjunction with their experiences on the ground. As noted in Chapter 4.1.4, the methodical yet flexible adaptation of Pendleton's rules is a major issue that facilitators have to contend with in their mentoring roles for the students.

Last but not least, the observations derived from the present data can be incorporated directly into the existing clinical communication curriculum and its pedagogical development. In particular, the two general features of the simulated consultations highlighted, namely students' orientation to information sharing over empathic understanding and their inadequate calibration of language use, are matters of broad relevance to all medical students and even practising doctors that have significant consequences on healthcare outcomes. Operationally, the importance of applying Pendleton's rules with prudence can be emphasised to facilitators.

To these ends, amongst other issues that educators may consider relevant, the corresponding excerpts and perhaps even anonymised videos can possibly be adapted as teaching materials in medical school. The possibilities that may emerge in using the examples in this thesis are virtually limitless, giving their enduring value as actual simulated consultations and feedback discussions that could shed light on the minutiae of interaction in a group-based CCP.

5.3 Limitations

Despite best efforts to ensure the quality of research, there are always limitations to any study that have to be acknowledged. Firstly, although CA is a proven methodology for providing novel insights into clinical communication, operational problems still exist in our implementation of it. The most basic would be the inaccuracies within and inconsistencies across transcripts. As stated in Chapter 2.2.2, each transcript was first transcribed by a student RA before being cross-checked by another. Although all the RAs have received substantial training in the Jeffersonian transcription system, and measures were taken to ensure that the transcripts are up to task, there is still an element of personal subjectivity on the part of each RA that cannot be negated, but which hinders the accuracy and consistency of the transcripts. More essentially, given the huge volume of conversational data recorded from the CCP, it is virtually impossible to: (1) uncover each and every noteworthy phenomenon that exists, and (2) encapsulate all instances of phenomena discovered across all simulated consultations and feedback discussions. As such, despite the apparent veracity of the arguments I have made throughout my thesis, there is the possibility that certain conclusions I have derived may be overturned by looking at more data just from this study.

Critics have also argued about the authenticity of SP-based communication training. One critique, for instance, is that SPs' interactions with students may be exaggerated in the desire to fulfil the task given instead of re-enacting a clinical interaction which resembles the 'real deal' (Stokoe 2013). However, this inauthenticity can be rectified by employing CA to

identify a stock collection of ‘conversational regularities’ (Pilnick et al. 2018), which may be used to create realistic role-playing situations. These may include the multitude of ways that a patient may respond to a diagnosis given or treatment suggested, which can be used to help prevent conversational trouble such as the simulated consultation coming to a standstill, as in the case of Team III Student 4.

Finally, while one can identify numerous features of talk which bolster or hinder effective communication from any given set of conversational data, one has to bear in mind the fundamentally fluid nature of human interaction. Even though I have provided in the last section suggestions for improving clinical communication training in medical school based on actual practices seen in the CCP, care must be taken in implementing them to ensure that we do not ironically lapse back into rigidity by creating yet another framework for ‘effective communication’. Instead, it is hoped that these observations and recommendations can ultimately increase the awareness of students, facilitators and SPs alike towards the various conversational strategies that abound, as well as the value of paying attention to the needs of their interlocutors and the interaction at hand. Only through such an adaptable approach can they derive and deploy truly effective methods in managing conversations without adhering to a particular schema, thereby allowing them to sustainably handle institutional interactions under any circumstance or situation.

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APPENDIX A

INFORMED CONSENT FORM

1. Study Information

Protocol Title:

Feedback dialogue in Clinical Communication Practicum: Investigating the relationship of interaction dynamics and medical students' experiences of feedback process.

Principal Investigator & Contact Details:

LER Lian Dee
Tan Tock Seng Hospital
7 Jalan Tan Tock Seng
Annex 2, Level 3, West Wing
Singapore 308440
Tel: 63596363
Email: lian_dee_ler@nhg.com.sg

2. Purpose of the Research Study

This is a research project to investigate the feedback dialogue session in Clinical Communication Practicum. We are conducting such research to investigate the feedback interaction process in Clinical Communication Practicum and we would also like to see how such process affects students' experiences. The results from this study will help us determine the feedback interaction in such context and so to identify the effective communication strategies or training needs for feedback conversation in medical education.

You are invited to participate in this research study. You have been chosen because you are a member contributing to the development of the feedback dialogue session in Clinical Communication Practicum.

It is important to us that you first take time to read through and understand the information provided in this sheet. Nevertheless, before you take part in this research study, the study will be explained to you and you will be given the chance to ask questions. After you are properly satisfied that you understand this study, and that you wish to take part in the study, you must sign this informed consent form. You will be given a copy of this consent form to take home with you.

This study will recruit approximately 60 participants of the Clinical Communication Practicum sessions in March 2017.

3. What Procedures Will Be Followed in This Study

If you take part in this study, the Clinical Communication Practicum sessions you participate today will be video recorded for subsequent data analysis and you will be asked to complete a questionnaire on your experiences of the sessions at the end of all sessions. Only the research team will be able to listen (view) to the recordings and your responses to the questionnaire. The video tapes will also be transcribed. Transcripts of the recorded sessions may be reproduced in whole or in part for use in presentations or written products that result from this study. However,

your identity will be kept anonymous and any other identifying information (such as your voice or picture) will NOT be used in presentations or in written products resulting from this study.

After the video recording/observation and questionnaire, there might be a chance that the participants will be followed up for an interview session that will last no longer than 60 to 90 minutes. You will be asked for your opinions and experiences as a member of the Clinical Communication Practicum under video-taped. Our interview will be audio/video-taped for the purpose of data analysis. The audio/video-tapes will be transcribed ad verbatim. However, your identity will be kept anonymous and you will not be identified in any report of the research findings.

4. Your Responsibilities in This Study

If you agree to participate in this study, you will NOT be asked to perform any tasks different from your usual Clinical Communication Practicum setting. You will only be required to take part in the interviews as outlined above.

5. What Is Not Standard Care or is Experimental in This Study

Your performance, opinions or views will be strictly respected for the purpose of the research study and it will not influence your grade or your supervisor's assessment of your work performance.

6. Possible Risks and Side Effects

There are no risks or disadvantages to participation. The owners of the views and experiences co-constructed during the recorded sessions will be de-identified and their names and identities kept strictly confidential.

7. Possible Benefits from Participating in the Study

There is no known direct benefit from participation in this study. However, your participation in this study will help the investigators understand the constraints and enablers of the communication processes in Clinical Communication Practicum feedback dialogue. Knowledge about the relevant factors will help enhance the quality of teaching and learning in medical education or feedback process in general.

8. Alternatives to Participation

Your participation or non-participation in this research will not influence your grade, your supervisors' evaluation of your work performance or the benefits to which you are entitled.

9. Costs & Payments if Participating in the Study

There will be no costs involved for participating in this study. Each participant will be given \$10 voucher as an appreciation of his/her participation in the follow up interview.

10. Voluntary Participation

Your participation in this study is voluntary. You may stop participating in this study at any time. Your decision not to take part in this study or to stop your participation will not affect your grade, your supervisors' evaluation of your work performance or the benefits to which you are entitled. If you decide to stop taking part in this study, you should tell the Principal Investigator.

However, the data that have been collected until the time of your withdrawal will be kept and analysed. The reason is to enable a complete and comprehensive evaluation of the study.

In the event of any new information becoming available that may be relevant to your willingness to continue in this study, you will be informed in a timely manner by the Principal Investigator or his/her representative.

11. Compensation for Injury

By signing this consent form, you will NOT waive any of your legal rights or release the parties involved in this study from liability for negligence.

12. Confidentiality of Study and Medical Records

Information collected for this study will be kept confidential. Your records, to the extent of the applicable laws and regulations, will not be made publicly available.

The respective Clinical Communication Practicum sessions and interview you attend will be audio/video-taped. The recordings made during the study will only be used for analysis and no one outside the project will be able to access the original recordings. In event of any presentations or written products regarding this study, your identity will remain confidential.

NHG Domain Specific Review Board and Ministry of Health will be granted direct access to the study records to check study procedures and data, without making any of your information public. By signing the Informed Consent Form attached, you (*or your legally acceptable representative, if relevant*) are authorizing such access to your study records.

By participating in this research study, you are confirming that you have read, understood and consent to the Personal Data Protection Notification available at TTSH PDPA: weblink is <https://www.ttsh.com.sg/patient-guide/page.aspx?id=4468>.

13. Who to Contact If You Have Questions

If you have questions about this research study, you may contact the Principal Investigator, Ler Lian Dee, Contact No 6359-6363 or Co-investigator, Lim Yong Hao, Contact No 6359-6372.

The study has been reviewed by the NHG Domain Specific Review Board (the central ethics committee) for ethics approval.

If you want an independent opinion to discuss problems and questions, obtain information and offer inputs on your rights as a research subject, you may contact the NHG Domain Specific Review Board Secretariat at 6471-3266. You can also find more information about participating in clinical research, the NHG Domain Specific Review Board and its review processes at www.research.nhg.com.sg.

If you have any complaints or feedback about this research study, you may contact the Principal Investigator or the NHG Domain Specific Review Board Secretariat.

Thank you for taking the time to read this information sheet, which is for you to keep.

CONSENT FORM

Protocol Title:

Feedback dialogue in Clinical Communication Practicum: Investigating the relationship of interaction dynamics and medical students' experiences of feedback process.

Principal Investigator & Contact Details:

LER Lian Dee
Tan Tock Seng Hospital
7 Jalan Tan Tock Seng
Annex 2, Level 3, West Wing
Singapore 308440
Tel: 63596363
Email: lian_dee_ler@nhg.com.sg

I voluntarily consent to take part in this research study. I have fully discussed and understood the purpose and procedures of this study. This study has been explained to me in a language that I understand. I have been given enough time to ask any questions that I have about the study, and all my questions have been answered to my satisfaction.

Please tick:

- ☐ Yes, I agree to allow the videotape of my proceedings during Clinical Communication Practicum sessions to be used in this research
- ☐ Yes, I agree to complete the questionnaire on my experiences of the Clinical Communication Practicum sessions in March 2017
- ☐ Yes, I agree to be interviewed and allow my interview to be recorded

Name of Participant

Signature

Date

Investigator Statement

I, the undersigned, certify that I explained the study to the participant and to the best of my knowledge the participant signing this informed consent form clearly understands the nature, risks and benefits of his / her participation in the study.

Name of Investigator /
Person administering consent

Signature

Date

APPENDIX B

LKCMedicine Year 3 AY2016/17 Clinical Communication Practicum

Station 1A

Main Issue: Dengue Fever

Briefing for the student

Please note that this is Part 1 of 2 of a linked station.

Ms Cheryl Tan is a 45-year old woman with a history of hypertension and hyperlipidaemia. She takes amlodipine 5mg every morning, and simvastatin 20mg every night. She works as a lawyer. She does not smoke, and drinks a glass of red wine every night.

She has been having fever for 4 days, associated with a severe headache and myalgia. She also felt that her joints were slightly painful. She noted a petechial rash over both lower limbs.

She came to the Emergency Department as the headache was getting worse, and she started to feel pain behind her eyes. She did not have abdominal pain or vomiting. She did not notice any bleeding or easy bruising.

She was febrile (T 39°C), slightly tachycardic (HR 110), blood pressure was 110/90 and saturations were 98% on room air. The blood tests came back as positive for dengue and platelet count was 30.

She was admitted to the general ward for further treatment.

Your task

You are a medical student embedded with the primary medical team. The consultant has asked you to speak to Miss Cheryl Tan regarding her diagnosis of dengue fever and treatment plans.

LKC Medicine Year 3 AY2016/17
Clinical Communication Practicum

Station 1A (Instruction to SP)

Main Issue: Dengue Fever

Name: Ms Cheryl Tan

Age: 45

Dress: Home clothes

SP requirements: Female, middle age

Summary

Ms Cheryl Tan is a 45-year old woman with a history of hypertension and hyperlipidaemia. She was admitted to the General Ward last night for dengue fever.

The consultant has asked the medical student embedded with the team to speak to Miss Tan regarding her diagnosis and treatment plans.

Background

You are Ms Cheryl Tan. You work as a lawyer but you have been on medical leave the last 4 days due to fever and a severe headache. The GP told you that it was a viral flu but you got worried when your headache was not getting better despite the Panadol and you started getting pain behind your eyes.

You live with your husband and 15-year old daughter at Bishan. Both of them are well.

You are worried to find out that you have dengue fever as you have heard on the news that people can die from it. You were keen to be admitted and worried that you may spread it to your family. You know that some of your neighbours have gotten dengue fever before but are unsure about the details.

The student should be able to provide you, in **clear and simple** language:

1. Confirm the diagnosis of dengue fever
2. How you were diagnosed (blood test) and reason for admission (platelet count 30)
3. Explain dengue fever, symptoms and complications
4. A management plan – mainly supportive treatment but need to watch out for complications and treat accordingly, symptomatic treatment

Behaviour, affect and mannerisms

You are worried about your condition as you heard have that people can die from dengue fever. You are feeling lethargic and still having a severe headache.

You are shocked that there is no specific treatment for dengue fever as you thought that was the reason for your admission.

You are bewildered by the possible complications, albeit you remain cooperative and reasonable. You listen carefully to what the student says and ask for clarification where needed.

If the student is honest about not knowing something, but assures you they will find out or directs you to speak to the doctor later, you accept it.

Ideas and concerns

You have limited knowledge of dengue fever. You know that you live in one of the 'hot-spots'. You never thought that it would affect you, as you are young and healthy.

You are worried that you may spread it to your husband and daughter.

Questions you may ask:

- Will I spread it to my husband and daughter?
- Why do I need to be hospitalised if there is no treatment?
- How do I increase my platelet count? If it is in my blood, can I get a transfusion?
- Will the red spots on my leg spread to my whole body? (petechiae rash)
- What should I look out for now?

Expectations

You expect to be provided a clear and jargon-free update on your medical condition, complications and treatment plan.

Your concerns should be dealt with empathetically, and you expect the medical student to be non-judgmental with your lack of knowledge and misperceptions about the condition.

To address your concerns on whether you will spread it to your husband and daughter, the student should be able to explain that it is spread by mosquitoes and is not spread directly from person to person. The student should be able to give you a broad overview of dengue fever – symptoms, complications and treatment. You are shocked that you cannot have a platelet transfusion unless there is obvious bleeding but accept the explanation that it does not help in dengue fever. You want to be discharged if there is no cure but agree to stay in hospital when the student explains the complications of dengue fever.

You will accept that the medical student may have limited detailed knowledge about this condition or its management.

LKCMedicine Year 3 AY2016/17
Clinical Communication Practicum

Station 1B

Main Issue: Discharge against medical advice

Briefing for the student

Please note that this is Part 2 of 2 of a linked station.

You have just spoken to your patient, Ms Cheryl Tan, on her diagnosis of dengue fever and further management plans.

She was admitted last night for dengue fever, complicated by thrombocytopenia with a platelet count of 30. She was febrile (T 39°C), slightly tachycardic (HR 110), blood pressure was 110/90 and saturations were 98% on room air. She is currently in the General Ward to monitor for complications of dengue fever and supportive treatment.

Health background

Ms Cheryl Tan is 45-year old woman with a history of hypertension and hyperlipidaemia. She takes amlodipine 5mg every morning and simvastatin 20mg every night. She works as a lawyer. She does not smoke and drinks a glass of red wine every night.

Current management

These are Ms Tan's medications on admission:

Amlodipine 5mg OM

Simvastatin 20mg ON

Amlodipine has been stopped in view of a borderline blood pressure. She is also given regular Paracetamol 1g 6H and put on an intravenous normal saline drip 1.5 litre per day.

Your task

You are a medical student embedded with the primary medical team. Your consultant was informed that Ms Tan wants to be discharged from the hospital today. Your consultant has requested to speak to Ms Tan first and explain why she is not medically fit for discharge.

LKCMedicine Year 3 AY2016/17
Clinical Communication Practicum

Station 1B (Instruction to SP)

Main Issue: Discharge against medical advice

Name: Ms Cheryl Tan

Age: 45

Dress: Hospital attire or casual clothes

SP requirements: Female, middle age

Please note that this is Part 2 of 2 of a linked station.

Summary

Ms Cheryl Tan is a 45-year old woman with a history of hypertension and hyperlipidaemia. She was admitted to the General Ward last night for dengue fever. She wants to be discharged today as she was told that there is 'no specific treatment' for dengue fever.

The consultant has asked the medical student embedded with the team to explain to Ms Cheryl Tan why she is not medically fit to be discharged from hospital.

Background

You are Ms Cheryl Tan.

You have been quite healthy and this is your first admission to hospital. You work as a lawyer but you have been on medical leave the last 4 days due to fever and a severe headache. The GP told you that it was a viral flu but you got worried when your headache was not getting better despite the Panadol and you started getting pain behind your eyes.

You have hypertension and hyperlipidaemia, which are well controlled as you are compliant to your diet and medications. You do not smoke and drink 1 glass of red wine a day.

You live with your husband and 15-year old daughter at Bishan. Both of them are well.

Behaviour, affect and mannerisms

You were initially worried when they told you that you had dengue fever. You were shocked when they told you that your platelet count is 30 and the normal count ranges from 150 to 400. You wanted a transfusion but accepted it when they told you there was no need to have a transfusion now if there is no bleeding.

You are surprised that there is no curative treatment for dengue fever and want to go home today as you feel that the only medication that you have been given is Panadol.

You are not unreasonable but insistent that you want to be discharged from the hospital. You need a more detailed explanation before you will be convinced to remain hospitalised.

Ideas and concerns

You had limited knowledge about dengue fever but the team have explained to you on admission about what to look out for.

You understand that there is no medication to cure dengue fever. You understand that you do not need a blood transfusion for your low platelet count. You feel that you are only given Panadol in hospital. You rather rest at home as the hospital is very noisy and difficult to get proper rest.

You are worried about leaving your daughter and husband alone at home as they are always used to having you around.

If the student manages to persuade you with reasons why you need to remain in hospital (e.g. risk of dengue haemorrhagic fever), you become very worried and will agree to remain hospitalised.

Expectations

You should have your concerns and anxiety allayed professionally and empathetically, and you expect the medical student to be non-judgmental with your lack of knowledge and misperceptions about the condition.

The student should be able to convince you that there is a risk of major bleed due to the low platelet count and you need to remain in hospital until the platelet count is up trending or stable. The student should be able to emphasise on the possible complications of dengue haemorrhagic fever and importance of watching for such symptoms until the fever lyses and platelet count up trends.

You will accept that the medical student may have limited detailed knowledge about this condition or its management.

LKCMedicine Year 3 AY2016/17
Clinical Communication Practicum

Station 2A

Main Issue: Acute appendicitis

Briefing for the student

Please note that this is Part 1 of 2 of a linked station.

Ms Susan Tan /Ms Susan Thevar is a 30yr old lady who was admitted from the Emergency Department for right iliac fossa (RIF) pain. She has no past medical history of note. She works as a clerk. She does not smoke or drink alcohol.

Her pain started this morning over the suprapubic region. The pain subsequently migrated to the RIF. The pain was described as intermittent and sharp. She has nausea but no vomiting. She has no urinary symptoms.

Her vital signs are: T 38.2, BP 110/62, HR 110, SpO2 95% on room air. On examination, there was RIF tenderness with localized guarding. There is no rebound tenderness. The rest of the abdomen is soft. The per-rectal and per-vaginal examinations are unremarkable.

She was given intravenous Tramadol 25mg in the Emergency Department for pain relief.

Her current investigations so far:

TW 14.1 Hb 12.1 Plt 252

Na 140 K 3.8 Cr 86 Ur 2.4 Glu 6.7

CXR: Lung fields are clear. There is no free subdiaphragmatic gas.

Urine pregnancy test negative

UFEME: WBC 3 / RBC 6 / EC 5

The surgical team on call that you are attached to has made the provisional diagnosis of "possible appendicitis". The plan is to keep the patient nil-by-mouth (NBM) and arrange for a CT scan of the abdomen and pelvis (CTAP) to confirm the diagnosis.

Your task

You are a medical student embedded with the surgical team on-call and your registrar has asked you to update Ms Tan and explain to her the team's plans.

LKC Medicine Year 3 AY2016/17
Clinical Communication Practicum

Station 2A (Instruction to SP)

Main Issue: Acute Appendicitis

Name: Ms Susan Tan / Ms Susan Thevar

Age: 30

SP requirements: Female, 20 – 40yo

Summary

You are Ms Susan Tan / Ms Susan Thevar, a 30yr old lady who works as a clerk. You do not smoke or drink. You started experiencing abdominal pain this morning at 1am. The pain started over the central lower abdomen and subsequently migrated to the right lower abdomen. Despite taking over the counter painkillers, the pain worsened and you went to the Emergency Department (ED). You were assessed by the doctors in the ED and had your bloods and X-rays taken. Subsequently, you were told that you require admission.

You are now in the general ward. The team in charge of you has sent a medical student attached to the team to update you about your condition.

The student should be able to provide you, in clear and simple language:

1. A succinct summary of the findings so far.
2. An explanation of the current suspected diagnosis (acute appendicitis)
3. The subsequent investigation and plan

Behaviour, affect and mannerisms

You are distressed by your pain. The intravenous painkillers (Tramadol 25mg) given by the ED have helped relieve some of the pain but you are afraid that the pain will return again. Your pain score was 8/10 in the ED and now 5/10. The pain is present and you grimace when the doctor pressures on your right lower abdomen. You are not drowsy from the painkillers.

You are anxious to know what is happening. You are keen to know whether the doctors are able to find the cause of the pain and treat it appropriately.

Ideas and concerns

Your fears are compounded by the fact that you have a distant family member who had severe abdominal pain and needed emergency surgery. You do not know much details except for the fact that he/she needed to stay in the ICU for a few weeks after that.

You have heard of the term “appendicitis” before but have limited knowledge on what exactly it is. You want to know how is this condition diagnosed and how can it be treated. You want to know whether the condition is life threatening.

Questions you may ask:

- How are my blood tests and X-rays so far?
- What is appendicitis? Is it dangerous?
- How are the doctors going to confirm my diagnosis?
- Do I need surgery? How can I be cured?

Expectations

You expect a clear and jargon-free update on your condition, including investigations done so far.

Your concerns should be dealt with empathetically, and you expect the medical student to be non-judgmental with your lack of knowledge and misperceptions about the condition.

You expect a broad overview of your management plan from the student. You will accept the current uncertainty of your condition before further investigations are performed.

LKCMedicine Year 3 AY2016/17
Clinical Communication Practicum

Station 2B

Main Issue: Acute appendicitis

Briefing for the student

Please note that this is Part 2 of 2 of a linked station.

Ms Susan Tan/Susan Thevar is a 30yr old lady who was admitted from the Emergency Department for right iliac fossa (RIF) pain. She has no past medical history of note. She works as a clerk. She does not smoke or drink alcohol.

Her pain started this morning over the suprapubic region. The pain subsequently migrated to the RIF. The pain was described as intermittent and sharp. She has nausea but no vomiting. She has no urinary symptoms.

Her vital signs are: T 38.2, BP 110/62, HR 110, SpO2 95% on room air. On examination, there was RIF tenderness with localized guarding. There is no rebound tenderness. The rest of the abdomen is soft. The per-rectal and per-vaginal examinations are unremarkable.

Her current investigations so far:

TW 14.1 Hb 12.1 Plt 252

Na 140 K 3.8 Cr 86 Ur 2.4 Glu 6.7

CXR: Lung fields are clear. There is no free subdiaphragmatic gas.

Urine pregnancy test negative

UFEME: WBC 3 / RBC 6 / EC 5

The surgical team on call that you are attached to has made the provisional diagnosis of “possible appendicitis”. The plan is to keep the patient nil-by-mouth (NBM) and arrange for a CT scan of the abdomen and pelvis (CTAP) to confirm the diagnosis.

You have just spoken to Ms Tan and she is agreeable with the team’s management plan.

Your task

You are a medical student embedded with the surgical team on-call and your registrar has tasked you to call the duty radiologist for approval for the CTAP.

It is now 2am. The radiologist on call is Dr Tan.

LKC Medicine Year 3 AY2016/17
Clinical Communication Practicum

Station 2B (Instruction to Actor)

Main Issue: Acute Appendicitis

Name: Dr Tan (radiologist on duty)

SP requirements: Doctor

Summary

Ms Susan Tan/Susan Thevar is a 30yr old lady who was admitted from the Emergency Department for right iliac fossa (RIF) pain. She has no past medical history of note. She works as a clerk. She does not smoke or drink alcohol.

Her pain started this morning over the suprapubic region. The pain subsequently migrated to the RIF. The pain was described as intermittent and sharp. She has nausea but no vomiting. She has no urinary symptoms.

Her vital signs are: T 38.2, BP 110/62, HR 110, SpO2 95% on room air. On examination, there was RIF tenderness with localized guarding. There is no rebound tenderness. The rest of the abdomen is soft.

Her current investigations so far:

TW 14.1 Hb 12.1 Plt 252

Na 140 K 3.8 Cr 86 Ur 2.4 Glu 6.7

CXR: Lung fields are clear. There is no free subdiaphragmatic gas.

Urine pregnancy test negative

UFEME: WBC 3 / RBC 6 / EC 5

The surgical team on call that you are attached to has made the provisional diagnosis of "possible appendicitis". The plan is to keep the patient nil-by-mouth (NBM) and arrange for a CT scan of the abdomen and pelvis (CTAP) to confirm the diagnosis.

The student should be able to provide you:

1. A succinct summary of the findings so far.
2. The indication for the CT scan.
3. The presence or absence of any contraindications for the scan.

Behaviour, affect and mannerisms

It has been a long day. You have already reported over 20 scans since the start of your call. You are feeling tired and irritable. You will get annoyed if the student is unable to explain the indication and urgency of the scan.

Ideas, concerns and expectations

You require a succinct summary of the patient's clinical progress in order to report the relevant radiological findings. You expect the team to have done their due diligence to rule out other obvious causes of RIF pain. You expect the student to know the indication of the scan. You want to know whether the scan is urgent and whether it will change the management of the team. You will also want to know whether there are any contraindications to the scan.

Questions you may ask:

- Has the team ruled out other obvious causes of RIF pain? (mainly genitourinary causes)
- Is this scan urgent? Could it be done tomorrow morning?
- If your team is so sure that it is appendicitis, why not proceed with the surgery? (differentials such as ovarian cyst torsion/rupture/haemorrhage and mesenteric adenitis cannot be reliably differentiated clinically)
- Are there any contraindications to the scan? (If student unable to name any, may prompt with following)
 - Is the patient pregnant?
 - How is the renal function of the patient?
 - Does the patient have any asthma?
 - Is the patient on metformin?

LKCMedicine Year 3 AY2016/17
Clinical Communication Practicum

Station 3A

Main Issue: Acute Myocardial Infarction

Briefing for the student

Please note that this is Part 1 of 2 of a linked station.

Mr Richard Tay is a 60-year old man with a history of ischaemic heart disease. He is a smoker with a 120-pack year history. He has no other history of note, and was not on medication. He rarely exercises and his job – as a director of a financial analysis firm – is very stressful, especially with recent volatility on the stock market.

He has been having occasional chest pain and breathlessness for the past 4 weeks, but this pain, which he describes as ‘dull and squeezing’ in nature, would generally resolve after 5-10 minutes of resting. He was intending to consult his company doctor but he just hasn’t been able to find the time.

He developed central crushing chest pain at 3pm yesterday, which continued to worsen over the next 1 hour. He presented at the Emergency Department at 5pm with diaphoresis, severe dyspnoea, and tachycardia.

An ECG confirmed ST-elevation in the anterior leads, and a provisional diagnosis of an acute myocardial infarction was made. He was started on oxygen supplementation, and given Aspirin 300mg + Ticagrelor 180mg stat. The on-call interventional cardiology team was activated, and the patient was transferred for an emergency percutaneous coronary intervention. After successful angioplasty and stenting to the culprit vessel, the patient’s condition stabilised, and he was monitored in the Coronary Care Unit overnight. No events of note arose; the patient remained arrhythmia-free and his blood pressure, heart rate, and oxygen saturation remained in the normal range.

He has been transferred to the General Ward.

Your task

You are a medical student embedded with the primary medical team and your consultant has asked you to update Mr Richard Tay’s next-of-kin, his daughter Ms Amelia Tay. Mr Tay has given you permission to update his next-of-kin.

LKC Medicine Year 3 AY2016/17
Clinical Communication Practicum

Station 3A (Instruction to SP)

Main Issue: Acute Myocardial Infarction

Name: Ms Amelia Tay (next-of-kin of Mr Richard Tay)

Age: 35

Dress: Office attire

SP requirements: Female, 20 – 40yo

Summary

Mr Richard Tay is a 60-year old man with a history of heart disease and heavy smoking. He was admitted last night for sudden, crushing chest pain which was confirmed to be a heart attack. After undergoing emergency percutaneous coronary intervention, he was transferred to the Coronary Care Unit for overnight observation, and transferred to the General Ward this morning.

The consultant has asked the medical student embedded with the team to update the Mr Tay's next-of-kin about his condition, with Mr Tay's permission.

Background

You are Ms Amelia Tay, Mr Tay's daughter. You stay with him, but you rarely spend much time with him as you work full time as a property agent. He is a director at a financial analysis firm, and you understand that it is a stressful job.

You are visiting Mr Tay in the General Ward after a harrowing night. You first knew of his symptoms at about 5pm, when you received a very breathless phone call from him just before he was attended to at the Emergency Department (ED). All you managed to hear was: *"I'm at the Emergency Room...Bad chest pain for the last 2 hours and I really can't breathe. They are going to see me shortly..."* After that you received no further calls from him, which worried you. You were informed about 2 hours later that he was admitted to the Coronary Care Unit, and that he was stable. The team recommended you visit only the following morning as he was recovering from an emergency procedure and that he would require close monitoring and (possibly) additional procedure(s) overnight.

After visiting Mr Tay in the ward you requested a full update from the team. You understand that the team consultant has asked the embedded medical student to provide you with as much information as possible and you welcome the update.

The student should be able to provide you, in **clear and simple** language:

1. An account of Mr Tay's presentation at the ED and the diagnosis
2. The reasons for the urgency of the emergency intervention
4. A brief description of his transfer to CCU

5. An explanation of how plaque rupture/embolism results in the symptoms, signs, and ultimately myocardial infarction
6. A management plan that includes medication, risk factor modification, and close follow-up

Behaviour, affect and mannerisms

You are worried and anxious about your father. You were not aware that your father was having chest pain in recent weeks, so you are quite shocked by his admission. A lot happened overnight, but you are unaware of the details of what has transpired since his admission.

You are bewildered by the diagnosis and names of medical procedures mentioned, albeit you remain cooperative and reasonable. You listen carefully to what the student says and ask for clarification where needed.

If the student is honest about not knowing something, but assures you they will find out or directs you to speak to the doctor later, you accept it.

Ideas and concerns

You have limited knowledge of heart attacks; you do know that it is a potentially life-threatening condition, but are uncertain about the actual process and risk factors, and are keen to learn more. You have previously heard the term “acute myocardial infarctions” but you didn’t know exactly what it meant – is it the same as “heart attack?”

You are also worried that heart attacks may run in the family, as your paternal grandfather too, passed away of a heart attack.

Questions you may ask:

- What is acute myocardial infarction... is it the same as heart attack?
- Why did my father need to go to CCU? Is he in critical condition now?
- How do we know if he is having another heart attack?
- Does it run in the family? Will we get a heart attack like my father?
- What can he do to prevent this from happening again?

Expectations

You expect to be provided a clear and jargon-free update on Mr Tay’s medical condition, which is currently stable.

Your concerns should be dealt with empathetically, and you expect the medical student to be non-judgmental with your lack of knowledge and misperceptions about the condition.

To address your concerns on how you can reduce your father’s risk of having further heart attacks, the student should be able to give you a broad overview on what he can do: exercise, dietary modification, smoking cessation; you will accept that the medical student may have limited detailed knowledge about this condition or its management.

LKCMedicine Year 3 AY2016/17
Clinical Communication Practicum

Station 3B

Main Issue: Acute Myocardial Infarction

Briefing for the student

Please note that this is Part 2 of 2 of a linked station.

You have just spoken to your patient, Mr Richard Tay's daughter, Ms Amelia Tay on his treatment progress and further management.

He was admitted last night for an acute myocardial infarction, underwent emergency percutaneous coronary intervention and was observed overnight at the Coronary Care Unit. He is now in the General Ward, and if all goes well, he will be discharged from hospital soon.

Health background

Mr Richard Tay is a 60-year old man with a history of ischaemic heart disease. He is a smoker with a 120-pack year history. He has no other history of note, and was not on medication. He rarely exercises and his job – as a director of a financial analysis firm – is very stressful, especially with recent volatility on the stock market.

Current management

During this admission, Mr Tay was found to have hyperlipidemia and hypertension as well, of which oral medications were commenced. His current medications are:

Aspirin 100mg OM	Ischaemic heart disease
Clopidogrel 75mg OM	Ischaemic heart disease
Simvastatin 20mg ON	Hyperlipidemia
Enalapril 10mg OM	Hypertension

Your task

You are a medical student embedded with the primary medical team. Your consultant has requested that you discuss with Mr Tay and educate him on medication adherence, and managing modifiable risk factors for ischaemic heart disease.

LKC Medicine Year 3 AY2016/17
Clinical Communication Practicum

Station 3B (Instruction to SP)

Main Issue: Acute Myocardial Infarction

Name: Mr Richard Tay

Age: 60

Dress: Casual/hospital attire

SP requirements: Male, 45-70yo

Please note that this is Part 2 of 2 of a linked station.

Summary

Mr Richard Tay is a 60-year old man with a history of heart disease and heavy smoking. He was admitted last night for sudden, crushing chest pain which was confirmed to be a heart attack. After undergoing emergency percutaneous coronary intervention, he was transferred to the Coronary Care Unit for overnight observation, and transferred to the General Ward this morning.

The consultant has asked the medical student embedded with the team to update and educate Mr Tay on medication adherence, and reducing his risk of future heart disease.

Background

You are Mr Richard Tay. The student who is about to speak to you has spoken to your daughter, Amelia about your condition.

You have been a smoker since your teens, and smoke about 3 packs a day. You work as a director of a financial analysis firm; the hours are long, and work is stressful. Recent volatility on the stock market also meant that you had to put in extra hours on weekends to chair team meetings. As a result, you barely have time to exercise, and rely on fast food takeouts for meals.

You stay with your wife and 2 daughters, Amelia and Shannon. Your father passed away of a heart attack when you were very young, though you never thought it was something that would happen to you. A few years back, your family doctor told you that you might have some form of heart disease, though you were not on medications, and did not have time to return for a follow up.

Behaviour, affect and mannerisms

You are traumatised by the events that have transpired. During the heart attack, you felt a gripping, crushing pain over your chest, and had difficulty breathing – “I felt like I was drowning, with a brick wall over my chest”. This episode lasted for close to two hours, before you decided to call for an ambulance. You were alone in the office, and while waiting for paramedics to arrive, had worried that you would die in office that night, and regretted not spending more time with your family.

You are cooperative and ready to listen to the student, though still mildly anxious and bothered by the heart attack. You appear worrisome, rueful and guilty about not taking care of yourself.

Ideas and concerns

You have limited knowledge about heart attacks, hypertension or hyperlipidemia. You have never gone for a health screening, or had your blood checked for blood pressure, cholesterol or sugars. As your hypertension and hyperlipidemia was diagnosed only this admission, you are alarmed by the fact that you have to be on long-term medications.

You acknowledge that you work in a high-stress environment, and wonder if managing stress alone will reduce your risk of a heart attack.

Should the student broach the subject of exercise, and/or smoking cessation, you adopt an apprehensive stance. If the student manages to persuade you with reasons why exercise and smoking cessation is important, you become more open to the suggestion.

Questions you may ask:

- How does blood pressure and cholesterol affect my heart attack?
- Must I exercise to reduce my risks of a future heart attack? I mean, would like to but I really can't find the time...
- How long do I need to be on the medications?
- Can I stop the medications if I no longer have chest pain?

Expectations

You should have your concerns and anxiety allayed professionally and empathetically, and you expect the medical student to be non-judgmental with your lack of knowledge and misperceptions about the condition.

To address your concerns on how you can reduce your risk of having further heart attacks, the student should be able to give you a broad overview on what you can do: **exercise, dietary modification, smoking cessation**. The student should also be able to explain why these measures are important in preventing future heart attacks.

As this is a serious medical condition, you would like to know about the short- and long-term impact; you will accept that the medical student may have limited detailed knowledge about this condition or its management.

APPENDIX C

Transcription Convention (taken from Jefferson 2004:24–31)

[	<i>A left bracket</i> indicates the point of overlap onset.
]	<i>A right bracket</i> indicates the point at which two overlapping utterances end, if they end simultaneously, or at the point which one of them ends in the course of the other. It is also used to parse out segments of overlapping utterances.
=	<i>Equal signs</i> indicate no break or gap. <i>A pair of equal signs</i> , one at the end of one line and one at the beginning of a next, indicates no break between the two lines.
(0.0)	<i>Numbers in parentheses</i> indicate elapsed time by tenths of seconds.
(.)	<i>A dot in parentheses</i> indicates a brief interval ($\pm$ a tenth of a second) within or between utterances.
–	<i>Underscoring</i> indicates some form of stress, via pitch and/or amplitude. A short underscore indicates lighter stress than does a long underscore.
::	<i>Colons</i> indicate prolongation of the immediately prior sound. The longer the colon row, the longer the prolongation.
↑↓	<i>Arrows</i> indicate shifts into especially high or low pitch.
.,??	<i>Punctuation markers</i> are used to indicate ‘ <i>the usual</i> ’ intonation. (The italicized question-mark [?] substitutes for the question-mark/comma of my non-computer transcripts, and indicates a weaker rise than indicated by a standard question-mark.)
WORD	<i>Upper case</i> indicates especially loud sounds relative to the surrounding talk.
°word°	<i>Degree signs</i> bracketing an utterance or utterance-part indicate that the sounds are softer than the surrounding talk.
word<	<i>A post-positioned left carat</i> indicates that while a word is fully completed, it seems to stop suddenly.
–	<i>A dash</i> indicates a cut-off.
> <	<i>Right/left carats</i> bracketing an utterance or utterance-part indicate that the bracketed material is speeded up, compared to the surrounding talk.
< >	<i>Left/right carats</i> bracketing an utterance or utterance-part indicate that the bracketed material is slowed down, compared to the surrounding talk.
.hhh	<i>A dot-prefixed row of ‘h’s</i> indicates an inbreath. Without the dot, the ‘h’s indicate an outbreath.
wohhrd	<i>A row of ‘h’s within a word</i> indicates breathiness.
(h)	<i>Parenthesized ‘h’</i> indicates plosiveness. This can be associated with laughter, crying, breathlessness, etc.
()	<i>Empty parentheses</i> indicate that the transcriber was unable to get what was said. The length of the parenthesized space reflects the length of the ungotten talk.
(word)	Parenthesized words and speaker designations are especially dubious.
(())	Doubled parentheses contain transcriber’s descriptions.

Reference

Jefferson, Gail. 2004. ‘Glossary of Transcript Symbols with an Introduction’. Pp. 13–31 in *Conversation Analysis: Studies from the First Generation*, edited by G. H. Lerner. Amsterdam, The Netherlands and Philadelphia, PA: John Benjamins.