

THESIS

CARE-ING ABOUT PATIENTS: THE CONSTRUCTION, PERFORMANCE, AND  
ORGANIZATION OF COMMUNICATION AND CARE IN MEDICAL EDUCATION

Submitted by

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In partial fulfillment of the requirements

For the Degree of Master of Arts

Colorado State University

Fort Collins, Colorado

Fall 2010

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## ABSTRACT

### CARE-ING ABOUT PATIENTS: THE CONSTRUCTION, PERFORMANCE, AND ORGANIZATION OF COMMUNICATION AND CARE IN MEDICAL EDUCATION

In an era where health care is becoming increasingly expensive and reform is on the political agenda, it is important to understand what specifically can be reformed or altered to change the way health care is both understood and administered. To begin, what can be revealed through analyzing the way that health care providers themselves understand both care and communication?

This master's thesis uses a dialogic approach to understand how both communication and care are taught and understood in medical education programs. Medical educators at five medical schools in the United States were interviewed regarding their role in teaching communication and clinical skills at their respective schools. Interview data was coded and categorized in effort to better understand how each school constructs and performs the concepts of communication and care. After uncovering how these ideas are understood, suggestions were put forth regarding how medical education curriculums might be changed in the future to better equip future doctors with the demands of delivering quality health care to a multitude of patients with varying desires, needs, and understanding of what it means to be "healthy".

After analyzing interview data, this study reveals that the ways in which medical students understand communication and care have material implications for the ways they engage in clinical interactions. Therefore, altering the way these concepts are understood can potentially change the ways doctors interact with their patients. In a time when health care is changing drastically each year, these findings provide tools to make cost and time effective changes in medical education that create important changes for future of medicine. The specific changes offered by this study provide a framework for future curriculums to follow to ensure that programs meet accreditation standards, while also providing the most innovative and advanced teaching and learning methods to educate future doctors.

While the sample used for this study is small, its findings still illustrate how medical education might change to better educate students. Further, the study illustrates a need for change and suggests how the methods used here might be combined with others to reveal further areas of focus for curriculum reform. The conclusions of this study reveal that health care reform can begin in the context of medical education and how reconceptualizing foundational ideas like communication and care can better equip medical students for their future clinical interactions.

## ACKNOWLEDGEMENTS

This project would have remained nothing more than an idea if it weren't for the encouragement, knowledge, and curiosity of many people. While a title page does not leave room for all the voices that participated in this project, I humbly thank the many people who helped me find my voice.

I first extend many thanks to the interviewees that took the time to talk to me and further my passion for communication in medical education. While each program was unique in many ways, I am so grateful for the willingness each of you had to share your knowledge, role, and suggestions with me. Ultimately, every interviewee reminded me that my work is meaningful and has a place in the world of academics.

Second, I owe a huge debt of gratitude to my thesis committee who agreed to throw conventions out the door and view my project not only for its academic merits, but personal and professional ones as well. Your dedication and willingness to turn tradition on its head is appreciated more than I can say. Jane, as I left your office after asking you to join this wild ride you said, "Elise, your dad is very proud," and throughout this journey your guidance and vision has reminded me of this fact each and every day. You kept the heart of this project alive and this project benefited greatly from your wisdom and guidance. Andy, going all the way back to "conflict class," you have challenged me academically and personally to think about things in new ways by encouraging me to answer my own questions, find my own resources, and push the limits of inquiry. You helped me understand that often the process, not the product, can be the most rewarding. Thank you for challenging me, encouraging my abilities as a student, and taking such interest in this project. And Kirsti. There is not enough space and I am nowhere near

articulate enough to express my gratitude for you and your guidance through my graduate school experience. I could not have asked for a better mentor to show me how to cope with loss, handle stress, and produce good work that is true to my heart, passions, and desires. Thank you for never giving up on me and instead teaching me that good things truly are worth waiting for. To put it simply, I am a better person because of you. And I quote, if you think this is the end of our journey together you have another thing coming!

Thank you also to the friendly faces of Eddy Hall who helped me survive two long years. Marian, your door was the boundary between chaos and safety and knowing that tears, laughter, anger, and silence were all okay was constant comfort, especially when I did things like forget I had class! And to Dr. Griffin. Your compassion helped me remember that even though I will probably not save the world, I can still make a difference in the lives of others. Because of you I am a better listener, more perceptive, and more reflective on who I am and how I am connected to others. While you did not oversee my work directly, your influence is present in the pages of this project. Aly, your kind notes and surprises always brought a smile to my face and reminded me that there was indeed light at the end of the tunnel. You often reminded me of my dad's presence in my life and still serve as a role model and example of how to be a daughter that is worthy of a father's pride. Julie, thank God we found each other! And thank you for always being willing to laugh, cry, yell, listen to Rihanna, eat, drink sweet tea, and shop, even if said activity took place in a dark parking lot at midnight. You always helped me remember what was important, which often meant letting go of school for awhile, and then awhile longer. And if anything, I now know where Dubai is!

And last but not least, thank you to my wonderful friends and family! Christine, the idea of a Masters began with you in journalism when you thought you could get away with making me dance in outdoor gear in front of class. Now look at us! I could not have made it without your love and support. I am so thankful you were on this journey with me! To the Coopers, you provided a home away from home that allowed me to both escape from and cope with the many challenges that were thrown my way. Thank you for dinner, dessert, wine, and great conversations over the last few years. Many of my most memorable smiles and laughs were in your company and I am forever grateful. Cooper, while life threw us a few curve balls over the last two years, you were there when I needed you and for that I am grateful. You helped me understand the power in my own two feet, and you always remind me how important it is to follow your dreams, even when doing so is hard. I love you. To my family near and far, I am who I am because I am loved by you. Thank you for always encouraging me with the reminders of the celebrations that follow hard work. I am so lucky! Mom, while I will never be as eloquent as you, you taught me about the power of words and I have tried desperately to remember those lessons in this project! Aja and Drew, being a “sissy” is the best job in the world and I hope I have made you proud. And to dad, maybe second grade math was manageable and French was a language I could learn. I never proved you wrong and am eternally grateful for your pride, love, and wisdom in my life. I love you first!

And now, onto the next chapter in this journey called life! Cheers!

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## **Confessions in my Academic Voice**

This project began when a light bulb went off . . . literally.

As I watched my normally vivacious father lie helpless in a hospital bed, a light went off, along with an alarm, and neither of us knew what to do. Within seconds, a nurse came on the intercom and asked what my dad needed. Mind you, my dad had just undergone surgery to remove a cancerous tumor from the back of his tongue and with his tongue stapled to his cheek to immobilize it and allow the incision to heal, he was unable to speak. Given that I had no medical knowledge or idea as to why lights were blinking and buzzing, I too sat silent. On the intercom, the nurse got increasingly frustrated as though my dad and I had purposely buzzed the alarm to spite her. As the silence continued, the nurse began yelling. I watched my dad's face fall as he accepted and acknowledged that at the young age of fifty, he was unable to help himself, and at the complete mercy of others.

This moment was more than my I could handle. Did this nurse know what it was like to have to drive home from college to care for her dad when she should be focused on the letter that was expected to arrive from Colorado State any day to hopefully announce she was accepted to their graduate program? Had this nurse had her Christmas interrupted with a cancer diagnosis that questioned the mortality of her best friend? Did this nurse have any desire to help, or was she just going to sit screaming into a microphone to a man that simply wanted her to know his IV fluid was empty?

As I stared at the flashing red light on my dad's IV machine, I knew. I knew that I would get accepted into graduate school. I knew that the current moment that left me uncertain about whether to scream or cry was significant. I knew that my dad was not the only patient who had experienced a situation similar to this. I knew I wanted to make the situation better then, and in the future.

There was also a lot that I did not know. I did not know that this moment was the beginning of my dad's eighteen month battle with cancer that would end with his death. I did not know that my graduate school experience would be unlike anything I could have predicted or planned. I did not know how much of my identity, life struggles, and challenges would be ignored by myself and my colleagues. I did not know that for the first time in my life I would know what it felt to be silenced.

But in that moment, not knowing what I did not yet know, I moved. I moved my rear end down to the nurse's station to kindly ask that they keep a note on file that the bright-eyed man with the beautiful smile down the hall was unable to speak, unable to communicate what he needed unless the nurse would kindly join me down the hall to read the white board my dad had in his lap that served as his voice. Without much choice, she joined me. Together we walked down the hall, and as I promised, a handsome gentleman with bright eyes and beautiful smile greeted her, still unable to speak, but beaming anyway.

This moment is one that I reflect upon often. It serves as a reminder as to why I have done the work I have and what I hope to do in the future. What many do not understand is this project was one way to finally be the person I always viewed my dad to be: a person so intelligent who knew many things about the world that others did not.

Embarking on this project and talking about it with my dad was the first time my dad told me he did not understand, nor could he contribute to what I was saying. We happened to be talking about Foucault and the constitution of patients through the medical gaze. I want to be intelligent like my dad and I thought writing a big paper and getting another degree was the way to show that I had achieved such feat. My heart broke when my dad did not know what I was talking about. In my mind, what good was I doing if I spent all this time researching, reading, and writing, yet still unable to engage others in conversation? This moment was a pivotal one in the process of this project. At this moment, the project ceased to be just an academic project for me, instead becoming both personal and professional.

With a shift in perspective, I have to admit that this project has failed to follow the course of what most would consider a Master's Thesis. My first ideas were abandoned. I did not finish with my cohort. I will not publish sections or chapters from this manuscript. Instead, this project ultimately serves as the closing of the door on two years of my life that were utterly painful and at many times miserable. This project no longer serves as a symbol of my intelligence, but rather of my endurance and resilience; not as an academic, but as a person. In the midst of being inspired by my dad's cancer diagnosis and wanting to change the lives of others in similar situations, my dad's cancer got worse, much worse.

With the disease's progression came the onset of horrific side effects, the first of which occurred on the day I was to attend "teacher training" for my new role as a public speaking instructor. On my way to training on my first official day of graduate school, my mom called to tell me my dad was in the hospital after fracturing his C4 vertebrae in

his spine the night before. He fell after getting lightheaded and went to the emergency room when overtaken with pain unlike any other he had ever experienced. Long story short, the cancer spread to his spine weakening his vertebrae, causing it to fracture upon impact. This was the beginning of another journey in my life: cancer metastases.

As the year progressed, my dad underwent both chemotherapy and radiation in attempt to stop his cancer's progression and rid it from his body. All the while, I was in graduate school trying to stay focused on my studies and accept the fact that all I could be was supportive and love my dad regardless. Ultimately, while I did not realize it at the time, part of me believed that I would uncover something in my studies that would be more powerful than chemo, prayer, radiation, and oncologists. Subconsciously, I believed, or perhaps hoped with every ounce of my being, that I alone could save my dad.

As the months passed, my dad's hair fell out, his cheeks sunk in, his body shrunk rapidly, and his skin reflected the rashes and burns caused by the many treatments poisoning his body. With each trip home, my thesis project seemed less and less important, even with my dad's words of encouragement and pride in the work I was doing and hoped to accomplish. At the conclusion of my first year of graduate school, I had a preliminary prospectus which sought to uncover how oncologists communicate cancer diagnoses to their patients.

The summer between my first two years of graduate school provided yet another defining moment in my personal and academic life. My dad's condition had worsened to the point that maintaining hope for his recovery seemed naïve, and at times utterly ridiculous. At the conclusion of my first year, my dad's PT scan revealed that the metastases in his abdomen and lungs were not improving. It was time to consider quality

over quantity of life. The beautiful thing about my dad is that quality was always a priority and even in the midst of merciless progression of his cancer, my dad maintained his radiant smile and positive attitude each and every day. On June 10, 2009 my dad was told that treatments would do him no good and hospice was the next step. His reply to this news that shattered my family was “I would be a fool to be bitter. I have lived a good life.”

On the night before he died, I spent most of the evening with my dad, obviously unaware that this would be the last time I would watch him smile, or hear his voice. He prayed that night and thanked God for his beautiful daughter, his family, and asked that he be prepared for his long road home. We watched Jeopardy together. We watched the Red Sox beat the Yankees, which we both thoroughly enjoyed. And that night, my dad looked at me and said, “You are going to go far, and I don’t just say that because you are headed there already.” The next morning, June 12, 2009, my dad, my best friend, my confidant, my mentor, and my hero passed away leaving an enormous hole in my heart and in my life.

The confessions that accompany this battle and coincided with the graduate school experience have served in helping me make this thesis project meaningful for me, my family, and hopefully those in the field of medicine. This project has been a personal journey characterized by endurance and resilience. Enduring the rigors of higher education in combination with difficult life circumstances has meant overcoming the death of my dad and transforming elements of this tragedy into something meaningful and portable for me in the future. It has also been a professional journey as I discover

how and where I might make a living exploring the questions that have arisen out of my personal and academic endeavors.

The culmination and completion of this project serves selfish purposes as I know this project, its process, and its completion would do nothing but make my dad extremely proud. While he will never read these pages, I know that his presence in my heart and mind helped guide me to see this project to its end. His inspiration is present in each page, his wisdom is present in every poly-syllabic word, and his influence in my life permeates this project from cover to cover. While I thought this project's greatest accomplishment would be knowing my dad is so very proud, it is instead feeling the pride of having David Clement as my dad.

## Chapter 1: Introduction

Described as the “cornerstone to the medical system” (Parker-Pope, 2008, p. 1), a good relationship between doctors and patients is necessary to deliver quality health care. Most often, encounters between doctors and patients are studied through an interpersonal lens, where “patterns of provider-patient communication are related to the attributes of the patient, provider, and their relationship” (Street, Jr., 2003, p. 64). Relationship, in this context, can be defined according to rapport and trust built between doctors and patients. Within this relationship, talk, or communication, serves as the primary activity, given that doctors and patients must “exchange information about health-related concerns; make decisions about medical care; and, in the best of cases, establish or maintain a relationship characterized by rapport, trust, and respect” (Street, Jr., 2003, p. 66).

However, an article in *The New York Times* found that an increasing number of people do not trust their doctors (Parker-Pope, 2008, p. 1). Such a lack of trust in a doctor greatly impedes doctor-patient relationships, and may even lead a patient to refuse treatment and/or challenge a doctor’s authority (Beisecker, 1990). These findings are important for communication scholars. An early communication study found that the lack of quality communication with their doctor is the primary cause of patient dissatisfaction (Roter, 1983). Further, the quality of communication in medicine “determine[s], to large extent the effectiveness of health care” (Ballard-Reisch, 1990, p. 91).

So, how can we improve communication in health care and how health care is both delivered and administered? The first way to begin uncovering how health is communicated and administered is to examine how doctors understand their role as care providers. The initial place that this information is learned is in medical school. Here, doctors begin to learn how to use science to read the body for signs of illness. In contemporary times, doctors also learn clinical skills and must pass the Step 2 Clinical Skills (CS) examination in order to be a licensed doctor. This exam “uses standardized patients to test medical students and graduates on their ability to gather information from patients, perform physical examinations, and communicate their findings to patients and colleagues” (National Board of Medical Examiners [NBME], 2010). In order to pass this exam, students must learn how to communicate and interact with patients in order to obtain necessary information to treat, diagnose, and build rapport with patients. Since doctors often learn communication skills in medical school, one might ask how their initial instruction influences clinical interactions in the future. Does the way in which students learn clinical skills have implications for how they care for patients once they are licensed physicians?

This study seeks to answer this question drawing both on the dialogic and cultured perspectives of organization and health communication, which suggest that recording life as it occurs in a particular time and place can help suggest how phenomena might be changed in the future. Poststructuralism theory illuminates how the reality of medical school is constructed in and through discourses used in everyday interaction and how power, knowledge, and health are constructed in relation to the human body. These discursive constructions are accomplished through both macro and micro level organizing

processes in the field of medicine. This leads to micro level interactions reflecting these macro level processes. Ultimately, this view illustrates the poststructuralist belief that social reality, both on macro and micro levels, is created, sustained, and revealed by and through discourses used within organizations.

Since discourses reveal macro and micro level organizing processes, this study examines these processes as they relate to clinical skills instruction. By examining the history of medical school, discourses help reveal how and why medical schools have fulfilled particular purposes. For example, at their inception, medical schools served the interests of young men who followed a mentor as an apprentice. After three years, these men could become doctors. As the organization grew, medical schools fell under tighter scrutiny, which led them to organize more formally, beginning around the end of eighteenth century. Over the course of the next two hundred years, the organizing processes of the medical school saw the birth of medical specialties, strict admission guidelines, a shift from treating the poor to reserving the newest medical advance for those who could pay, and the rise of affinity groups. These changes have helped establish the medical school as it is known and recognized today.

To investigate the characteristics of the contemporary medical school, specifically its understanding of communication and care, this study conducted five descriptive telephone interviews with medical schools from around the country using a semi-structured interview schedule. Through a snowball sample, educators were selected purposively based on geography. In the end, educators from the University of Iowa, University of Indiana, University of California San Francisco, University of Colorado, and Harvard University participated in this study. Each interview transcript was coded

using an open coding system that aimed to uncover discursive themes. Codes that related to one another were then put together to create categories used to analyze how medical schools understand both care and communication in their program, as well as how these ideas are taught and learned by students in attempt to answer two questions that guided this study. First, how do medical schools in the United States construct understandings of care through their clinical skills/medical education programs? Second, how is communication conceptualized and developed in clinical skills/medical education programs at medical schools in the United States? The findings from this study reveal that constructions of both communication and care do indeed influence models of care employed in clinical interaction. Therefore, this study proposes alterations for medical education that have the potential to change how clinical interaction unfolds. It appears that the primary skill students need to learn is how to be flexible and adaptable in the way they execute models of care to account for the multitude of patient needs and desires.

The proceeding chapter outlines the theoretical framework for this project including a thorough description of dialogic scholarship and commitments. Chapter two also discusses how poststructuralism operates as a useful frame for examining discursive processes and their organizing functions. It traces the history of the medical school to help delineate how and why the medical school operates as it does. Then, both models of care and models of human communication are discussed in order to understand how these models might intersect to influence each other. Chapter two concludes with an overview of the methods used for this study and a restatement of its research questions.

Chapter three attempts to answer the first research question of this study, which asks, “How is communication conceptualized and developed in contemporary clinical

skills/medical education programs in medical schools in the United States?” To answer this, discourse analysis of interviews is presented and the chapter concludes with the explication of a communication model that outlines how each program interviewed views and understands communication through their program.

Chapter four answers the second research question of this study which asks, “How do medical schools in the United States construct understandings of care through their contemporary clinical skills/medical education programs?” Here, a discursive analysis as it relates to care is presented. This analysis reveals both macro and micro processes that operate to construct understandings of care, which include the program’s development over time and its evaluative procedures. The chapter ends by discussing three conclusions that emerge from the data suggesting how and when care is constructed, practiced, and performed.

In chapter five, the intersections of care and communication are discussed in an effort to answer the larger question guiding this study -- how can we improve the instructions of communication in health care as well as how health care is both delivered and administered? By merging the data from chapters three and four I argue that changing the way care and communication are understood and taught in medical education programs can indeed change the way that health care is delivered and administered. I then offer some suggestions about how these changes can begin to take place including how the course might change and which practices should be abandoned and/or incorporated.

Chapter six, the final chapter in this thesis, concludes the project summarizing key findings and discussing both the theoretical, pragmatic, and methodological contributions

this study makes to both the field of health and communication. It also offers direction for future scholarship related to medical education, communication, and care.

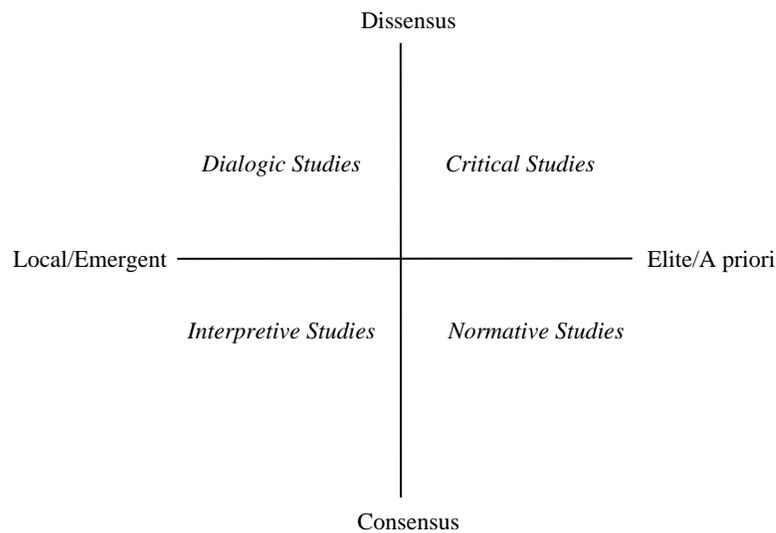
## **Chapter 2: Theoretical Framework and Methods**

Before a study begins, a researcher must first understand his or her commitments regarding “fundamental assumptions about the nature of the world [and] methods of producing knowledge” (Deetz, 2001, p. 3). Deetz’s (2001) work helps outline how scholars can organize their theoretical commitments in the field of communication. Mohan Dutta and Heather Zoller (2008) extend this conversation and contextualize such approaches within the context of health communication.

To begin, Deetz (2001) organizes research dimensions with the hope that scholarly conflicts and discussions can be more productive by “rethinking the differences and similarities among different research approaches” (p. 9). These are placed in a quadrant with the x-axis relating to the “origin of concepts and problem statements as part of the constitutive process in research” (Deetz, 2001, p. 11). The x-axis runs from local/emergent to elite/a priori. Local/emergent is characterized by an open language system where knowledge arises from observation itself and is not believed to exist prior to the observed interaction. Elite/a priori assumes research often favors one language system over another and suggests that the researcher is the expert in the situation. As a result, the language system is held constant when conducting research from this pole.

Unlike the x-axis, the y-axis “draws attention to the relation of research to existing social orders” (Deetz, 2001, p. 14) and relates to the degree of structure that is present in the construction of knowledge. Above the x-axis is characterized as dissensus

and Deetz (2001) describes this as relating to research programs aimed at investigating “struggle, conflict, and tensions to be the natural state” (p. 15). The opposite end of this dimension is called consensus and instead refers to ways that some research programs assume order to be the natural state of being. The four programs Deetz describes are referred to as normative, critical, interpretive, and dialogic. The visual representation of the x and y-axis below helps to explain and uncover commitments that researchers have.



A normative approach tends to move toward consensus and elite/a priori understandings of knowledge. As a result, researchers in this category attempt to uncover law-like generalizations through their work through theory testing. Research is “expressly apolitical and value neutral” (Deetz, 2001, p. 19). Systems theory is favored in this perspective with regard to its focus on both order and regularity within organizations.

The critical approach is similar to a normative approach with regard to elite/a priori understandings of language. Researchers who adopt a critical approach “see organizations in general as social historical creations accomplished in conditions of

struggle and power relations” (Deetz, 2001, p. 25) suggesting that such conditions are fixed rather than fluid. Critical scholars hope to free organizations from domination and their research investigates how practices of domination and power are both initiated and maintained. Scholars who tend to favor this approach include Frankfurt school theorists and structurationists.

Interpretive work strays from the first two approaches by adopting a local/emergent view of language. The goal for interpretive researchers is to uncover “how particular realities are socially produced and maintained through ordinary talk, stories, rites, rituals, and other daily activities” (Deetz, 2001, p. 23). Further, interpretive scholarship is often understood to be a response to post-positivist research as it seeks to study “issues of local meaning rather than universal generalizations” (Dutta & Zoller, 2008, p. 12) where local meaning refers to activities of daily life that are often considered mundane or unimportant. Typically, this work attempts to preserve life as it occurs in a particular historical moment.

Dialogic studies, like critical studies, moves toward dissensus, but unlike critical and normative approaches, it abandons elite/a priori understandings of language. Dialogic scholars are similar to interpretive scholars, however they extend the goal of merely recording life as it occurs in a particular time and place to making a change for the future based on what is happening in the present. This goal is what moves dialogic research toward dissensus, whereas interpretive work moves towards consensus. For the purposes of this project, I will conduct my research and my study from a dialogic perspective. After investigating communicative problems in health care and how communication is understood and taught in medical schools, I hope to be able to make

suggestions about how changes can be made in order to improve patient care.

To understand how to achieve this goal through both theory and methods, Dutta and Zoller extend Deetz's conversation within the context of health care to illustrate how these commitments and goals can be organized in a different setting. What Deetz refers to as dialogic studies, Dutta and Zoller call cultural studies. They suggest that cultural studies "provides a bridge between the interpretive and critical approaches" (Dutta & Zoller, 2008, p. 7) by focusing on local contexts within health while also investigating questions of power that shape the way discourse unfolds.

Another key feature of cultural studies within the context of health is its examination of the interplay between micro and macro processes. This perspective examines how social structures such as hospitals and medical schools are constituted through such processes. This approach is similar to interpretive work in that it explores local meaning and understandings, yet differs with regard to its concern with how discourse can create new possibilities and change for organizations. Cultural studies explore the local level of meaning with the understanding that culture is "dynamic and transformative, constituted through the locally situated meanings that are co-constructed in the realm of social structures" (Dutta & Zoller, 2008, p. 8).

Moving toward dissensus and studying health and organizational communication at local levels, dialogic and cultural scholars need a way to understand how meaning is created at the local levels to move toward change upon uncovering findings of their work. Poststructuralism serves as a useful tool to achieve these goals as it examines the ways in which meaning is constructed and how reality is constituted for both researchers and their objects of study.

## **Poststructuralism**

Poststructuralism is a perspective that attempts to make sense of everyday interaction by exploring how social reality is discursively constructed. This perspective is useful to dialogic scholars because it assumes that “language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested” (Weedon, 1997, p. 21). As such, poststructuralism assumes that meaning is “constituted within language and is not guaranteed by the subject which speaks it” (Weedon, 1997, p. 22). Viewing language as a site of struggle leaves its system more open and fluid. This view avoids essentialist notions of language. Instead, language is understood to be a collection of competing discourses, and as a result meaning comes from the struggle inherent in discourse. The way meaning is assigned is then determined and influenced by “the range and social power of existing discourses, our access to them and the political strength of the interests they represent” (Weedon, 1997, p. 26).

Scholars who have been labeled poststructuralists include, but are not limited to, Jacques Derrida, Michel Foucault, Jacques Lacan and Julia Kristeva. While these scholars are all labeled as poststructuralists, this way of thinking is not characterized by common themes or beliefs. Rather, these scholars are similar with regard to their distaste toward structure and the belief that language constitutes reality, moving away from structuralist ways of thinking which view “events and phenomena as autonomous and as governed by internal rules and mechanisms” (Mills, 2003, p. 28). Instead of trying to understand intentions of the author of a text for example, poststructuralists attempt to understand how knowledge is produced and meaning is constituted through language.

One of the most notable poststructuralists is Michel Foucault. Foucault, like other poststructuralists, views discourse in terms of the interconnection of language and practice. Discourse, he says, is “*a priori* of what can be expressed in it” (Foucault, 1970, p. 297) meaning that language is laden with structure that the speaker rarely realizes.

Foucault also pays particular attention to power and knowledge as they are enacted and accomplished through discourse. In the context of medicine, power plays a particular role because, according to Foucault, the body is very political given that one can have “*power of the body and over the body*” (Harland, 1987, p. 161 which leads doctors to possess a particular form of knowledge the individual does not. On the other hand, patients also have power with regard to the information they share with their doctors. Thus, a doctor’s power of and over the body is often limited by the patients power to reveal information concerning their body.

Foucault argues specifically that knowledge in and of itself serves as a form of power that regulates and disciplines (Sarup, 1989). An individual becomes constituted as a patient at the intersection of various discourses and accompanying forms of knowledge as language both defines and contests subjectivity. These processes have material implications with regard to the ways organizations such as medical schools and clinics are constituted and functionally defined at a macro level. The constitution of patients and the accompanying discourses of knowledge and power that occur at the micro level are a reflection of such processes occurring within institutions. At an organizational level, Fairhurst and Putnum (2004) illustrate how discourse aids in constituting these realities and their inhabitants.

## **Discourse and the Organizing of Medicine**

The becoming orientation, as discussed by Fairhurst and Putnam, aligns closely with poststructuralism with regard to its understanding of both discourse and meaning. Rather than viewing discourse as an artifact within an organization, this perspective suggests that “discourse creates, sustains, and transforms” (Fairhurst & Putnam, 2004, p. 13) the process of organizing and exists prior to the organization. More specifically, language exists prior to the organization itself. Discourse serves a formative function in constructing the organization.

Within the organization itself, Fairhurst and Putnam’s becoming orientation suggests that macro and micro processes of organizing are also constituted in and through discourse. Because organizations and macro and micro processes are created through discourse, organizations are in a constant state of becoming. Researchers then ask the question, “‘What is organizing about discourse?’” (Fairhurst & Putman, 2004, p. 13).

Another unique feature of this perspective is its distinction between discourse and Discourses. While this view holds that discourse is language in use, it also attempts to examine Discourses which “reside in power/knowledge systems” (Fairhurst & Putnam, 2004, p. 14). Analyzing Discourses in organizations attempts to uncover how people are disciplined by both micro and macro organizational processes. For example, Holmer-Nadesan (1997) conducted a study investigating how personality tests operate as a form of power in the workplace as they divides workers based on the results of the test. While Discourses are embedded within power/knowledge systems and work to discipline workers, discourse refers to language in use in everyday interaction.

## **The Medical School**

The medical school is an organization that can be viewed as constituted and sustained in discourse. Examining its history illustrates how the organization developed and grew and how its functions have changed over time. Foucault's clinical work is also useful to examine alongside the inception and history of the medical school because it illustrates the evolution of what was being taught at the same time the clinic was undergoing particular changes, including the ways that both power and knowledge were emerging in new ways within clinical interaction.

The profession of medicine in America began to officially organize around 1760. Prior to this time people relied upon family and community members for medical care. As cities began to develop, the need for a more formal structure arose. Attempting to reproduce the structure in England, educated doctors began separating medicine from religion. Clergymen were no longer the only members of early medical societies or the only people administering care to their communities. Instead, doctors sought to create a profession of elite status composed of competent and qualified individuals trained in medicine.

The result of these desires solidified in 1765 when the first medical school in the United States received its charter. Founded by John Morgan, the College of Philadelphia sought to replicate the European image of medicine with apprenticeships as the means of training. Doctors would take young men under their wing as apprentices and these young boys would have full access to the practitioner's library and were fed and clothed for the duration of three years. Following the completion of their apprenticeship, men were provided a certificate "of proficiency and good character" (Starr, 1982, p. 40).

At the same that the College of Philadelphia was founded, Morgan also began to organize the first formal medical society with licensing authority to oversee the schools. He believed this was another step that must be taken to maintain medicine's elite status. Licensing, it was argued, would "distinguish between the honest and ingenious physician and the quack or empirical pretender" (Starr, 1982, p. 44). While his charter was approved for the College of Philadelphia, his request to establish a licensing organization was denied.

Without a governing or oversight organization, the medical community lacked formal structure. Morgan's school was the first of many to appear in the decades following 1765. Initially, these schools consisted of five to seven unsalaried professors who taught classes from November to March. Degrees were obtained after two years and the second year was spent repeating the coursework from year one. The only prerequisites required were competence in natural and experimental philosophy and an understanding of Latin. Following coursework, students completed their three-year apprenticeship and completed a thesis. Exams were given as well, but not always taken seriously because faculty did not get paid unless students passed their exams. As a result, most, if not all, students passed.

While medical schools were organizing around the end of the eighteenth century, Foucault argues that field of medicine and the organization of clinics was also changing. In his book titled *The Birth of the Clinic: An Archaeology of Medical Perception* he argues that the last years of the eighteenth century marked "a sudden, radical restructuring" where the clinic would become "detached from the theoretical context in which it was born" (Foucault, 1973, p. 62). At the time, the clinic's purpose was to teach

and accumulate medical knowledge by “striking a balance between *seeing* and *knowing* (*le voir et le savior*)” (Foucault, 1973, p. 55). Medicine, as mentioned previously, was learned and administered at the bedside of the patient, free from philosophy, privacy, and writing. The shift Foucault discusses began to take place when observation, processes of seeing and knowing, and medical knowledge became restricted to groups of privileged people.

Like the evolution of the medical school, clinics also began to evolve in ways that restricted access and attempted to remain elite. As medical knowledge became restricted, it provided an opportunity for the medical school to offer particular types of training that only select individuals were capable of learning. As both of these organizations progressed and evolved, the field of medicine became more specialized as a result of medical knowledge being organized in new ways around parts of the body, rather than the whole body itself.

With an increase in specialization came a new understanding the human body and illness. As a poststructuralist, Foucault suggests that language played a key role in the changes that took place in medicine, especially in relation to the understanding of disease and the human body. Prior to the restructuring of medicine, Foucault argues that disease was believed to be “the invisible ‘other’ of the visible human body” (Harland, 1987, p. 102). As pathological anatomy and its accompanying discourse of medical advancement became more prevalent and accessible Foucault argues, the meaning of disease shifted.

As the meaning of disease shifted, the field of medicine had to redefine knowledge in order to maintain its elite position. As a result, “an absolutely new use of scientific discourse was then defined” (Foucault, 1973, p. 196) to reestablish the

relationship between seeing and knowing in a way that constituted a new medical language. This new language created the “discursive space of the corpse” and constituted “the historical condition of medicine that is given and accepted as positive” (Foucault, 1973, p. 196). This new shift suggested that through the gaze of a newly formed group of elite medical professionals, human bodies could be understood, as well as charted, in ways like never before by using a new discourse to describe what one saw. This new description and discourse of the body could then constitute medical knowledge.

While the medical field underwent the restructuring discussed by Foucault, patients become subjects constituted within medical discourse and scientific progress. Once inflicted with a disease, a patient becomes subject to the gaze of a doctor who examines the body in order to determine its illness. Under such scrutiny, the doctor begins to understand the individual through his/her display of illness and disease. Essentially, the patient is the disease itself, according to Foucault, because the medical gaze creates a portrait of the disease which is indistinguishable from the patient.

This creation of the patient/individual is only possible in and through language and occurs in three stages. First, a patient is questioned about symptoms and signs of illness. Second, a patient provides information regarding his/her state before the illness such as previous medical history, occupation, hobbies, etc. Finally, the patient is subjected again to the gaze of the doctor in order to determine how to remedy existing health problems. This progression of events illustrates the interplay between seeing and speaking in order to constitute the subject position of “patient”. To inquire without observation, or to observe without inquiry, fails to constitute the individual as a patient.

Foucault summarizes these processes by saying, “It is the description, or, rather, the implicit labour of language in description, that authorizes the transformation of symptom into sign and the passage from patient to disease and from the individual to the conceptual” (Foucault, 1973, p. 114). This process in its purest form would result in a “speaking eye” where:

It would scan the entire hospital field, taking in and gathering together each of the singular events that occurred within it; and as it saw, as it saw ever more and more clearly, it would be turned into speech that states and teaches; the truth, which events, in their repetitions and convergence, would outline under its gaze, would, by this same gaze and in the same order, be reserved, in the form of teaching, to those who do not know and have not yet seen. This speaking eye would be the servant of things and the master of truth (Foucault, 1973, p. 114-115).

While the speaking eye is the ideal result of the processes Foucault discusses, language allows us to proceed through the three steps outlined below in order to still record what one sees; thus, it is through language that medicine advances because it “give[s] speech to that which everyone sees without seeing” (Foucault, 1973, p. 115).

While the clinic undergoes shifts with regard to its function, language becomes increasingly more important because it is the only way to communicate what we know in order to constitute individuals as patients, and symptoms as disease.

### **The Medical School of the Nineteenth Century and Beyond**

As medical knowledge and the importance of language in the clinic began to transform, the medical school still lacked a cohesive organization structure and strong

clinical ties which ultimately continued to challenge its elite position. Because there was no organizational structure that oversaw schools and their development, or a governing body that helped transition from medical students into the clinic, both organizations arose apart from one another. Consequently, medical schools began to emerge throughout the country with unrestricted competition and a lack of consistency with regard to requirements and credentials. Following the War of 1812, the country saw a surge in the creation of medical schools. According to a report in 1910, “twenty-six new medical schools sprang up; between 1840 and 1876, forty-seven more” (Flexner, 1910, p. 596) and in the following twenty years, this number more than doubled.

As schools became more prevalent, the number of doctors increased substantially and arguably threatened the elite status of the medical profession. Newer schools lacked ties to universities and an increase in facilities resulted in an abundance of doctors, mostly at lower levels of education and quality. To remedy this problem, Flexner (1910) wrote to the Carnegie Foundation for the Advancement of Teaching and suggested that every two physician vacancies that arise due to death should only be replaced by one doctor. This, argued Flexner, would prevent “inflation of an inferior product” (p. 596) and would begin the process of destroying schools and restricting the number of people who had access to a medical education.

At the turn of the 20<sup>th</sup> century, medicine and surgery began to divide and by 1930 departments were “well established as the basic organizational units of American medical schools” (Braunwald, 2006, p. 457). By 1960, departments began working together to create a multidisciplinary approach to teaching. Organizational divisions were met with an increase in medical specialties. Various doctors began to coordinate care and work

with one another to enhance patient care.

### **The Rise of the Affinity Group**

While divisions and departments began to emerge, medical schools still had the same underlying problem as they did during the 19<sup>th</sup> century: the absence of a formal organizational structure. While groups were created and care was coordinated, most organizing occurred in affinity groups which were informal organizations that met weekly. As a result, “patient care, education, and research remained solely with the departments” (Braunwald, 2006, p. 458) which meant patients had to bounce between these affinity groups to coordinate their own care.

The changes in the organizational structure of the medical school were also influenced by the evolution of research disciplines. At the beginning of the twentieth century, medical schools were founded upon six distinct disciplines which included anatomy, biochemistry, physiology, microbiology, pharmacology, and pathology (Braunwald, 2006). Each of these disciplines had departmental status at most medical schools and a major course was taught in each subject. These distinct disciplines began to change in the 1970s, when cellular and molecular biology became more popular. While medical schools were facing an absence of a formal organizational structure, they now had to account for an emerging discipline within the field.

By 1980, affinity groups became more important and more formal. Departments began to focus on interdisciplinary styles of learning and teaching. The previous decade illustrated the importance of multispecialty care so the organization of the medical changed yet again to account for these benefits. By the 1990s most medical schools moved toward a multidisciplinary approach to their department and their organizational

structure was becoming more formal. With this change, clinics and medical centers became more focused. For example, cancer centers, cardiovascular clinics, and HIV-AIDS centers began to emerge during this time. Care within particular specialties became centralized; however, these clinics and centers now work together to coordinate care.

### **Contemporary Construction of the Medical School**

Today, the medical school reflects the wide array of changes that have occurred over the last hundred years in the establishment of its function and structure of medical school today. Medical schools are now overseen by a governing body that Morgan first conceptualized when initially establishing the institution. The Liaison Committee on Medical Education (LCME) is responsible for outlining accreditation requirements for all medical schools in the country. In order to be accredited, the organization of the medical school must be outlined in the bylaws of the university in which it is a part and should be overseen by a governing board. The school is required to have a dean with “ready access” (Liaison Committee, 2006) to the university president. The dean should have a comprehensive education in the medical field and needs to have the support of associate deans as well.

The school itself is required to be part of a larger university where other graduate degree programs are offered. Unlike the early medical school, today it must be part of a larger organization and education takes place outside a mentor’s office. Medical students should also have opportunities to conduct research, work in a clinical setting, and work closely with the school’s faculty. The faculty also needs to work together in “teaching, research, and health care delivery” (Liaison Committee, 2006, p. 1). Faculty need to

teach across an array of disciplines and subjects including anatomy, biochemistry, genetics, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine. Lessons on these subjects should include both lecture and laboratory instruction.

Beyond basic science, students need clinical instruction as well. While clinical instruction was deemed important in the inception of medical schools, it has broadened as the organization has evolved and covers a wide array of material. For example, students must review all organ systems in both inpatient and outpatient settings. With these changes, Foucault's argument concerning the patient's body as the site of the medical gaze remains intact. As students branch out into the clinic, their experiences construct a body that inhabits the reality of the laboratory. In their study of medical education at Harvard Medical School, Good and Good (1993) argue that changes in medical education and the medical itself distinguish the body in normal reality from the body in the laboratory. In normal reality, "personhood" is conveyed, while the body in the laboratory is bound by its materiality and remains the "object of sustained attention" (Good & Good, 1993, p. 95). So while current curriculum outlines the necessary ways in which students should learn, the doctor as the possessor of the medical gaze remains intact and a doctor's knowledge is communicated and reified and s/he documents what is seen through the medical gaze.

Besides clinical experience, the final curriculum area necessary for a medical school's accreditation is communication skills. The LCME (2006) states that:

There must be specific instruction in communication skills as they relate to physician responsibilities, including communication with patients, families,

colleagues, and other health professionals. The curriculum must prepare students for their role in addressing the medical consequences of common societal problems, for example, providing instruction in the diagnosis, prevention, appropriate reporting, and treatment of violence and abuse. The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery. (p. 2)

Thus, teaching communication skills in medical school has become of increasing importance in recent years and ranks just as high as clinical skills and science courses within medical school curriculum. Not only do students need to know how to talk with patients and their families, they are also expected to be able to account for cultural and gender differences in the clinic.

While the LCME states the skills that should be taught, they do not indicate how medical schools can or should go about teaching these topics. Again, aspects of the organizing practices of the medical school remain undefined. To attempt to instill some level of structure, the American Medical Association (AMA) collaborates with the LCME in creating accreditation standards for medical schools and they have established a Clinical Skills Assessment Exam (CSAE) which attempts to evaluate the degree to which students understand and can utilize the skills set forth by the LCME standards. This exam consists of twelve simulated patient encounters. In these interactions, students have fifteen minutes to take a history of their patient, gather enough information to make a

diagnosis, and formulate a treatment plan (“Clinical skills”). This exam costs \$975.00 and is only offered at five testing sites in the country which means travel is often required.

The AMA has strong policies regarding competence in clinical skills and the debate about whether or not a standardized test for clinical skills is necessary is long and ongoing. It does however, speak to the fact that clinical skills training, much like the organizational structure of medicine, needs to be more formally organized across schools. The CSAE is one way to ensure that the standards set forth by the LCME requirements are truly being met and that all medical students are adequately trained in communication skills.

In summary, medical schools have come a long way since their inception in the United States in the 1765. While they are regulated more tightly and have more standardized requirements, debates still continue regarding both the purpose and requirements for schools and their physician students. While standards have been set by the LCME, these guidelines still reproduce the doctor/patient relationships Foucault critiqued given that patients are still at the mercy to a doctor’s gaze and knowledge in defining and treating disease. Disease and illness is still defined by and through discourse. The discourses that are employed have material consequences to how care is both communicated and implemented.

Medical schools are also the first place that students learn fundamental skills related to communicating and care. Good and Good (1993) suggest that “individual practitioners draw upon distinctive models of the world, and these are reflected in their diagnostic work” (p. 82). Further, the way that doctors and patients understand health,

illness, and healing are culturally embedded which can often make talking about such understandings difficult. The ways students are taught to communicate with their patients in an attempt to achieve the goal of good health is likely to predict models of care employed by students in the clinic, therefore uncovering how communication is understood may suggest the model of care that is likely to be employed in clinical interaction.

### **Models of Care**

The extent and variety of clinical skills training in medical school helps to understand models of care employed in clinical interaction. Barbara Korsch was one of the first scholars to study such interactions. She argued that the quality of medical care largely depends on the relationship between doctors and patients “and there is abundant evidence that in current practice this interaction all too often is disappointing to both parties” (Korsch & Negrete, 1972, p. 66). She came to this conclusion after her research team at Children’s Hospital in Los Angeles, California investigated the relationship between doctors and their patient over the course of five years in over 800 clinic visits. Her study at Children’s Hospital was done with the intention of providing resources to the medical community that may help overcome such problems. While doing this research, Korsch commended medical schools for training students with regard to “the complexities of medical science,” (Korsch & Negrete, 1972, p. 66) but suggests that medical students were not adequately trained in getting messages across because they used technical, and often unnecessary language.

Korsch and Negrete’s (1972) study initiated inquiry into the doctor/patient relationship and this scholarship has become increasingly prevalent since the 1970s.

Over the last few decades, scholars have attempted to illustrate models that assist in uncovering how patients and doctors communicate, while also uncovering weaknesses that impede both communication and the relationship in general. Roter and McNeilis (2003) for example, summarize four relational models “that result from various configurations of patient and physician control” (p. 122), which they call paternalism, consumerism, mutuality, and default. Much research has been conducted on the first three models, while the default model is a result of “a dysfunctional standstill” (Roter & McNeilis, 2003, p. 123) that occurs due to a lack of clarity and alignment with regard to the goals and expectations of both parties. The default model characterizes such a relationship until a change is made on the part of the doctor and/or patient, and at such time the relationship falls into one the other three models.

### **Paternalism**

The first of these models is paternalism. This relational model is defined by the domination of the agenda by the doctor with little to no room for the patient’s voice. Doctors seek to operate in the best interest of the patient; however, what is best is defined by the doctor. In this setting the role of the doctor is “to direct and prescribe” and the patient is expected to “obey and cooperate” (Beisecker & Beisecker, 1993, pp. 44-45). This model is often compared to that of a parent and child because the doctor’s primary goal is to look out for and protect the patient. The patient is expected to cooperate with the doctor’s requests and demands. Further, this model assumes that patients should trust their doctor even when his/her demands challenge fundamental beliefs and values that the patient holds to be important.

In looking at the relationship between power and knowledge in this model it is likely that doctors possess most, if not all, power and knowledge in this situation as patients are completely dependent upon the doctor to communicate about and diagnose health problems. In interaction, it is likely that this model of care does not encourage the patient to ask questions as this would be a threat to the paternal nature of the relationship. Instead, the doctor is the information seeker, while the patient is the information giver. The doctor's knowledge supersedes that of patient which further reinforces a doctor's power in interaction. The doctor's relationship as "all-knowing" begins to change as the relationship moves toward a different model of care known as consumerism.

### **Consumerism**

The model of consumerism differs from paternalism because patients take a more active role than in paternalism given that they "set the goals and agenda for the visit and take sole responsibility for decision making" (Roter & McNeilis, 2003, p. 123). Patients still turn to their doctors for medical advice, but in the end patients, rather than doctors, make the ultimate decision regarding care. This model has become increasingly popular as technology provides access to medical information and expertise that was previously accessed solely through speaking to a doctor. With easier access to information, patients assume the role of buyer rather than child, while the doctor moves from being like a parent to a seller (Beisecker & Beisecker, 1993).

The patient has more power in this model, but still relies upon the doctor's knowledge with regard to diagnosis, potential treatment, and more detailed information regarding conditions that cannot be accessed. As patients begin to advocate for themselves and their health they begin to possess more power than a patient in a

paternalistic interaction. Patients begin to resemble doctors as information seekers and as patients adopt the role of consumer they too ask questions that require the doctor to provide information. With that said, patients ultimately rely upon a doctor's knowledge which maintains an asymmetrical relationship between doctors and patients.

### **Mutuality**

The final model characterizing the doctor/patient relationship is that of mutuality. Here, doctors and patients have the most symmetrical relationship as "power in the relationship is balanced, the goals, agenda, and decision are the result of negotiation between the participants" (Roter & McNeilis, 2003, p. 123). This model acknowledges the idea that "every medical decision should be based on the facts of medical science, but a decision to perform a test, write a prescription, or give some medical advice always has to go beyond the science" given that it will always "involve a value judgment about the expected outcome if one course or another is followed" (Veatch, 2009, p. 10). Within a model of mutuality, the patient is the expert regarding such value judgments, and as a result they play an active role in diagnosis and treatment plans. As patients take on this new role, the power/knowledge relationship begins to shift more drastically. Rather than doctors possessing most, if not all, knowledge and power patients begin to also contribute to the interaction. The nature of communication begins to change as doctors operating within this model turns to the patient for advice just as much as the patient relies upon the doctor. Because this model is so different from the previous models discussed it is important to understand how such an environment can be both created and sustained.

Ballard-Reisch (1990) argues that doctors can foster a model of mutuality and participative decision making through four steps. These include creating a conducive

atmosphere, understanding patient goals and expectations, educating the patient about diagnosis and treatment, and finally accounting for patient concerns and expectations regarding the medical encounter.

While these models help to explain doctor/patients relationships, it is important to remember that each model is fluid and multiple models can characterize one medical encounter. Further, patients can often affect the model employed as much doctors. Thus, these models illustrate the complexity of communication, as well as communicative negotiations that must be made when doctors and patients interact. For example, if a patient assumes a paternalistic role of a doctor, but the doctor favors a mutual approach the two parties must negotiate and renegotiate in order to create a successful encounter.

### **Models of Human Communication**

Human communication has been an area of study for more than 2,000 years. Throughout that time people have set out to discover how and why people communicate the way they do. Many researchers have created models and theories which suggest what a message is, how it is received, and how people then interact as a result. Few models treat communication as a static and fixed process, but rather serve to explain communication processes in an illustrative and intelligible way. Two of the most well-known views of communication are Shannon and Weaver's transmission model and dialogue.

#### **Shannon and Weaver**

In their article titled, "The Mathematical Theory of Communication," Claude Shannon and Warren Weaver attempt to explain the process of transmitting data electronically. In doing so, they assume that human communication shares key

characteristics with electronic communication, such as the radio and telephone. As a result, their model views communication to be linear. The process of communication is depicted “as a series of steps in which a message is conveyed from a source or sender to a destination or receiver, and ‘communication’ is defined as the replication of the original message at the receiver's end of the transmission” (Bowman & Targowski, 1987, p. 23).

While criticized for ignoring the dynamic nature of communication, the Shannon and Weaver model has “shaped the directions taken by the field of human communication, determined many of its main concepts, and contributed toward the closer intellectual integration that arose from diverse multidisciplinary roots” (Rogers, 1994, p. 411). This model was intended to focus exclusively on syntax given its scientific and mathematical focus, and Rogers (1994) argues that communication scholars have poorly constructed and applied this model in their field. Even still, this model is ever present in communication theory today.

Shannon and Weaver posited communication occurs when “the order of words and other data remains the same from the sender to the receiver” (Bowman & Targowski, 1987, p. 24). Interpretation of meaning is not accounted for in this model, as its intent was to improve the transmission of information over telephone lines more efficiently through repackaging information. Failure to address intentionality has led to increased criticism of this approach; however, Shannon and Weaver intended the model to “explain the channel capacity to carry messages” (Rogers, 1994, p. 415) rather than the effects of communication. The model is useful however in explaining and depicting elements of a communication act which are often referred to as source, channel, message, receiver, noise, and feedback. A communication act occurs when a source, for example a

politician, sends a message to a receiver, or audience. The channel refers to the means through which the message is sent which can include speaking, a media message, or radio. Noise and feedback refer to variables that can interfere with the message being sent such as external noise like a heater buzzing, or the receivers own thoughts that are distracting him/her from listening to the sender. Besides outlining these components, this model's linear nature is useful in attempting to explain the complexity of communication and provides "a powerful unifying force for scholars seeking to understand communication systems" (Rogers, 1994, p. 417).

Even though this model was intended to explain communication technologies, it is still useful in the field of communication theory as we attempt to explain how and why communication messages are both sent and received. In the context of the clinic, this model is also useful in understanding the communicative needs of both doctors and patients. There are instances where communicative parties wish to communicate efficiently and directly, and have little to no regard about the interpretation of a communicative message. In such instances the transmission model is useful as it suggests that one person acts as sender and the other as receiver without paying attention to external factors such as time, culture, and gender. When communicative partners wish to simply transmit information to one another this model is useful.

A specific context that illustrates the importance of this model is in the emergency room (ER). Eisenburg et al. (2005) argue that the ER is different than other clinical settings due to the fact that case load is unpredictable, doctors must care for multiple people simultaneously, there is a high level of uncertainty with regard to patient information and medical decision making, and care is under intense time constraints. In

this environment, there are “extreme pressures on time and space” which tend to create three options for responding to patient care. ER doctors can discharge patients, admit them to the hospital, or patients unfortunately die. With such organizational pressures, Sharon and Weaver’s model becomes useful given that doctors need to make quick decisions with little information. Relying upon this model allows ER physicians to communicate efficiently and directly as they seek to get patients well enough to return home or diagnosis their condition and admit them to a hospital. This model is useful in that ER doctors need to simply receive information that informs the decision to send patients home or to the hospital. In this context, the linear model of communication arguably allows doctors to run an ER in an efficient and direct fashion while ensuring that patients get the immediate care they require.

### **Revisions to Shannon and Weaver**

Besides the transmission model, other models have attempted to further explain communication processes by adding on to Shannon and Weaver’s initial model. In 1953, Carnap and Bar-Hillel revised Shannon and Weaver’s model to account for meaning in the communication process. A year later, Schramm expanded this idea even further when he suggested that meaning is both encoded and decoded by senders and receivers within “a shared field of experience” (Bowman & Targowski, 1987, p. 25).

In 1960, the Shannon and Weaver model was revised again when Berlo argued that its mathematical roots be removed entirely. To do this, Berlo defined the components of source, message, channel, and receiver while illustrating how each affects and is affected by communication processes. Rejecting the mathematical nature of Shannon and Weaver’s model, Berlo argued that such models “do not contribute

significantly to our understanding of what happens when two or more people attempt to communicate” (Bowman & Targowski, 1987, p. 27). The accuracy of information transmission is not nearly as important as the meaning that is conveyed when such a transmission takes place.

This shift in understanding of communication processes also shifted the understanding of what communication is. Rather than communication being the result of data being accurately sent from a sender to a receiver, communication was understood to be the “value or meaning is assigned to that information” (Bowman & Targowski, 1987, p. 27). This shift began to focus “how messages create change in the sender and receiver” (Bowman & Targowski, 1987, p.23) given that inferred meaning on the part of senders and receivers is the assumed catalyst for action. If the sender and receiver are motivated, or find meaning in communication, they can be compelled to change their behavior in some way.

Additionally, Thayer (1967) notes that incorporating meaning into the communication model helps explain how and why "the message a receiver ‘gets’ is almost always composed of factors which are well beyond the shared informational ‘content’ of the originator’s statements or questions" (p. 123). Therefore, communication is more complex than the accuracy of its replication. The added components of value and meaning created a shift in communication models of the future as they moved from being mathematical and syntactical to semantic.

Beyond moving from mathematical to semantic models of communication, newer models and theories also began to look at the pragmatic purpose of communication. This view embraced the realities that communicators reside within. Communication in this

view is understood to be “a goal-directed activity in that it always has a purpose” (Bowman & Targowski, 1987, p. 28), even if the purpose is not always apparent to the sender or receiver.

## **Dialogue**

A current model that accounts for the purposeful and goal-directed nature of communication is dialogue. Jenlink and Banathy (2005) state that “*Dialogue [sic]* is a culturally and historically specific way of social discourse accomplished through the use of language and verbal transactions” (p. 4). It is purposeful and goal-oriented given its focus on an egalitarian relationship between senders and receivers. Engaging in dialogue also assumes that communicators share a common space and come together to form a community. It differs from discussion with its goals of inquiring to learn, sharing meaning, understanding diverse perspectives, and uncovering assumptions instead of persuading, agreeing, selecting what one views as best, or defending a position (Gerard & Ellinor, n.d).

David Bohm, a physicist, spent the latter years of his career exploring dialogue and how it differed from conversation and discussion. Bohm (1996) believed dialogue to be “a multi-faceted process, looking well beyond typical notions of conversational parlance and exchange” (p. vii). This differs from discussion because in dialogue, goals shift from trying to win to sharing meaning. Rather than talking at one another, individuals begin to talk with one another.

After reading Bohm’s work, Cayer (2005) proposed a descriptive model for dialogue that illustrates its five dimensions of conversation, inquiry, creation of shared meaning, participatory processes, and collective meditation. Conversation refers to idea

that dialogue is “a non-judgmental way of listening” (Cayer, 2005, p. 174). Because it strips judgment from interaction, this dimension can be distinguished from discussion because it does not action for trying to win or change another’s behavior. Instead, conversation is the element of dialogue that seeks to understand people for who they are, rather than judge how one is different from another. To abandon judgment necessary for conversation, one must express empathy and respect with the goal of understanding another’s experience, rather than just hearing content.

The second dimension of inquiry focuses on “the exploration of individual and collective assumptions, beliefs, ideas, and feelings that control the participants’ behaviors and interactions” (Cayer, 2005, p. 176). In order for this dimension to be achieved, communicators must abandon the assumption that they possess a correct or right version of reality. In doing so, they can then explore assumptions and their effects upon each of their lives. Mastering this dimension is achieved through open questioning and reflexivity on the part of all communicators.

The third dimension to Bohm’s dialogue is the creation of shared meaning. This tenet embraces the idea that humans both create and re-create meaning. Bohm argues that it is through dialogue that humans “become aware of and responsible for the effects of this meaning-making capacity” (Cayer, 2005, p. 178). This dimension also embraces the diversity of opinions that people often have and dialogue provides a way for all voices to be heard. Like the second dimension, participants must abandon the idea that their understanding of reality is correct or true in order for meaning to be created and then shared.

The fourth dimension in this model refers to the participatory nature of dialogue. By welcoming a variety of perspectives and beliefs, dialogue creates a sense of openness that is lacking in other models of communication. By embracing a diversity of opinions with the goal of creating shared meaning through questioning and understanding, dialogue only works when people participate in the process. This model of communication establishes an environment that abandons hierarchical understandings of the world by believing that there is not right or wrong way in which to understand the world. Such an understanding comes through participation in dialogue where meaning is both created and recreated for participants.

The final dimension in this model stems from the idea that dialogue is a form of collective meditation. Both Bohm and Cayer (2005) believe dialogue is similar to meditation because it “does not attempt to change people, behaviors, or situations, but brings people to simply be aware and be attentive to what is without judging” (p. 184). Bohm classifies the meditative function of dialogue as collective because participants are not trying to do anything in particular, but are instead seeking to understand one another in new ways. In order to accomplish this task, dialogue must occur in the present moment. This means that participants must be aware of their body, emotions, and thoughts, which requires an abandonment of assumptions regarding the status and/or beliefs of other participants. This illustrates how dialogue requires a balance between individuality and collectivity in order to unfold productively.

Dialogue is often critiqued for being vague and ambiguous. It is often difficult to distinguish between what is dialogue and what is not, and the terms dialogue, discussion, and conversation are often used interchangeably. Cayer’s model is helpful in explaining

how dialogue differs from other models of communication such as conversation or discussion. Conversation, in its truest form is merely a social skill that allows communicative participants to share information. Jenlink and Carr (1996) use conversation as an umbrella term that encompasses both dialogue and discussion. Because different scholars use a variety of terms synonymously with dialogue it is important to understand how it differs theoretically from other concepts like conversation.

To better understand this distinction, Craig's (1999) article titled, "Communication Theory as a Field" helps to separate these terms by first delineating seven traditions within communication theory. Craig suggests that communication theory fails to exist as a coherent, unified field and is instead comprised of seven traditions "according to underlying conceptions of communicative practices" (Craig, 1999, p. 135). The phenomenological and cybernetic traditions help explain how dialogue and conversation differ. According to Cayer's conceptualization, dialogue falls into the phenomenological tradition because communication is theorized as "the interplay of identity and difference in authentic human relationships" which "cultivates communication practices that enable and sustain authentic relationships" (Craig, 1999, p. 138). Because dialogue involves collective assumptions, shared meaning, participatory exchange, and mediation, Craig classifies it as part of the phenomenological tradition which is "founded on the experience of direct, unmediated contact with others" that sets "aside the dualisms of mind and body, subject and object" (Craig, 1999, p. 138). When compared to the other six traditions, dialogue is upheld as the "ideal form of communication" (Craig, 1999, p. 139).

While dialogue is closely aligned with the phenomenological tradition, Cayer's understanding of conversation is more in line with the cybernetic tradition which views communication in relation to information processing. This relates to Bohm and Cayer's understanding that conversation is way for communicative partners to share information. It lacks the complex dimensions of dialogue "and explains how all kinds of complex systems . . . are able to function" (Craig, 1999, p. 141). While conversation does not deny the complexity of communication, it serves the function of sharing information.

Besides dialogue and conversation, Cayer also mentions discussion. This is a type of conversation that is "characterized by disciplined, logical, and emotional arguments used to promote ideologies and beliefs" (Cayer, 2005, p. 310). The result of discussions is typically polarization or alienation of beliefs. These goals fall in line with Craig's sociopsychological tradition which view communication as "the process by which individuals interact and influence each other" (Craig, 1999, p. 143). Dialogue differs from this type of conversation in that it "facilitates the development of a 'oneness'" (Cayer, 2005, p. 311) as communicative partners acknowledge the assumption they have in the interaction and suspend them. The goal of dialogue is to create community, so the goals of communicators differ.

Cayer's explication of dialogue's dimensions illustrates how it differs from other forms of conversation and shows how far communication scholars have come with regard to illustrating communication processes. It is important to note however that no model is free from tension, misrepresentation, or flaws. Just like the models of care previously discussed, these models for human communication should not be used confine interaction, but rather can be used to uncover how and why particular communicative

actions unfold as they do. It appears that understanding how communication is conceptualized suggests how two people will approach and carry out a care interaction. If a doctor and a patient follow a dialogue model of human communication they will be more likely to foster a care relationship of mutuality because communicators are seeking to understand one another. Dialogue is more open than other models and as discussed previously, mutuality is characterized by openness and balance where the patient is understood to be an expert in their own life.

On the contrary, paternalism is more closely aligned with the transmission model of communication where communication is reduced to its simplest components: doctors speak and patients listen. Viewing paternalism as a model of care assumes a more rigid view of health administration than other models propose. The transmission model adopts a linear view of communication leaving little to no room to account for the complexities often involved in medicine.

## **Summary**

Looking at the intersections between communication and care presents an interesting opportunity for dialogic scholars. With the poststructuralist understanding that language constitutes social reality, scholars like Foucault uncover how the reality of medicine can be understood by examining processes of seeing and knowing that occurred as the field of medicine began its first dramatic shift in eighteenth century. Tracing the history of the medical school demonstrates that discourse not only constitutes reality, but also creates and maintains organizations and organizing processes. As an organization, medicine has transformed as discourses such as disease and illness have shifted. When these micro level discourses begin to change, the organization does also.

Thus, the influential nature of the intersections of models of care and human communication appear as an important area of study. Altering the way one views communication could alter the way one views or engages in care and vice-versa. Because students learn about these topics in medical school, this organization serves as an important place of study in order to investigate how the discourses of medicine currently influence how both care and communication are understood. Thus, this study will ask the following questions to understand the consequential relationship between models of care and models of communication as they are experienced in medical education.

### **Research Questions**

- 1) How do medical schools in the United States construct understandings of “care” through their contemporary clinical skills/medical education programs?
- 2) How is communication conceptualized and developed in contemporary clinical skills/medical education programs in medical schools in the United States?

### **Methods**

As stated previously, this project takes a dialogic approach to the study of health communication. With that said, Deetz’ grid illustrates why particular perspectives employ certain methods when conducting research.

Like interpretive scholars, dialogic scholars view language as local and emergent, but because they seek to uncover aspects of daily life that are lost in routine practices they typically use analytical methods such as deconstruction, resistance readings, and genealogy. They also use “qualitative methodologies in order to provide thick descriptions of texts, phenomena, and processes” (Dutta & Zoller, 2008, p. 15). Because

these scholars wish to capture communication in its historical context other methodologies used include interviews, ethnography, focus groups, and textual analysis. Each of these methods allows dialogic scholars to move from consensus to dissensus given that they seek to make a change in the environment in which they are studying.

### **Data Collection**

When I began this study I initially wanted to investigate how communication and care is constructed and understood at each of the top five medical schools in the United States. After contacting these schools I was unable to reach someone who could assist me, and when I did get in touch with a faculty member, he or she had no idea what I meant by ‘clinical skills’ or ‘communication training’. The information they forwarded me was incomplete and unable to answer the research questions set forth by this study. My lack of success led me to contact three people who work in medical education. They provided me with contacts that they knew at schools where clinical skills training was in place, defined, and actively taught. As a result, the sample for this study snowballed from these contacts but was also purposive for geographical distribution.

**Description of sites.** This study was conducted with faculty members at five institutions in the United States which included the University of Iowa, the University of Indiana, the University of California at San Francisco, the University of Colorado at Denver, and Harvard Medical School. Each institution was unique with regard to their program design and implementation as it relates to communication. Before discussing my findings, I will first provide an overview of each school including how the course is designed, the models that influence the program, the nature of the medical educator, and the program’s future plans in order to understand how and why communication and care

are conceptualized as they are in each program.

*University of Iowa.* Located in Iowa City, Iowa, the University of Iowa was founded in 1847 as the first public institution of higher education in the state. Further, the University was the “first public university in the United States to admit both men and women on an equal basis” (“About the college,” 2008). The Carver College of Medicine at the University of Iowa is a “nationally ranked medical school whose students learn to become accomplished clinicians and top-flight researchers” (“About the College,” 2008). The school is one of the highest ranking medical schools in terms of primary care and research, and across all medical and health disciplines, case-based learning is the primary method by which students learn.

The University of Iowa teaches communication skills as they relate to history taking and physical exam skills explicitly in years one and two of medical school through a three credit course. At the end of year two, every medical student attends a four-day workshop that focuses on bad news telling, where approximately 180 students spend six hours a day learning and practicing bad news telling in groups of five students and five standardized patients.

At Iowa, the communication curriculum is influenced and guided by the Calgary-Cambridge Model. The medical educator at Iowa does extensive research both in the United States and in Cambridge, UK with the model’s creators Silverman and Kurtz and as a result, has adapted chapters of their book are assigned for students to read. This model is also used for both teaching and assessment for the course in an attempt to create consistency for all students.

Besides the organization of the curriculum and the model it follows, the nature of

the medical educator is also unique. At Iowa, the primary instructor of communication skills has the responsibility of lecturing in the history taking/medical interviewing course, as well as supporting faculty with curriculum and aiding them in becoming better teachers. Coming from an educational background of medical anthropology, the medical educator is an employee in the Office of Consultation and Research in Medical Education (OCRME) at Iowa and took initial interest in communication in medicine when interviewing women with breast cancer in attempt to understand their psychosocial adjustment after undergoing breast cancer surgery.

The primary characteristics of Iowa's program include its bad news telling workshop, following of the Calgary Cambridge Model, and the primary educator's background in medical anthropology.

*University of Indiana.* The second school interviewed for this study was the University of Indiana. Established in 1903, the Indiana University School of Medicine (IUSM) was "only the fourth medical school in the United States, after Johns Hopkins, Harvard, and Western Reserve, to require two or more years of collegiate work for admission" ("About us," 2010). Four years later the first Doctor of Medicine (M.D.) degrees were awarded to the first graduating class of 25 people in 1907.

Since the twentieth century, the medical school at Indiana has grown substantially and is now the second largest program in the country behind the University of Illinois. As the only medical school in Indiana, the 2010 academic school year witnessed 322 students admitted into Indiana's program. To accommodate this growing student body, students have the option to attend Indiana's main campus in Indianapolis, or eight regional campuses across the state. With the school spread out geographically, the

curriculum is designed to create some standardization to ensure a consistent experience for all medical students. The primary form of standardization lies in the competencies that all medical students at Indiana are expected to achieve. These include: effective communication, basic clinical skills, using science to guide diagnosis, management, therapeutics and prevention, lifelong learning, self-awareness, self-care and personal growth, the social community and context of health care, moral reasoning and ethical judgment, problem solving, and professionalism and role recognition (“MD curriculum,” 2010).

Students at Indiana begin their clinical education with the “Introduction to Clinical Medicine” course, designed to provide first year medical Students with an introduction to the principles and practice of the medical interview, the physician/patient relationship . . . [and] provide the student with an opportunity to have contact with patients early in their medical school career” (“Introduction to clinical medicine I,” 2010).

The organization of the “Introduction to Clinical Medicine” course is influenced by Robert Smith’s text titled *Patient Centered Interviewing*. This is an evidence-based book that sets forth the information used for the pocket card that students receive the first week of medical school. The book helps Indiana students with their competency-based curriculum in establishing benchmarks they expect all students to meet. Also, both the book and pocket card help students with the medical interview since they lack some of the medical knowledge that is often necessary to speak with patients about symptoms and make diagnoses. In year two, students then build upon skills and learn how to perform more difficult history taking skills.

Besides texts and materials, the program at Indiana is also heavily influenced by their new Clinical Skills Center which opened in August 2009. This center consists of ten exam rooms equipped with cameras, a simulation center, a virtual hospital, and is used for interdisciplinary exercises. For example, pharmacology students and residents will use the center to simulate a medicine error. The medical student will work with a standardized patient in the exam room, make a phone call to the pharmacist who is outside the room, and together they will work through the scenario. This center is also used for first year students to practice both history taking skills and take their OSCE at the end of year one. Overall, the center helps provide students with clinical experiences as early as possible through simulation and virtual technology.

The medical educator at Indiana is the Director of Communication Competency and has been in this position since 2007. Further, the educator also works as a preceptor in a small group and assists students in role playing. With a background in geriatrics, the educator gained experience with communication directly through their work with the Reynolds Foundation as a PI on communication. With this experience, as well as the role as director, the educator hopes to move the curriculum at Indiana forward by establishing clearer benchmarks for students in how they meet competency requirements. For example, by 2011, students will be expected to take a complete history by the end of year one. Also, the program consists of eight competencies and faculty and staff are currently working to infuse communication exercises in and throughout each.

Overall, the program at Indiana can be characterized by its competency-based curriculum and clinical skills center which affords students the opportunity to practice history taking skills in order to meet their first benchmark of completing a history by the

end of year one.

*University of California at San Francisco.* The third school that participated in this study was the University of California at San Francisco (UCSF). With a unique history, UCSF was founded in 1864 as Toland Medical College and did not become part of the University of California until 1873. UCSF has and continues to receive accolades for important medical advancements which include but are not limited to several Nobel laureates on faculty, the identification of HIV as the cause of AIDS, and consistent rankings among the top ten in the medical school specialty programs of AIDS, women's health, and internal medicine.

In addition, UCSF has a course used to teach communication and clinical skills to the program's 153 medical students is entitled "Foundations of Patient Care" (FPC) and it focuses primarily on communication, interviewing, and the physical exam. Since 2003, the course has been divided into organ system blocks and in each module students are provided with integrated learning exercises with standardized patients that highlight what they are learning in each block. This allows students to utilize newly learned medical information in the context of communicating with and interviewing patients.

Besides these communication opportunities, students also meet in small groups with eight people and a standardized patient to further practice interviewing skills under the guidance of two facilitators. These facilitators are either medical doctors or social scientists. Students meet in these groups sixteen times across the first two years of medical school. Also, within their small groups, students participate in narrative writing workshops. These skills and activities are taught and practiced to prepare students for the California state-wide exam that is given to all medical students at the end of medical

school. Students take clinical skills assessments at the end of years one and two to further prepare them for the state-wide test.

The development and evolution of the FPC course is influenced by the Kalamazoo Model which is used at UCSF because it separates information gathering from information delivery. Also, the program uses Paul Heyda's work in building the history. These two influences have changed the program in regard to how the history is taught. Rather than teaching it all at once, the history is taught in smaller pieces and built upon as students move through the organ system blocks.

Besides texts and resources, the medical educator at UCSF is also influential in the course. With a background in molecular immunology, the educator is a medical doctor who spent time teaching communication skills to internal medicine residents before attending the AACH Enrichment Course in 1999. This course sparked the educator's interest in communication which led to developing and teaching FPC in 2001. The primary responsibilities of the medical educator at UCSF include running the physical exam unit, which runs the first two months of medical school, as well as remediation training for students that have failed, or are at risk to fail, the patient interaction piece of their clinical skills assessment. Also, the educator teaches a physical exam elective for students in their fourth year of medical school.

As the program at UCSF moves forward, they hope to keep the curriculum divided by organ systems, but want to increase the opportunities for experience with written and oral presentation. Also, they hope to add problem based learning exercises into each block to better prepare students for the communicative challenges that are often unique and challenging when one considers a cardiovascular issue in comparison to a

neurological disorder. The hope is that adding problem based learning opportunities will equip students with the skills needed to meet patient needs regardless of the issue presented.

The FPC course at UCSF can be distinguished by its curriculum organization around organ systems, its extensive remediation program for struggling students, the narrative writing students do in small groups, its influence by the Kalamazoo Model, and its future plans to incorporate more problem-based learning exercises into each organ block.

*University of Colorado at Denver.* The University of Colorado at Denver (UCD) was the fourth school that participated in this study. From humble beginnings the school began in 1883 with two students and two professors in Boulder, Colorado. Since its inception the school has struggled with a lack of funding, ongoing budget cuts for state schools, and uncertainty about the future. After moving the campus to Denver in 1924, the future of the Colorado's medical school looked bright, however some argue was saved by World War II and soldiers' return from war. Following this period in history, governmental funding increased and the school finally had enough financial resources to thrive. Since then the campus has moved again to Aurora. While state funding is once again tight leaving financial resources limited, the program at UCD is still recognized one as one "of the country's newest, most technologically advanced education, research and healthcare sites" ("School of medicine history," 2008) that just welcomed a first year class of 160 students.

When it comes to clinical education, the course titled, "Foundations of Doctoring" is the primary course that teaches students about communication and clinical skills. Like

other schools interviewed, this course is focused primarily on taking a history and conducting a physical exam. Students attend several hours of lecture as first year medical students and one hour of lecture during their second year. Following the lecture, students attend a workshop where they interact with standardized patients and are provided feedback by a group facilitator and other members in their small group. The course also helps organize time with real patients in wards. Medical students begin interacting with real patients within the first two months of medical school and spend time one-on-one with preceptors in the clinic.

While the course is organized around both standardized and real patient encounters, the course is not heavily influenced by a particular model. With that said, as the program moves into the future the hope is to include the Calgary-Cambridge Model in both instruction and evaluation. Even though the course does not follow a model, it uses a text titled *The Field Guide to the Difficult Patient Interview* which is written by an instructor of the course and used to help reach the course's goal of teaching students to connect with patients.

Like UCSF, the primary medical educator at UCD is a medical doctor. With a practice, the educator divides time seeing patients and teaching the Foundations course. The educator's desire to be involved in clinical skills arose after attending a course sponsored by Bayer Drug Company. Following this experience, the educator went on to teach about doctor/patient interaction for Copic, which is an insurance company for "physicians, medical practices, hospitals, and health care facilities in Colorado, Nebraska, and Iowa" ("Copic Insurance," 2010). These opportunities encouraged the educator to divide time between treating patients and educating medical students. These passions

collide when students are in their third year of medical school and do rounds in county hospitals where the educator practices medicine. The students are able to watch their instructor with patients while also interacting with patients on their own.

As the program at UCD moves to the future, the educator hopes that the curriculum will be spread out further to prevent the students being overburdened with work in the first three years. Currently, the fourth year is lacking in material so students do not really do much during this time. The educator hopes to spread the curriculum out to keep the workload consistent across all four years. As the program looks to increase its size from 150 students to 200 per year, the educator hopes to see changes in the curriculum to meet the needs of the growing numbers of students.

The program at UCD can be characterized by having a practicing doctor as a primary educator, the absence of an influential model used for both teaching and evaluation, early interactions with real patients, and a more loosely organized course for clinical and communication skills instruction.

**Harvard.** The final school that participated in this study was Harvard. The medical school, which was created by Joseph Willard on September 19, 1782, began with a faculty of three and a handful of medical students (“Harvard medical school,” 2010). By 1810, the school had grown in size and two faculty members created Massachusetts General Hospital (MGH). Like most hospitals in the early 19<sup>th</sup> century, the primary population seen was those who were poor, as more wealthy individuals would be seen by doctors on their own homes. Also, at this time the apprenticeship system was still in place and curriculum and degree requirements were not standardized in any way. This system remained in place until 1860 when a new college president raised admission

standards, created a three year degree program, and established new departments. With these changes, “Harvard Medical School became a professional school of Harvard University, setting the United States standard for the organization of medical education within a university” (“Harvard Medical School,” 2010).

Throughout the last 150 years, Harvard has continued to set standards that other medical schools follow with regard to medical education. More recently, the school underwent a major reform of the MD curriculum and launched a new curriculum titled, “New Pathway.” This new curriculum includes clinical skills education that runs through the first and second year of medical school. The medical educator interviewed previously assisted with the interviewing portion of the course which is required for Harvard’s 135 first year students. In this course, students focus primarily on interviewing, history taking, and communication skills. In their second year, the course focuses on the physical exam. When taking these courses, students interact primarily with standardized patients for both practice and evaluation.

Currently, the educator practices medicine at Massachusetts General Hospital (MGH), which is still strongly connected to the medical school and serves as one of the school’s primary teaching hospitals. With that said, the educator is employed by MGH and still continues to work with Harvard residents. All residents working in the clinic are videotaped interacting with live patients and these tapes are reviewed by both the student and the educator. While residents function as primary care doctors, this program acknowledges the idea that they are still in training and need to develop and foster particular skills.

The video tapes and medical interviews are evaluated using the Kalamazoo

Consensus Model of Medical Interviewing. This assessment form is given to the student prior to their interviewing session with patients and assesses various elements of the interview that include but are not limited to setting the stage, agenda setting, and gathering information.

The medical educator who works with Harvard residents and was interviewed for this study is an internist who runs his own clinic with several other doctors. Communication became a subject of interest when the educator was required to do a project as a senior resident. After reflecting upon what skills were required to be a better doctor, the educator decided that communication skills were of primary importance so the project involved videotaping interactions with patients, as well as having fellow residents do the same. These tapes were then reviewed by the group and analyzed and reflected upon with regard to what went well and what skills still needed more development. From there, the educator began volunteering in Harvard's interviewing course until residency was complete.

While this final school differs from the previous four, it provides insight to residency and the role of communication skills at this level of medical education. Students at Harvard participate in courses similar to those of previous schools during the first two years of medical school. The interview conducted with this medical educator can be characterized by the videotaping residents do as well as the role that the Kalamazoo Model plays in both teaching and evaluation.

### **Interviews.**

*Participants.* I conducted interviews with one faculty member who teaches communication and/or clinical skills at each school and has a dominant role in program

construction and implementation. Speaking with one person from each program allowed me to understand why and how communication is both understood and taught, as well as how the course fits into the larger medical education program. Interviewing also allowed me to inquire about pedagogical choices that are made in the classroom and how such choices educate medical students about care and communication. Finally, interviews provided insight regarding why course materials are chosen and explained how communication is understood in contemporary medical education programs.

*Procedures.* First, my contact in the field of medical education sent an initial email to people she knew that might be interested in my project. The recruitment script used can be found in Appendix A. If an educator did not reply, my contact resent the recruitment script. If an educator responded saying they were unable to participate, my contact replied asking if they knew or worked with someone that might be interested in helping with my study. If those educators replied with contact information of others, the initial recruitment script was sent to them. If an educator emailed back and expressed interest, I emailed them to set up a time to conduct a phone interview.

After I made contact with each interview participant, I set up a convenient time to conduct a phone interview. In some instances educators requested I call them and in others, I provided my phone number so the educator could call me. Once a phone interview was scheduled, I emailed the participant the consent form found in Appendix B. I instructed them to read over the consent form and email it back to me signed and initialed if they agreed to the conditions of my study. Further, I requested that each educator send me the syllabus and printed materials used in their course prior to the interview.

On the scheduled day and time of each interview I used the interview schedule found in Appendix C to guide the conversation. Additional questions were asked as the conversation unfolded. Each conversation was audio-recorded with participant consent. I took my own notes during the interview to ensure accuracy of data. The interviews lasted between thirty and sixty minutes.

*Interview instruments.* A standardized interview schedule was used with each participant and involved questions about the faculty member's role at the institution, how communication is conceptualized, what texts are used, and how the clinical skills program fits into the larger curriculum of the medical school. The interviews lasted between thirty and sixty minutes. The interview schedule used can be found in Appendix C. This schedule served as a guide and helped to ensure consistency with each participant, however the open-ended nature of the questions allowed me to probe for more information as the conversation unfolded.

### **Data Analysis**

For this study, I understand discourse to be the means through which both identities and realities are constituted and reproduced. With that understanding, I believe that analyzing discourse allows a researcher to understand more about the realities individuals inhabit and how they communicatively understand phenomena occurring around them. Therefore, analyzing the discourse used regarding clinical skills training provides an opportunity to understand how communication and care are understood and taught in the medical schools in the country.

After conducting my interviews, I transcribed each of them. Each interview was transcribed using an open coding system to look for discursive themes across each

interview. I also analyzed the materials sent to me by the educator. I coded both the interviews, syllabi, and course materials based on my understanding of discourse analysis.

Each code was marked with its own color with several code grouped together to become categories or themes. This color process provided a visual representation of each theme's prevalence and the underlying discourses that structure the ways in which communication and care are conceptualized by personnel charged with their instruction in the medical schools involved in the study.

After coding was completed, I organized all of the codes into seven categories which I titled 'materials used,' 'forms of evaluation,' 'nature of the medical educator,' 'specific communication skills,' 'perspectives of communication,' 'program development,' and 'pedagogical methods.' Each of these themes will be discussed in detail in the chapters that follow according to how they relate to each research question.

In following a dialogic position, I examined how medical schools understand and view communication and care in their medical education programs. I conducted phone interviews with one faculty member at each school in my sample who teaches clinical skills to understand how communication and care are both taught and conceptualized in the department's medical education program. I also requested a copy of the course syllabus in order to understand how the course is outlined and structured from a student perspective.

Conducting interviews with clinical skills faculty in medical schools provides data on about the ways medical schools understand and teach communication, as well as how this can be improved in the future. These interviews also helped me understand

communication as each school understands it, in addition to the program's motivation for constructing understandings of care in particular ways. Further, this study allowed me to investigate how communication is understood in medical education programs and how these understandings are both sustained and reproduced in each school's curriculum.

### Summary

In summary, the following table provides a visual representation of both similarities differences between these schools as it relates to the course name, materials used, pedagogical models, and evaluative measures. This table will serve as a reference for understanding how and why schools teach clinical skills in particular ways and how such methods teach students what it means to be a practicing doctor.

	Course Title	Educator Background	Evaluations	Book	Pedagogical Model Used
Iowa	Foundations of Clinical Practice	Medical Anthropologist	Not mentioned	<i>Teaching and Learning Communication Skills in Medicine</i> By: Kurtz and Silverman	Calgary-Cambridge
Indiana	Intro to Clinical Medicine	Geriatrics	OSCE, boards	<i>Patient Centered Interviewing</i> By: Robert Smith	Competency Based Curriculum
Harvard	Patient/Doctor Year I	Internist	video taped	none	Kalamazoo Model for Medical Interviewing
CU	Foundations of Doctoring	Practicing Physician	None really but teach to the test	<i>Field Guide to Difficult Patient Interview</i> By: Fred Platt	None but Calgary Cambridge in future
UCSF	Foundations of Patient Care	Molecular Immunology with AACH Enrichment Course Training	clinical skills assessment end of year one and two, videotaped, CPX with SP, boards, OSCE, remediation program	Articles/syllabus	Kalamazoo Model

## **Thesis Chapter Preview**

The following chapters will outline this thesis and case study. Chapter three provides an analysis of how contemporary medical education programs conceptualize communication. A discursive analysis of interviews will be presented in this chapter as they relate to the conceptualization and construction of communication, as well as communicative behaviors in medical education programs. Chapter four explains how care is constructed and communicated in medical education programs. In both chapters three and four I compare and contrast discursive themes to uncover the ways in which communication and care are conceptualized across the schools I choose to study. Chapter five then discusses these themes more broadly to explain the relationship between communication and care taught in medical schools in the study, and proposes potential changes for contemporary medical education programs paying particular attention to the relationship between models of communication and related models of care. Chapter six concludes the thesis with a review of findings, discussion of implications and directions for future work.

### **Chapter 3: The Conceptualization and Development of Communication**

The first question this project sought to answer was, “How is communication conceptualized and developed in contemporary clinical skills/medical education programs in medical schools in the United States?” To answer this, five medical educators from schools across the country were interviewed regarding the clinical skills courses they teach at their respective schools. While the history of each school used in this study differs greatly, all are similar in the importance they place on teaching clinical skills to medical students. With that said, the history of each school illustrates how and why curriculum is developed and implemented in particular ways. For example, Iowa focuses on case-based learning which is manageable for their student population, where Indiana focuses time and resources in standardizing resources and materials to accommodate a much larger population. Further, Harvard illustrates close ties with community hospitals, most of which lead the nation in research dollars which affords students cutting edge clinical experiences. This differs greatly from schools like the University of Colorado whose history has been mired with a lack of resources, budget cuts, and a history of an uncertain future.

Understanding how each school has arrived to its current moment provides further insight into how and why communication and care are conceptualized as they are, as well as how they might be thought about differently in both the near and distant future. In trying to understand how communication is conceptualized and developed in contemporary clinical skills/medical education programs in the United States, two

categories titled “Perspectives on Communication and “Specific Communication Skills” emerged as potential answers to this question.

### **Perspectives on Communication**

The first category that emerged from the data is titled “Perspectives on Communication” and includes the codes ‘definition of communication’, ‘importance of communication’, ‘pedagogical methods’, and ‘future goals’. Each of these codes linked together to create the category of perspectives on communication because they create a broad umbrella under which specific skills can fall into, while also aiding with the explanation of why certain pedagogical methods are chosen and how this influences the future of each program. With these four codes, the category of “Perspectives on Communication” serves as an overview for trying to understand how communication is conceptualized and developed in medical education programs.

In the following section definitions of communication will be discussed first, while the importance of communication and pedagogical methods will be discussed together. While these two codes are separate, they work together to explain and understand how and why communication is understood as it is in each program.

#### **University of Iowa.**

*Definition(s) of communication.* At the University of Iowa, the educator said that communication is a “procedural skill and it’s very technical procedure so even if you know how to communicate you may not know how to interview patients.”

Communication is taught in this way to combat the common assumption that communication skills are less important than scientific skills. Just as interviewing patients is a procedural skill, so is communicating, and the ability to do one does not

guarantee the ability to do the other. Lastly, this program defines communication to be a process that occurs simultaneously with other skills like the medical interview. When asked about how the course is organized the educator said, “we give only one lecture to remind them you don’t stop talking to patients when you do a physical exam and then in the other semesters we are getting very specifically into disease process.” Here the educator discusses that students at Iowa are taught that communication is more than just conducting a physical exam and instead occurs along side that procedure.

*Importance of communication and pedagogical methods.* Besides defining communication as a procedural skill, the importance of communication in Iowa’s program can be seen in how it is taught. Prior to learning and mastering medical knowledge, students are first taught about communication as defined above. The educator justifies this pedagogical choice by saying, “they [students] don’t have to have a lot of medical knowledge” in order to communicate effectively. More specifically, the argument the educator makes that “seems to work well is that for our early students, we emphasize what are the other techniques you can use even if you don’t know what questions to ask.” When students learn these techniques, the educator notices that students are able to “probe symptoms” even when they are not entirely sure of how “to put them together” due to premature medical knowledge.

These methods support Iowa’s belief that communication can and should be taught and understood prior to students completing their science and content courses in medical school. As an important procedural skill, the program at Iowa supports the idea that as additional medical knowledge is acquired, communication skills can get better so long as a solid foundation is established early on. With that said, the educator at Iowa

believes the best way to learn how to communicate is through practice over time.

**University of Indiana.**

*Definition(s) of communication.* The University of Indiana is similar to Iowa in their belief that communication is essential to the medical encounter. When asked how communication is understood, the educator said, “A lot of what we do is based upon just the simple history and talking to the patient.” Throughout the duration of the interview with Indiana’s educator, communication was used synonymously with history taking.

*Importance of communication and pedagogical methods.* Again, Indiana’s program is similar to Iowa in that students are taught communication before they have much expertise with medical knowledge to fully conduct an interview, make diagnoses and suggest plans of action. When asked why the program teaches techniques prior to the acquisition of medical knowledge, the educator stated:

The notion is that they are really developing this fundamental skill which they are going to hang more information onto it as they evolve so they have to know at some point how to ask all the questions for a history. They may not understand all of the diagnoses and implications that are possible from each question but they have to know how to ask all of those questions. So at the beginning we are going to have them learn how to ask those questions and then it will be easier in their second and third years and they understand more about the clinical implications of it to refine those questions and improve upon them.

While the programs at Iowa and Indiana both teach communicative techniques prior to the learning of medical knowledge, they differ in the methods used to teach communication apart from students having much medical knowledge. Indiana’s program

teaches that students need not have medical knowledge because simply knowing what questions to ask in an interview is sufficient. Where Iowa provides students with techniques to “probe symptoms” rather than a list of questions to ask, the educator at Indiana highlighted that their program provides “tools that [are] created for the students like we give a history and physical pocket card and that goes to them in the first week of orientation.” These materials indicate the important things one must know about communication. Further, the educator claims that all handouts and materials are “based upon the Smith text and [are] very patient centered. In fact it talks about setting the agenda and setting the stage and all of those sorts of things first before it gets to these are the questions that you need to ask in the history of the present illness. And then like our checklist that we’re using for the OSCE and the end of the year OSCE are based upon the Smith text using the patient centered approach to interviewing.” Therefore, not only is the information included in materials considered to be the important communication skills students should learn, but their patient-centered focus also indicates that such an approach is the way in which students should employ these learned skills.

Besides materials, role plays that correspond with the course’s weekly theme help to highlight the importance of communication while also helping students develop history taking skills. With that said, educators “understand that the students are memorizing the questions” they are supposed to ask and that some questions “make sense to the students and some of them don’t.” The educator specified that the school’s goal has the “expectation that all students state wide will be able take the complete history through the review of systems by the end of the first year. So that’s where we have really focused our energy.” Even though they know students memorize and regurgitate materials,

Indiana's goal influences both methods and materials in order to help students focus on what communication skills are important to succeed in their year-end evaluation.

**University of California at San Francisco.**

*Definition(s) of communication.* The University of California at San Francisco (UCSF) defines communication differently than the preceding two schools. When explaining the structure of the course, the educator said:

Because the course is pre-clerkship for the first two years before students do clinical medicine our goal is be sure students are well prepared in terms of their clinical skills, so that is communication both with patients as well as with colleagues or supervisors, physical exam, oral presentations, and written presentations.

At UCSF, communication is understood to fall under the umbrella term of clinical skills and includes the specific skills listed above.

*Importance of communication and pedagogical methods.* UCSF believes that communicative practice opportunities should be tailored to specific medical processes, as seen in the educator's explanation of the organization of the "Foundations of Patient Care" course. The course is organized around organ systems and within each organ block specific skills are taught that are believed to be connected to a particular system and diseases within it. To further explain this the educator said:

So for example each of those blocks we will run a problem based learning module which supplements some of the work they have done and we also run an integrated learning exercise where students will meet an SP and have to do history and physical on that SP [standardized patient] and that also highlights some of the

concurrent learning they are doing in the basic science pieces of the blocks.

While UCSF's course is structured in a unique way, teaching communication skills practice occurs just as it does at both Indiana and Iowa.

Besides using methods similar to Iowa and Indiana, UCSF further emphasizes the importance of communication in medical education through their remediation program.

The educator explained how this program works by saying:

So every year, the clinical skills exam, the CPX, is run and at the end the students are graded. The SPs [standardized patients] grade them on a standardized checklist and there is a certain proportion of students every year who are deemed to fail the patient/doctor interaction piece. So that's the remediation program.

In this program, students work one on one with a medical educator. They have more opportunities to interact with standardized patients and these encounters are videotaped and reviewed with a supervisor. This additional instruction helps both students and teachers identify and address problems prior to students completing medical school.

Besides the remediation program, another unique element of UCSF's program that distinguishes it from others is its overall goal to use communication skills training as a way to remind students why they wanted to become doctors. Where other programs divert from this and use more formulaic methods of instruction, UCSF combines integrated and problem based learning to provide opportunities for students to tap into the characteristics that make them unique and how such traits influence their desire to practice medicine. Communication's importance is then taught as a means to use such diversity as a way to connect with and recognize the uniqueness in others, including

colleagues and patients.

**University of Colorado at Denver.**

*Definition(s) of communication.* The program at the University of Colorado at Denver (UCD) defines communication through the acronym ILS which stands for invitations, listening, and summaries. The educator explains each of these components by saying, “So Invitations is open questions. Listening is body language, listening to the patient. Summaries [are] a reflective listening thing. It’s basic communication.” This acronym helps define communication by making a distinction for students and the educator call the “biomedical model and the touchy-feely stuff” which they consider to be communication skills. In addition, the educator illustrates the belief that the model can be applied in many situations. For example:

My [the educator’s] brother is a businessman and when we watch a medical clip I ask him what to do and he says, ‘Well ya’ know this is somebody who is really mad so you need to say back what you’ve heard and elicit what they are really concerned about.’ He has a different model for it but it’s the same technique.

In addition to being applicable in a variety of contexts, the educator’s belief that skills related to ILS can be learned in many places as well is revealed in the following statement:

So with the first years we are saying how do you say hello to someone? What’s your introduction like? You look them in the eye or don’t you? Of course you look them in the eye. Do you use your name first or theirs? The thing they teach you if you work at Nordstrom.

In sum, communication is defined by UCD as it relates to ILS which can be both

taught and learned in various settings.

*Importance of communication and pedagogical methods.* The educator speaks directly to the importance of communication in UCD's program when saying, "Understanding communication is important and if you connect with the patient, that really advances the therapeutic relationship." Proficiency in communication is understood to be crucial if one is to be successful in his or her professional life. At one point, the educator mentioned the worry that corresponds with watching students struggle with their communication skills.

While these program goals, objectives, and communication perspectives are unique to UCD, the program is similar to others with regard to the belief that the learning of communication skills occurs by and through practice. More specifically, the educator explains that "the way to really practice is to not have any babble at you but actually sitting down with an SP [standardized patient] and practice trying to do some of these things." With this similarity, UCD employs different teaching practices than previous schools. For example, students at UCD begin interacting with real patients within the first two months of medical school, alongside a preceptor. For many other programs, encounters with real patients do not happen until the third year of medical school and during the first two years, interactions with patients are limited to standardized patients. These methods are implemented in order to achieve the program's goal of providing opportunities that allow students to learn through observation and practice.

**Harvard.** The final program that participated attempted to help answer the first question set forth by this study was Harvard via the medical educator at Massachusetts General Hospital. Again, while this educator teaches residents and its program is

different than others, it still helps reveal how communication and care are taught in medical education programs. This program's perspectives on communication differ slightly from others given that the educator works with residents rather than medical students. Even still, the perspectives from an educator that teaches residents still helps to understand how medical schools develop and conceptualize communication.

***Definition(s) of communication.*** For Harvard residents practicing at Massachusetts General Hospital, communication is defined according to the Kalamazoo Consensus on Medical interviewing. More specifically, the educator uses the model's "communication skills assessment form that has the different parts of the interview like setting the stage, agenda setting, gathering information." Students received this evaluation form prior to their interactions with patients so they know exactly what the educator will be assessing them on. This form guides all instruction regarding communication for Harvard residents.

***Importance of communication and pedagogical methods.*** The medical educator at Harvard has many similar views regarding communication when compared to educators at other institutions. First, Harvard students are provided with opportunities to learn through practice. The educator explained "that student[s] will see a patient, talk with me about the patient, and then I will see the patient, so the student does a lot of thinking by him or herself." In addition, residents are videotaped so they, along with their mentor, can evaluate interactions with patients and determine what communicative skills are proficient or not.

After participating in these activities, residents are provided with surveys on their experience in the clinic. The educator developed the survey and stated that the it

measures the “residents’ self-assessed skills at particular components of communicating with patients and for that same skill the level of importance they put on that skill.” While this survey is new, the hope is that it will help provide data to better understand how students understand communication, as well as which skills they find to be the most important when interacting in the clinic.

The primary place where Harvard differs from other institutions is the educator’s perspective of how communication skills instruction should be changed. The educator said:

I feel like there is an unspoken sense out there that communication skills you are taught in medical school and then you are fine and so I would advocate a change of priority, a change of focus of teaching, that communication must be continued beyond medical school and the perfect place to do that is residency, and I think video is such a rich way to help improve those skills.

Each of the other four programs teaches clinical skills primarily in the first two years of medical school which speaks to this educator’s point about its assumed terminal nature.

Besides believing communication is best learned through practice, Harvard is similar to Iowa with its belief that communication skills need to be taught in a more tailored manner. The educator believes that “some general communication skills are important in all fields but if someone ends up doing pathology after medical school just the way they communicate is going to be different than doing what I do [as an internist].” This belief that communication skills should be taught generally and specifically relates to the educator’s previous point about the terminal nature of clinical skills programs. The

educator connects these ideas by saying, “It doesn’t even make sense that communication skills end in medical school when you are teaching an undifferentiated group of students so it has to continue as the trainees become more differentiated.” This belief acknowledges that general skills are important, but suggests that specific skills be taught additionally to better equip students to be doctors and specialists.

To conclude, the educator at Harvard is similar to others in the belief that communication must be learned and trained as it is not intuitive. Where the differences lie is how to go about teaching students and for how long to ensure they are equipped to meet the communicative demands of the clinic.

**Summary.** In looking at the codes that make up the category of Perspectives on Communication, several similarities exist which include the idea that communication is best learned through practice, is an essential piece of the medical encounter, and should be learned early. Differences lie with regard to the methods used to teach communication. More specifically, this includes the duration of instruction and the amount of time that should be spent within the first two years teaching and learning skills. Lastly, differences also exist with regard to how communication is defined by each program. Across the five programs, communication is referred to as a ‘procedural skill’, ‘touchy-feely stuff’, history taking, an assessable skill, and it is understood as the means to foster interprofessional relationships. With this variety of conceptualizations, it is important to understand how skills are labeled and defined in practice in order to uncover how and why medical education programs teach communication in particular ways.

## **Specific Communication Skills**

The second category that can help answer how communication is understood in medical schools is titled “Specific Communication Skills.” This category emerged from three different codes which I titled ‘communication training examples’, ‘defining bad news’, and ‘specific skills mentioned’. These codes were all related in that they identified very specific skills that are taught in programs, as well as how they are understood and defined. Because these skills are taught in the primary clinical skills/communication course that medical students take, it can be assumed that all skills are believed to be components of communication. Knowing how and which skills are labeled, identified, and understood as important provides answers to how communication is conceptualized, taught, and developed by a particular program.

In the following section, the specific skills that were mentioned will be discussed, as well as the methods used to develop and foster those skills.

### **University of Iowa.**

*Specific communication skills.* At the University of Iowa the specific skills that were mentioned during the interview included interviewing, history taking, physical exam, bad news telling, end of life care, family history, communicating with colleagues, sexual history, cultural competence, screening, signposts, and patient handoffs. Several of these skills are taught to illustrate how communication must be tailored according to your patient. For example, when students think about giving bad news they often think about “telling someone they have a bad illness like cancer or an STD.” What they often fail to consider is that bad news can be as simple as “telling someone they cannot return to work for several days.” Further, students often lack the ability to understand *why*

something is bad news. The educator at Iowa gave the example of telling someone they have an STD. For many this would obviously not be good news but this becomes problematic when the patient is “someone who thinks they are in a monogamous relationship.” Teaching skills and how they are used in doctor/patient encounters also helps illustrate to students that “even things that seem simple and medically straightforward can be bad news.” For example, an STD diagnosis then does not just reveal a medical condition, but also a hidden truth in a relationship.

Besides bad news telling, the program at Iowa seeks to encourage students that there is not a single skill that is appropriate to use all of the time. For example, while open-ended questioning is highly encouraged, students learn that it is not appropriate to use this skill all the time. Not all patients are the same which means some patients will choose not to participate in shared decision making and will instead want the facts of their condition with little to no participation. In such an instance, open ended questioning is not productive.

In addition to the aforementioned skills, Iowa is now incorporating information delivery as a new skill in the program. Much of the course at Iowa has focused on information gathering but with the influence of the Calgary-Cambridge model in curriculum development, information delivery is now emerging as its own skill. Information delivery includes but is not limited to patient education, delivering bad news, and patient handoff. While it incorporates previously taught skills, this curriculum change will once again tailor information according to a particular context.

***Methods of instruction.*** In order to teach students these skills, several training methods are used which include but are not limited to the previously mentioned bad news

workshop, interviewing standardized patients, and role playing in small groups. Again, with the belief that learning occurs through practice, these provide opportunities to both learn and develop the multitude of skills set forth by the program.

**University of Indiana.**

*Specific communication skills.* At the University of Indiana, specific communication skills appear to be synonymous with history as mentioned earlier. Besides history taking, the skills that were mentioned explicitly included setting the stage, agenda setting, and differentiating laymen's terms from medical terms. Because students are required to conduct a complete interview by the end of their first year, instructors and preceptors focus on teaching students the interview checklist and pocket card. Beyond these skills, no others were mentioned.

*Methods of instruction.* In order to teach history taking, students at Indiana use the Clinical Skills Center to interview standardized patients and interact with other colleagues in their own and other disciplines. The educator explains that the center is:

State of the art . . . [with] 10 exam rooms, all of which have cameras in them and you can watch your students in real time interview a standardized patient or real patient or what have you in that exam setting. It also has . . . so that's on one side of the simulation center and on the other side a virtual hospital where they have models and mannequins that students can practice and be assessed on different clinical procedural skills.

Essentially, the Clinical Skills Center provides a place for students to engage in authentic interactions and practice using learned skills in combination with biomedical knowledge under the supervision of faculty.

In addition to the center, students perform pre-written role plays in small groups that correspond to the course's weekly theme. Small groups are also used to practice interviewing. These methods further support the upheld belief that learning communication is a result of practice and are also used with the intention of preparing students to pass their year end interview exam.

**University of California at San Francisco.**

*Specific communication skills.* UCSF provided the most extensive list of specific communication skills that are addressed and taught in their program. These include interviewing, the physical exam, sexual history taking, difficult conversations with patients, colleagues, and supervisors, oral and written presentations, case presentations, cross cultural interviewing, spiritual and sexual history, motivational interviewing, and delivering bad news. In addition, UCSF focuses on two other skills that no other program mentioned. These include oral and written presentations.

*Methods of instruction.* In order to teach students how to excel with both written and oral presentations, UCSF engages its students in narrative writing workshops. According to the educator these involve “narratives on cultural forces and . . . a narrative on end of life and death and dying.” These exercises are supported by the educator's belief that:

Communication skills is understanding what one brings to the table when a student is doing an interview and enhancing that personal awareness and we found [were] the two places that personal awareness comes up the most in terms of not just what each of the student's ideas are, but they bring to the table in terms of their experiences, have been are in the realm of cultural identity and their prior

experiences with death and dying in their families, or other experiences they have witnessed.

These exercises are then presented to peers to practice oral communication skills. In addition, participating in these workshops helps students maintain a level of empathy for their patients by actively reflecting upon experiences that they have had that future patients can relate to. Therefore, while this workshop is conducted with the intention of enhancing personal awareness, it also teaches several other skills.

Besides oral and written presentations, UCSF also spends a great deal of time teaching the medical interview. While the program used to teach the interview in its entirety as Indiana does, it now breaks it down and teaches it piece by piece. The educator said:

I was one of the people who changed the basic communication curriculum so it would be clearer and more tagged to the student's developmental progression early on so for example it used to be that student's would have to do an entire interview from the very beginning of medical school and that didn't make any sense to me so the first interview is you know the first couple pieces of the interview and then the next one is those pieces plus a couple more so each session adds on a couple more things to review and learn.

While Indiana's program reverses this philosophy by suggesting the whole interview should be learned so then medical information can be added to its entirety, UCSF breaks this down both in parts and by organ system blocks. While the methods differ, the skill of medical interviewing is treated as one of the most important skills to learn by both programs.

Not only has UCSF broken down the pieces of the interview in their curriculum, but they also separate information delivery from information gathering as Iowa hopes to do in the future. Information gathering is the primary focus of year one of medical school, while information delivery is taught in year two. The educator defines both of these skills by saying:

Collecting information is soliciting the patient's symptoms and viewpoint and experience of illness and the specific things about culture . . . doing the cross cultural interview and the spiritual history and the sexual history. So those are all eliciting information and the second year is more of the patient education, so a little more behavior change counseling, breaking bad news.

The educator states that this separation has helped students master each skill individually prior to using them together in interaction with either standardized or real patients. Because so many skills are involved with both delivery and gathering, the educator feels they should be taught separately in order for students to be proficient with each skill.

An additional component to the medical interview that is different from other programs is UCSF's understanding of how to approach interview questions. While Indiana supplies students with a checklist of interview questions to ask, UCSF teaches students *how* to ask the next question rather what the next question to ask is. They attempt to teach students how to ask hypothesis generated questions rather than "a laundry list of questions." The educator believes exercises like the narrative workshop will help to fine tune these skills.

Lastly, the remediation program at UCSF helps uncover communication skills

that students struggle with. The most prevalent of these is clinical reasoning. The educator explains that clinical reasoning involves “able to ask a hypothesis generated series of questions opposed to a laundry list of questions.” This skill addresses what was previously discussed with regard to understanding how doctors think and being able to ask questions guided by a hypothesis rather than a template. To address this challenge, UCSF is incorporating more problem-based learning opportunities into the curriculum to allow students to practice using hypotheses rather than routine to conduct an interview.

While UCSF is similar to other programs with regard to the importance placed on the medical history and physical exam, it differs greatly when it comes to the extent to which specific communications skills are discussed.

**University of Colorado at Denver.**

*Specific communication skills.* The previously mentioned acronym ILS (Invitations, Listening, Summaries) encompasses the specific skills taught by UCD’s program. As defined by the educator, “Invitations is open questions. Listening is body language, listening to the patient. Summaries is a reflective listening thing.” This acronym encompasses all of the specific communication skills that were mentioned which include “saying hello, eye contact, using names, behavior modification, concluding an interview, and getting patients to do what you want.”

*Methods of instruction.* Besides the above listed skills, the program at UCD expects students to learn these through practice and take their knowledge into the clinic with preceptors. Further, the educator noted that all skills are taught to the clinical skills exam in an effort to help students pass. Essentially, the exam guides what skills educators chose or do not choose to teach. Lastly, UCD uses similar methods to other

schools. The primary ways students practice skills is with standardized patients and shadowing preceptors. When asked about the guiding principles of the program, the educator stated that:

I think a more advanced learning technique is to actually practice it so I think that's the principle this is based on, that you learn best by actually doing and it's hopefully a safe environment so you can make a mistake and don't feel taken out when you do it.

This guiding principle results in the majority of students' time spent in the clinic rather than the classroom and they are provided two to three opportunities to interview standardized patients each year in a small group setting.

**Harvard.**

*Specific communication skills.* When it comes to identifying specific communication skills that are taught to Harvard residents, the medical educator from MGH said agenda setting and checking for understanding were two areas students struggle. With that said, the educator said:

I am not sure without me presenting to them these are the skills of the medical interview I am not sure that many of them would say I don't check for understanding or agenda set. Like for agenda setting, they are not calling it that but they do have a vague sense of 'I don't feel like the flow of the interview goes well.

While students do not explicitly discuss agenda setting and gathering information, one thing they do mention frequently is efficiency. As residents they begin to focus more on being efficient, they must rely upon mentors and supervisors with regard to how to do

this while also utilizing proficient communication skills. To help balance these skills, the educator reminds students that “improving communication skills will lead to efficiency.”

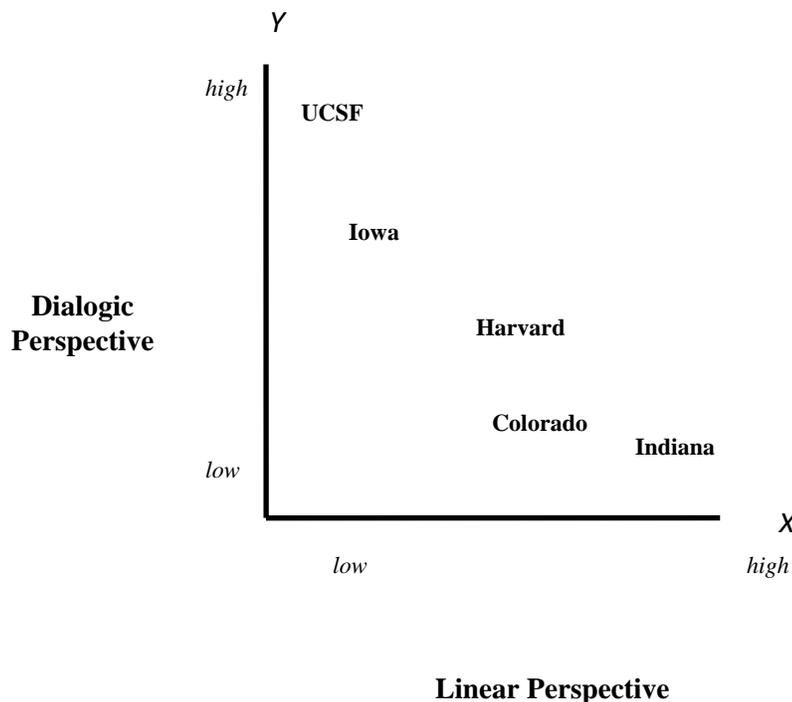
***Methods of instruction.*** Alleviating some of residents’ concerns occurs through the video tapes that the medical educator requires students to record. While reviewing patient interactions with their mentor, students can learn new techniques for dealing with uncommon patient encounters. Further, the educator noted that meeting with students and reviewing tapes is an opportune time to illustrate that with better communication skills, issues and concerns around efficiency, health literacy, and language barriers can alleviate themselves. The belief is that a skilled communicator is better equipped to tackle more complex and intricate patient encounters.

**Summary.** Across these five schools, common communication skills that are taught generally pertain to those necessary to conduct and complete an interview. With that said, some schools like UCSF explicitly label and teach those skills they deem as important, while UCD encapsulates skills into their acronym ILS. Regardless, examining the perspectives that schools have on communication in collaboration with the specific skills they teach helps to answer the first research question of this project. In this final section, I will compare and contrast each school in an attempt to better understand how communication is conceptualized and developed in contemporary medical education programs.

### **Communication Model Map**

To understand how communication is conceptualized and understood, I created a map which shows how the understandings of communication evolve from program to program. I placed linear and dialogic models on the x and y axis to show each programs

embraces perspectives of each through their clinical skills instruction. Doing this does not suggest that one model is better or worse, but rather illustrates how understandings of communication have evolved over time and how elements of each model influence each program. With the map in place, I plotted each school along the axes according to how their program viewed both communication and communication skills. This representation only categorizes the sample used for this study and the placement of each school was determined according to the perceived similarities and differences between programs, recognizing each school is described by only one faculty member involved in the program. Therefore, high and low refer only to schools below and do not assume or speak to programs not included in this study.



**University of Indiana.** Indiana is placed the furthest right on the x-axis because their program understands communication to be repetitive and formulaic. Like Shannon

and Weaver's linear model, Indiana believes that communication occurs when "the order of words and other data remains the same from the sender to the receiver" (Bowman & Targowski, 1987, p. 24). Indiana supports this idea with their use of the interview checklist and pocket card. They have an a priori understanding of communication given that they believe communication exists prior to the interaction with a patient. For their students, it does not matter if a patient is presenting symptoms of strep throat, cancer, or high blood pressure they are to use the same questions in the same order with every patient. While these tools can be useful, they fail to acknowledge the diversity that is often present in medical encounters. For some patients a formulaic approach to the medical encounter would prove useful, but others it does not. Students at Indiana may not be fully equipped to address a diverse array of patients due to the programs perspectives and instruction on specific communication skills.

**University of Colorado at Denver.** The program at Colorado also sits to the far right of the x-axis and low on the y-axis. When asked why they organize the course the way they do and continue to use a book they know students do not read, the educator stated they do things that way because the course founder did, representing a linear view of communication given that the channel, message, and sender remain constant, even with new receiver(s), being new students. Following Shannon and Weaver's idea that communication can be depicted "as a series of steps in which the message is conveyed from a source or sender to a destination or receiver, and 'communication' is defined as the replication of the original message at the receiver's end of the transmission" (Bowman & Targowski, 1987, p. 23), the program at Colorado justifies the replication of the curriculum by noting that that is how it has always been done.

With that said, the program at Colorado is slightly lower than Indiana and sits slightly left on the map because their methods abandon formulaic approaches to the interview. Students enter the clinic earlier than any other program which allows them to witness the medical interview unfolding in a more natural state. Their acronym of ILS can be viewed as formulaic, but in practice students are taught some flexibility with regard to patient interaction. Rather than telling students exactly what to say, they are taught the skills encompassed by ILS with the goal of developing an empathic connection with patients they see in clinic.

**Harvard.** The next school on the map is Harvard. While this is a residency program, the school was still placed on the map as it relates to the other four schools. They are neither high nor low on the x or y-axis, so they sit toward the middle of map because the way communication is viewed by this program is more in line with Berlo's view which extended Shannon and Weaver's model more toward dialogue. Berlo argued that rather than looking at the accuracy of information transmission, we should instead pay attention to the value or meaning that is assigned to that information. The program at Harvard adopts this model with the way residents are evaluated and trained to improve their communication skills. Through video tapes residents must reflect upon how patients feel when talking with them, how they feel in the encounter, and then consider their evaluator's response regarding the video. The outcome for them is not so much about whether they said the right thing and used the right words, but is instead more focused on the process. Also, the educator from MGH made reference to the problematic nature of the belief that communication skills should end after year two of medical school. Currently, medical students are taught particular skills and are assumed to be

fine. Because Harvard acknowledges the value inherent in communication and understands it beyond the repetition of information, they hope to continue instruction in communication skills through residency as students begin caring for their own patients. Because they seek to observe and evaluate communication as it unfolds in a natural environment they align more closely with a dialogic perspective than both Indiana and Colorado.

**University of Iowa.** Iowa rests low on the x-axis and higher on the y-axis as their program illustrates a closer alignment with dialogic perspectives than linear with their conceptualization of communication and the instruction of particular skills; however, they also acknowledge the necessity for linear models like Shannon and Weaver's. More specifically, the educator noted that some patients do not wish to participate in shared decision making and would rather have their doctor tell them what to do and when to do it. Also, they consider communication to be a procedural skill which also embraces the linear idea of communication which involves a series of steps that are undertaken to convey a message.

Where Iowa strays from a linear perspective and moves toward a dialogic perspective is in their belief that no single skill is appropriate all the time and that interactions need to be patient rather than doctor centered. With this view, patients begin to have the ability to influence the interaction which means communication is something that is created by and between both parties. Further, communication is understood to have a multitude of functions such as interacting with patients and colleagues. Also, the program is the middle of changing instruction regarding information gathering and information delivery. Dividing these two elements helps students add value to two

different skills sets. Acquiring information often requires more listening than speaking, while information delivery takes a variety of skills depending on whether a doctor is delivering bad news, providing behavior change counseling, or handing off a patient to a colleague. Understanding that each situation requires a different skill set and that patients will further alter what skills students need to utilize begins to embrace a dialogic idea that communication is both purposeful and goal-oriented.

Iowa's future plans to add more communication opportunities into clerkships also align with a dialogic perspective. Different clerkships have different goals when it comes to talking to patients and the program's acknowledgement of this results in a higher positioning on the y-axis of the map. The unique characteristic about Iowa as it relates to the map is that it validates the positive intentions of linear perspectives like Shannon and Weaver's model, while also illustrating the importance of establishing an environment that fosters dialogue when interacting with patients.

**University of San Francisco.** San Francisco is the final school on the map and they are situated highest on the y-axis and lowest on the x-axis. This is a result of their narrative workshop, problem based learning activities, integrated communication opportunities, and their remediation program. The narrative workshop embraces Cayer's (2005) dialogue dimension of inquiry which focuses on "the exploration of individual and collective assumptions, beliefs, ideas, and feelings that control the participants' behaviors and interactions" (P. 176). By having students reflect upon their own spiritual, cultural, and sexual identifications in relation to why they wanted to become doctors, UCSF exemplifies Cayer's dimension of inquiry. Students do not undertake this exercise in an effort to discover which identities are right or wrong, but rather to uncover how such

identities affect their interactions with peers and patients.

Besides the narrative workshop, problem based learning activities and integrated communication opportunities stray from a linear model much like Iowa does. Both programs attempt to teach students about communication in its natural state recognizing that each encounter with patients will be different in some way from previous interactions. Rather than teaching through formulaic methods, UCSF is more process-oriented in their attempts to teach students *how* to ask the next question rather than which question to ask. Unlike Indiana, UCSF encourages students to let the interaction unfold rather than teaching them how to control it through a laundry list of questions.

Finally, UCSF's remediation program also aligns well with a dialogic perspective by illustrating that communication is a means to understand things in new ways. When students struggle with communicating to make new discoveries, they are provided further instruction to improve their skills. They are given more opportunities to practice using communication skills to work through complexities present in the medical encounter. Because students are learning more than a template of questions, this remediation program is necessary to help foster skills. If students struggle with communication at UCSF there is no checklist to memorize, but instead a process through which practice can continue.

This communication model map helps understand how schools relate to one another with regard to their perspectives on communication and the specific skills that are taught. While all programs agree that learning communication is done best through practice, how they choose to afford students such experiences differs greatly. In addition, how each school provides opportunities for students helps understand which model of

communication influences their program most directly. Based on these interviews it appears that each school has a place on the map with regard to how much or how little the school embraces elements of linear and dialogic perspectives. With a better understanding of how communication is understood, it becomes possible to attempt to answer the second question set forth by this project, which seeks to uncover how care is constructed in medical education programs.

## **Chapter 4: The Construction and Understandings of Care**

The second question this project sought to answer was, “How do medical schools in the United States construct “care” through their contemporary clinical skills/medical education programs?” This question proved to be more difficult to answer as no school discussed care specifically. Instead, each educator discussed how their teaching and instruction leads to care in the future. Their role is to provide opportunities to practice care, but given the nature of their position in the medical school, students are not yet qualified to be ‘care providers’.

So what is ‘care’ exactly? Merriam-Webster’s (1999) dictionary defines care as “anxiety, watchful attention, supervision” (p. 49). As a verb, the word caring means “to feel anxiety or concern, like, provide care” (p. 49). While the dictionary defines care explicitly, the programs interviewed for this study were not as forthright with how care is constructed in their respective programs. Instead, the construction of care began to unfold at the intersection of macro and micro processes that influence and guide the program. In order to understand what care means for each school I examined the organizing principles and objectives of each course. This included the models that influence the program, the way the educator talked about care, the way the course was organized, pedagogical methods used to teach, materials used, and how the course fit into the medical program.

From there, I examined how these organizing principles at the macro-level influenced the day to day learning of students. More specifically, how do the organizing principles of care embedded in each course manifest themselves in how care is actually learned and practiced by students? This inquiry requires an examination of the specific skills taught, who students interact with when learning to care, how students are evaluated, who evaluates them, and when and how each student is qualified as a care provider, or not. One way to do this is to examine what students are evaluated on and how this takes place. Evaluations are established to ensure that larger goals and objectives are being met through each interaction students have. To understand how organizing principles are broken down and measured helps uncover how students learn to care. In examining the interplay of these macro and micro processes one can begin to understand when and how students learn about care and its engagement, or care-ing. It is at these intersections that the construction and performance of care and care-provider begins to unfold.

Two major categories emerged in the data to describe the ways in which care is constructed, organized, and performed in medical school – “Developing a Program of Care” and “The Art and Evaluation of Care-ing”. The first category, “includes the codes of ‘current challenges’, ‘current program focus’, ‘program evolution’, ‘current objectives’, ‘program description’, ‘previous challenges’, ‘progress’, ‘future goals’, ‘course organization’, ‘location of instruction’, ‘organization of students’, ‘standards and expectations’, and ‘proposed changes’. Data in this category provides insight into how the learning of care is organized and how each school has responded to the field of

medicine as a whole in order to better train future doctors and improve the ways in which they care for their patients.

The second category that relates to how care is constructed is called “The Art and Evaluation of Care-ing” and includes the codes ‘evaluation from accreditor’, ‘evaluation techniques’, ‘influence of evaluations’, ‘types of evaluations’, ‘interviewee evaluation of program’, ‘what program does well’, ‘what students want to learn’, ‘example evaluations for students’, and ‘testing materials’. This category and its related codes help to understand how care is constructed on a micro-level by isolating the skills that each program finds necessary to evaluate and improve. It is through evaluations that programs alter their curriculum to meet the demands of both students and the medical profession as a whole.

### **University of Iowa**

**Developing a program of care.** At Iowa, the present clinical skills program titled “Foundation of Clinical Practice” has primarily focused on teaching students how to gather information from patients to aid in diagnosing symptoms and proposing courses of action for patients to follow. Initially, these skills were taught generally, but information was first tailored through their bad news telling course, which assists students in the complexities of informing a patient about something that is perceived as negative or affects their life in a negative way. Interestingly, the educator commented that students “absolutely want to learn about bad news telling” even though students “aren’t going to be anywhere near giving bad news to patients.” This suggests that students want to learn how to care prior to having to do so. While students will not be interacting with patients in such a context, their desire to begin learning such skills

helped bring about the weeklong course that occurs at the end of the second year of medical school and focuses on equipping students with such skills.

Besides teaching clinical skills contextually, Iowa is also presently changing the way they teach students about information in a clinical setting. In the past, the program focused “about gathering information because that’s what students do.” Currently, the program is beginning to incorporate more instruction on “giving information [and] educating patients.” Previously, the only way students learned about giving information was watching “their role models just give the shpeel,” but they were never equipped with a skill set prior to watching mentors interact with patients. The new development in the curriculum suggests that in order to care, one must be proficient in both gathering and giving information. Further, these skills are divided based on the nature of the care provider which means students are restricted to solely gather information, while their colleagues in the field are capable of also giving information to patients. With this shift, the construction of the student as a care provider shifts also.

Tailoring clinical instruction and including information giving into the curriculum are two specific areas where Iowa’s program is addressing issues from the past in the present moment and illustrate a few characteristics about the way Iowa understands care. By moving from general to specific skills, Iowa suggests that care as a general practice must be adapted and molded to be effective. Using bad news to show how some medical encounters differ from others constructs care in a way that suggests different contexts require different constructions of the concept. Also, recognizing the importance of both information gathering and information delivery speaks to the complex nature of care. Not only does it come through the information a doctor gathers, it also enacts itself in

information doctors deliver. In addition to looking at the evolution of the program, it is also important to understand the current curriculum including objectives, teaching methods, challenges, location of instruction, standards, and expectations in order to understand how the program currently organizes the learning of care.

Iowa uses opportunities, which allow students to practice skills, such as small group role plays, interaction with standardized patients, and reflective sessions where students reflect upon immersive clinical experiences and discuss challenges they are facing in interaction. Each of these opportunities is “learner centered” and allow students to work through “spontaneous cases” that address the “challenging things” they are seeing in clinic by “directly applying their learning” to such situations. This current method of instruction attempts to bridge learning and practice in a way that helps students learn by doing, while also reinforcing material in both contexts. These pedagogical methods suggest that care appears at the heart of interaction. Teaching in small groups suggests that care is not something delivered from the top down, but rather as something that occurs and improves between and through individuals. With a better idea of where Iowa’s program has come from and where it is currently, an examination of its future goals also helps to further uncover how care is constructed in this program via macro-level organizing processes.

Iowa has found great success with tailoring skills to particular clinical contexts, including information giving with information gathering, providing opportunities for students to practice learned skills, and helping bridge what is learned in the classroom to students’ clinical experiences. With that said, Iowa has several future goals that aim to further such progress, while also addressing challenges they are facing.

A recent LCME visit, for example, has greatly influenced where the program is hoping to move in the future. The LCME noted “that there is not anything wrong with your curriculum but you haven’t renewed it in ten years” which has led to the creation of the 20/20 vision curriculum renewal project. This initiative understands that “medicine is practiced very differently today than it was 15 years ago; and it will be very different in 2020 than it is today” (“20/20 vision,” 2010). This recognition of the evolving nature of medicine will change the way clinical skills are taught by providing earlier clinical experiences and “longitudinal exposure to patients over time to promote development of skills and relationships with patients” (“20/20 vision,” 2010), as well as the incorporation of new practice opportunities which include robotic simulation and computer based education. The revision also hopes to include communication training into clinical experiences to “reinforce and validate content and skills emphasized in preclinical curriculum,” while also supporting evidence that “indicates communication skills can deteriorate during clinical training” (Rosenbaum, 2010).

These future initiatives discursively construct and organize care as an evolving enterprise. Recognizing that medicine has changed and is continuing to do so at a much faster rate suggests that students and doctors need to be adaptable and flexible with their skills set. As medicine changes so too will the way care is provided. Twenty years ago technology did not have near the effect it does today in provider-patient interaction. Today many question if technology could interact entirely in the place of a human. With such changes, students need to be taught how to provide care in ways that are innovative, adaptable, and flexible if they are to keep up with the changing world of medicine.

The final goal Iowa has is to not only teach and educate students, but also clinicians. The hope is that by educating clinicians about topics students are learning about, information is more likely to be reinforced in clinical experiences. Currently the educator is finding gaps between what is taught and what is seen and finds this problematic because “if what [Iowa is] teaching pre-clinically is not being reinforced clinically then what’s the point?” To make the transition from the classroom to the clinic more seamless it appears that educating educators is one strategy to accomplish this goal.

**The art and evaluation of care-ing.** The first way that Iowa students are evaluated with regard to their clinical skills is by standardized patients. After every standardized patient interaction, students are provided “behavior specific feedback.” These evaluations “are not about evaluating performance,” but rather focus on the specific skills used in interaction.

A second form of evaluation used by Iowa is receiving feedback from students about their experience with clinical skills instruction. The educator speaks with students in residency to understand how their learning is being applied and reinforced in the field. For example, with regard to the bad news workshop students have said “gosh, I am so glad I had that bad news telling course” and “I saw someone do it so badly the other day and they just didn’t get that the patient couldn’t hear anything they said or didn’t ask their patient what their concerns were.” This feedback helps the educator understand that the course’s instruction is providing “a critical filter” so “as students are seeing those things they can develop and watch those role models and assess whether they are doing an effective job as opposed to learning just by watching people do better or worse jobs.”

In addition to hearing about what students are seeing on rounds, the educator also receives feedback from students that evaluates their educational experience through interviews with seniors. So far such interviews have uncovered “that they would like earlier clinical experiences and interactions with real patients.” Getting this feedback has led to the proposed changes and goals of Iowa’s 20/20 vision curriculum renewal project.

### **University of Indiana**

**Developing a program of care.** Indiana’s “Introduction to Clinical Medicine” course has an interesting history and is in the midst of reorganization and reprioritization mostly as a result of the program’s size. When compared to other programs interviewed for this study, Indiana’s program has twice as many students. The program’s past shows a lack of consistency in both teaching and evaluation, which is heavily influenced by the program’s 300 students who are spread between multiple campuses. Issues arose when second year students “would come in with variable levels of history taking skills” and the educator “would have to back up or have preceptors back up and teach some students really how to take a history while some already knew.” Because students were entering year two with such a range of skills, Indiana wanted “to establish this benchmark that they all know how to take a history” by the start of the second year. These “benchmarks” are part of the program’s competency based curriculum, which outlines the specific skills students need to learn by the end of each year in medical school. Arranging the curriculum in this way has helped Indiana manage such a large student body, while also installing consistency of teaching and instruction.

While addressing the issues of the program's size, Indiana's current curriculum is similar to Iowa with regard to the emphasis placed on practice as the preferred model of learning. Educators at Indiana have written role-plays for students assist with a variety of topics which include but are not limited to, "sensitive interview techniques as well as role plays that just help them take a history focusing on the family history or the social history." In the past students would just practice with each other and give their own history to their peer. The educator found this ineffective because students often felt uncomfortable sharing their own history and often just made information up rendering the activity unimportant. With the new role-plays, students are provided further opportunities to practice skills in a simulated clinical experience which allows them to develop and perfect skills as they learn how to become care providers.

These new teaching methods also help explain how care is understood at Indiana. Like Iowa, Indiana uses small group instruction to provide practice opportunities to students, however the size of the program hinders Indiana's ability to break students into groups and provide resources for practice. To combat this challenge, role plays serve as resources so students can still interact in a small group setting which supports the idea that care occurs in an intimate team environment.

In addition to the role plays, the simulation center and virtual hospital at Indiana provide manipulable, multiple, and diverse contexts for students to practice clinical experiences on their own and with other colleagues. The simulation center seeks to mimic clinical experience as closely as possible by creating resources for interdisciplinary work with other students and simulated patients. Essentially, it is a safe

context where students can focus on both clinical skills and biomedical knowledge simultaneously.

As Indiana looks to the future, their ability to establish goals and objectives is stalled while they wait for the hiring of their new dean. With their new competency based curriculum in place, they hope to continue to establish clearer benchmarks for each year of medical school to ensure consistency in instruction. Also, the educator hopes to take advantage of the Clinical Skills Center by providing students with more opportunities to use its resources to achieve their learning objectives.

**The art and evaluation of care-ing.** The primary way that Indiana evaluates its students and their care practices is through its competency based curriculum. The program delineates eight competencies that they expect students be proficient in. They include: effective communication, basic clinical skills, using science to guide diagnosis, management, therapeutics and prevention, lifelong learning, self-awareness, self-care and personal growth, the social community and context of health care, moral reasoning and ethical judgment, problem solving, and professionalism and role recognition (“MD curriculum,” 2010). The school’s “Competency Handbook” outlines that each of these competencies “will be evaluated through course activities scheduled during the courses and clerkships both using formal evaluation methods as well as by faculty observation” (p. 14) The fact that each competency is evaluated with methods that observe skills in action indicate that each competency is important to what it means to be a doctor, while also illustrating that care is complex and best learned through variety of practice opportunities.

In addition to the competency-based curriculum, another evaluative measure that organizes and guides the curriculum is the Objective Structured Clinical Examination (OSCE) that is given at the end of each year. Each student must pass this exam as it indicates proficiency in clinical skills. In the past, students reported “that they had enough time for the interview”, for example, but they “felt they didn’t have enough time to get the feedback which is a really critical piece of it.” The entire curriculum is organized to teach skills and techniques that will help students pass exams like the OSCE. Evaluative exams like the OSCE illustrate again that care is an active process that can be altered and changed when students are provided with feedback indicating their strengths and weaknesses. Further, such a process suggests that those individuals giving the exam possess some proficiency with regard to care, which affords them the ability to conduct such evaluations. Additionally, this evaluative process implies that there is some standard measure of care that students are measured up against to determine if they are proficient in these skills or not.

### **University of California at San Francisco**

**Developing a program of care.** When thinking about its past, the primary issue that the educator at UCSF wanted to address in the “Foundations of Patient Care” course was the lack of seriousness surrounding the clinical skills education. Overcoming this challenge has influenced the present state of the program’s curriculum. Currently, the program upholds the belief that “understanding what one brings to the table when doing an interview and enhancing that personal awareness” is the best way to teach students how to connect with and care for patients. Students are provided exercises, which help them to understand the forces that affect them in everyday life such as culture, sexuality,

religion, and health history. After acknowledging how such forces affect their own lives, students are then asked to reflect upon how the same forces affect the lives of their patients. These exercises add an empathic component to way care is understood. By acknowledging the necessity to know one's self before one can connect with another, care can be understood as a connection to another involving empathy.

Besides a lesson in empathy, UCSF's current program follows the preceding curriculum with its emphasis on practice as the primary way of learning. More specifically, practice helps students "not just feel comfortable, but achieve skills" related to interacting with patients. This objective illustrates the program's goal of having students take the course and its material seriously as the expectation is achievement, not simply comfort. With that said, the educator at USCF mentioned that "the approach to the interview can be learned fairly early on" but "the particulars" like clinical reasoning and asking hypothesis generated questions are often areas where students struggle. Because of this disparity in knowledge acquisition and the ability to perform such skills, practice is necessary if students are to graduate medical school proficient in the skills necessary to provide care. Therefore, not only does care involve empathy but it also requires a great deal of practice before one can be viewed as proficient in providing care.

Another characteristic of UCSF's current program is its remediation program, which provides extra resources to students who are risk of failing their OSCE. This program acknowledges that learning skills to provide care are complex and often take time to learn and master. Further, it recognizes that each student is different just as each doctor is different. As a result, access to a variety of resources is often necessary.

In looking at the development of UCSF's program, the previous issue of the lack of seriousness associated with the course has been addressed and the curriculum has moved to encourage students to think about how to increase and improve empathic feelings they have toward patients. It is also similar to other programs with its emphasis on practice, acknowledging that some skills are hard to learn. As the program looks to the future the educator hopes to accomplish several things which include the incorporation of problem based learning modules and an increase in "immersive experience."

**The art and evaluation of care-ing.** UCSF is very similar to Indiana with regard to the types of evaluations they use. They too give an OSCE at the end of years one and two, in addition to a standardized exam called "the CPX" which stands for Clinical Skills Examination and "is California specific." This exam "prepares students for the national board exam [known as] the step 2 clinical skills exam." In this exam "standardized patients grade students on a standardized checklist and there is a certain proportion of students every year who are deemed to fail the patient/doctor interaction piece." Those students who fail are then required to go through UCSF's remediation course to take advantage of additional resources and undergo further evaluation.

Once in the remediation program, students are evaluated using videotapes. They record interactions with standardized patients and then review those tapes with a faculty member, however even "before that the student looks at the videotape themselves and writes down the things that they think they were doing inadequately and things that they would like to improve." With those comments, the student sits down with a faculty

member and together they review the tape and those comments. The educator then “goes over both their learning plan and self-assessment.”

These evaluative techniques again suggest that care is a measurable standard that some people are proficient in and others are not. This assumption places faculty members in the position of expert, while students fulfill the role of “sightseer or tourist” while in medical school. This positioning of students and faculty indicate that students can witness and practice care, however they are not fully engaged in the action as students. It is only through evaluations from their superiors that they are able to inch closer to actively practicing care.

### **University of Colorado**

**Developing a program of care.** At the University of Colorado, the “Foundations of Doctoring” course previously had a reputation for its “four hour lectures” where you “definitely saw the whites of people eyeballs.” While the course provided “a lot of valuable information,” it was not taught in a way that was captivating or engaging, which prevented students from learning how to provide care in the best way possible. Since then, the educator has redefined goals and objectives of the course, stating that the ultimate goal of clinical skills is to teach students how to have an “empathic connection with every patient” recognizing that “that’s complex and often difficult” but with the right “practice techniques” it is possible. With that said, the educator also noted “that even if you are a great communicator naturally” it does not necessarily mean an empathic connection comes easily, suggesting that providing good care and being a good communicator are not one and the same. While these skills are different, the educator suggests that both are important as they “advance the therapeutic relationship.”

With unique goals, objective, and construction of care, the program at CU is similar to others as it relates to the importance of practice as the preferred method of learning. Students at CU are provided experiences to interact with real patients early on, following preceptors throughout the first two years of medical school so they can observe how to both take a history and conduct a physical exam. While practice is important, these methods of instruction suggest providing care can be learned by modeling given that the primary way students learn about care-ing is through watching their superiors in action.

Further, teaching the importance of practice with regard to learning is reified given that students learn how to care from people who were once medical students like them. This system implies that your mentor matters when it comes to learning about care. In their first year, students have not yet learned much biomedical and anatomical information with which to interact with patients on their own. As a result, they rely on watching their mentor when it comes to learning about care and how to care. This means that the construction and performance of care in this program is dependent upon the skills and ability of the doctors and preceptors students shadow.

The importance of practice is the primary organizing influence on CU's program as they lack a guiding model to organize instruction and learning. However, in the future, the hope is to "integrate the Calgary Model, in addition to teaching behavior modification" to further organize its curriculum. With its emphasis on the importance of practice, the educator hopes to spread the curriculum out more than it is currently to create more time to incorporate more practice opportunities. As it stands now, the program at CU "basically kicks the shit out of [students] for three years and the last year

they just sort of chill.” The educator would like to extend the curriculum into the fourth year, lightening the load in the first three and providing time to spread things out.

**The art and evaluation of care-ing.** The overarching characteristics of CU’s program -- a front-loaded curriculum, practice as a primary form of learning, and early interactions with real patients guides and directs the micro level processes and contexts where care is actually learned and practiced. While care is defined by CU’s educator as an “empathic connection,” evaluation techniques can begin to uncover if students are really learning skills to achieve this goal.

Evaluation techniques at CU, however, are limited to requiring students to report satisfaction, more so than examining how well the program meets its goals. After interacting with standardized patients the educator “gets very intensive evals from them” which report “what they liked and didn’t like.” In addition, students “give a grade on how your [lecture] went” prior to breaking up in small groups to interact with standardized patients. Beyond this, the educator did not mention any other types of evaluations that provide feedback to faculty about how their program is addressing student needs.

In addition to evaluations, the communication skills taught to students through Invitations, Learning, Summaries (ILS) with the goal of providing techniques that will help students connect with patients empathically. While “practicing techniques really helps you,” the educator questions if empathy is a teachable skill. This introduces complexity then to the construction of care. If an educator understands care to be an “empathic connection” with patients, then perhaps care itself cannot be taught. If this is

the case, it becomes difficult to understand how students are supposed to learn how to care and be prepared to excel in the field of medicine.

With this existing contradiction between macro and micro activities at CU, the lack of evaluative measures used also uncovers further assumptions around the performance of care. The educator justified the absence of evaluations by saying “I think the problem is they are third year medical students and I don’t think you ask the questions until ten years later and they are out practicing and saying that stuff I wish I paid more attention to.” The belief that students cannot provide adequate feedback regarding clinical instruction until ten years after practicing medicine suggests some interesting things. Not only is care questioned as a teachable skill, but also here care fails to be understood as an engaging process. Instead, this view suggests that care cannot be reflected upon and improved without an extensive amount of time in the field. Such a view helps understand why CU introduces students to patients earlier than any other program interviewed. With the belief that longevity leads to understanding and engagement student then must start such interactions as early as possible.

Besides questioning if empathy can be taught, CU also has “gaps” and questions with regard to “what to do with recalcitrant learners . . . to give them feedback.” The educator noted that one “wonders how people who don’t do well in [clinical skills] do in their professional lives,” yet there are no measures in place to gauge what particular aspects of communication and care with which student struggle. This statement illustrates that a lack of proficiency in clinical skills impedes a doctor’s professional life in providing care to patients. If empathy cannot be taught, but skills and techniques help

to understand how to be empathic, then providing resources to those who struggle with teachable skills is an area worth addressing.

In examining the organizing principles of CU's program in combination with the ways students learn to care, it becomes clear that while care is understood by the educator as an "empathic connection," it is also simultaneously questioned as to even being possible to teach and accomplish. Evaluative measures reinforce the belief that being proficient in skills like Invitations, Learning, and Summaries can help one get closer to being empathic, yet the program is still unsure of what to do with those who struggle with these skills besides "worry about them." Care is also constructed and understood at CU as a skill that takes a long time to learn. With this understanding it is interesting that minimal amounts of time are spent teaching the skills that are deemed necessary to know if one is to be empathic. While students see real patients early on, their time spent in the classroom learning and role-playing, as well as time with standardized patients, has been shortened rather than lengthened as time has gone on.

## **Harvard**

**Developing a program of care.** When compared to the previous four schools, Harvard's educator spoke the most explicitly about care and how it is constructed. Students begin their learning with the "Patient/Doctor I" course and the skills learned here are aimed at helping students in residency and beyond. In the past, clinical skills instruction was not even offered past year two of medical school. Now, residents participate in an integrative program that helps them provide care to the patients and cases they see everyday under the guidance of a mentor. This process suggests care is an ongoing learning process, rather than a supplemental or terminal learning experience.

As a mentor, the educator for Harvard residents acknowledges that providing care is often hindered by external variables such as time. For example, in the current academic year residents have often struggled with “how to be efficient when seeing and taking care of patients.” Even when a resident is well-versed in interviewing and history taking, time often complicates interaction and must be accounted for.

The current curriculum used by the educator follows the Kalamazoo Model of Medical Interviewing, which suggests “a strong, therapeutic, and effective relationship is the sine qua non of physician-patient communication” (Makoul, 2001, p. 391). Further, this model regards the physician–patient relationship as a partnership, and “respects patients’ active participation in decision making” (Makoul, 2001, p. 391). This model is used to extend clinical skills training from the first two years of medical school and aid residents as they begin seeing their own patients. In addition, it illustrates very clearly how Harvard residents are taught about care.

As Harvard looks to the future, the educator hopes to continue and strengthen the program as it is now. Because teaching clinical skills in residency is a new trend, the educator is still in the process of growing this curriculum. There is a survey that students now take that “asks about level of importance of different skills” and results that are culminated from this survey will be used to determine the future of Harvard’s program as it relates to clinical skills in residency programs.

**The art and evaluation of care-ing.** In order to extend clinical skills training from the early years of medical school into residency, the educator at Harvard uses videotapes as the primary means of evaluation. Each resident “videotapes real live encounters with patients” and then “goes over the videos on their own with a rubric of

skills on the medical interview so that they can self-evaluate themselves and self-assess themselves.” Then, the educator “look[s] at the videos and evaluate[s] them.”

Following, the student and educator “get together and discuss what they think went on in that particular visit and then in general what they feel about their own interviewing skills.” This method is similar to others because it assumes that there exists a standard of care that can be achieved through practice and guidance from a superior. Also, it acknowledges the importance of practicing interaction in an authentic or “real life” environment.

While Harvard’s evaluation techniques are similar to the other schools in the above ways, the program differs in its emphasis on student self-evaluations. Other programs do not provide such evaluation measures, which suggests that once students are residents, they have the knowledge, and ability to identify, provide, and access care practices. Even though “residents have their own patients” and “have an MD,” they also have “a supervisor looking over [them]” to help them gain their “autonomy” while also providing further guidance. Residents can engage in authentic encounters with “real live patients” and also evaluate such interactions. In this context, care is constructed as something performed authentically every day and open to evaluation.

In addition to videotape evaluation, the educator has also developed a “survey on the residents’ self-assessed skills at particular components of communicating with patients and for that same skill level of importance they put on that skill.” This data is collected to compare skills that students are taught with the skills they themselves find important once they interact with patients. These surveys are aimed at uncovering whether a disconnect exists between classroom instruction and clinical experiences.

Again, this evaluative measure constructs care in a particular way. It suggests care is dynamically constructed and performed, relying upon different skills in different contexts for different students. Care is adaptable and its execution flexible. While several programs imply that there is a standard of care against which students are measured, Harvard's evaluative techniques illustrate that care evolves and is performed differently according to the doctor, patient, and context involved.

### **Summary**

The categories of "Developing a Program of Care" and "The Art and Evaluation of Care-ing" help one understand motives for changing care education within programs. Evaluating care practices often uncovers catalyzing events that bring about growth, change, and organization within each program. When looking across schools, both the development of a care program and evaluation of care practices begin to reveal common trends and themes which speak to the construction, organization, and performance of care in medical education. These include a desire to increase practice opportunities, replicate authentic clinical experiences, understand that communication skills reside in the foundation of providing care, and the qualification of care and its provider.

**Care needs to be practiced in a diversity of contexts and opportunities.** Each school expressed a desire to increase the time students have to practice interacting with patients. This objective indicates that care is understood as a skill and interaction that can be learned through observation and modeling. Students currently learn how to provide care through role-plays, interactions with both standardized patients and real patients, and by observing mentors and preceptors. The desire to increase such opportunities acknowledges the complexity of doctor patient interaction as well as the fact that learning

how to provide care takes time. Because learning by doing is the primary method of instruction in medical school, increasing practice opportunities constructs care in a way that suggests it can be modeled and learned through both observation and rehearsal.

In addition to wanting to increase the number of opportunities provided, each program also explained how such opportunities are and will be evaluated in order to ensure students are practicing care in a way that is useful for their education and growth. Evaluating students in practice situations assumes care has a measurable standard, which acts as a goal set forth by medical educators and faculty. As more practice opportunities are provided and more rigorous evaluation standards are put in place, care becomes constructed as a learnable set of skills that can be measured. Yet, in order to begin measuring 'proficient care', one must consider the context in which such practices take place.

**Care happens in authentic interactions.** In addition to wanting to increase practice opportunities, schools discussed a desire to make the context of such opportunities as authentic as possible. The clinical skills center at Indiana illustrates this goal through its ability to reenact clinical encounters in many ways. The center's virtual hospital seeks to replicate clinical interaction as closely as possible through the use of mannequins and models that allow students to practice clinical procedures under the real-time supervision of superiors. Also, the clinical skills center provides resources for standardized patient interactions and the opportunity to work with colleagues.

Interestingly, with the intention of simulating authentic clinical experiences, the clinical center moves farther away from this objective. While contexts are successfully simulated, interaction lacks authenticity as students move from interacting with people to

interacting with mannequins. When practicing the clinical procedure of say, inserting an IV on a mannequin, students are denied an authentic human experience. A mannequin is unable to recreate, for example, a mother watching her child (the patient) get poked and prodded as a doctor attempts to find a vein. While the student has the chance to practice the actual use of IV needles, when it comes to clinical skills, the lack of authenticity denies students a safe context in which practicing communication skills might occur.

At Iowa, the idea of authenticity is being addressed through their inclusion of communication skills into clerkships. In everyday life, different specialties require different skills sets, so by contextualizing these skills, Iowa provides more authentic clinical experiences for students. Further, their incorporation of live patient procedures authenticates the clinical experiences of their students. While Indiana uses mannequins to practice procedures, Iowa uses live patients.

By expressing the goal of replicating authentic clinical experiences, these programs suggest that care giving is an authentic enterprise itself. Each program discussed the struggles students face when they lack resources that mimic the clinic. When this occurs, students are inhibited with regard to the skills they can learn about how to best provide care. Because care giving is best understood when constructed as authentic, how can instruction replicate reality as closely as possible in order for students to gain proficiency in such skills?

Authenticity becomes important in the context of evaluation as well. Iowa's educator discussed the desire to provide feedback, as well as practice opportunities that account for suggestions given. Not only does this desire speak to the importance of authentic interaction, but also suggests that timeliness is important with regard to

improving skills. Receiving feedback that is currently used six months later is not effective as the authentic nature of the original clinical encounter becomes irrelevant and without such a context to rehearse skills, continued or ongoing learning becomes difficult.

These findings suggest that the relationship between careful practice and time needs to be more adequately explicated. If practice is the best way to learn, practice and feedback must coincide to optimize the learning experience. Harvard's program reinforces this idea with its evaluation of residents and the belief that training must occur through residency. It appears that once residents are interacting with patients they still need the guidance of a mentor to continue to develop their clinical skills. At Harvard, residents have said that they have trouble with efficiency and agenda setting. By evaluating real-live encounters these residents have with patients, mentors can begin to use authentic experiences to provide timely feedback to improve skills. Care is now understood as an ongoing learning process that occurs through authentic experiences where timely feedback can improve future interactions.

**Care is constituted in communicative practices.** Besides expressing the desire to increase the number of opportunities that replicate authentic clinical interaction, each program also expressed that communication and care are not one in the same but rather effective and proficient communication skills build the foundation upon which care giving practices rest. For example, the educator at CU defines care as an “empathic connection” and communication as customer service skills you “learn at Nordstrom.” Customer service skills can be taught, where the educator is unsure if empathy can be taught because it comes from a genuine connection with a patient.

The future goal that other programs have of extending clinical skills into residencies speaks to this theme as well. Communication skills serve as a foundation of care practices, and as the educator at Harvard notes, such a foundation should not end in the second year of medical school. Instead, skills need to be built upon as students move into specialties and more immersive clinical experiences. While an oncologist and internist will both take histories of patients, the care practices they perform will most likely look very different in their respective contexts. As a result, both doctors need communication skills as a foundation but must go beyond such skills if they are to provide good care to their respective patients.

Finally, four out of five programs refer to their clinical skills programs as “foundational.” This titling explicitly acknowledges that learning about communication and how to interact with patients is foundational to medical education and medicine. Given that medical school is intended to adequately train future doctors, one can argue that clinical skills are not only foundational to medical school, but to doctoring and providing care as a whole. Each school spoke to the importance of having a solid foundation in care and communication as they accredited this to a student’s future success as a professional. With this construction of care we can begin to see how communication is both related and important to providing, but not synonymous with it.

**Care is administered by qualified providers.** A final theme that was found when examining all five schools was the assumptions of when students are qualified to provide care, and when they are not. As UCSF, medical students were referred to as ‘sightseers’ and ‘tourists’ suggesting they play a passive role in the ways care is performed, constructed, and accomplished. This view, combined with evaluative

measures like the CPX and OSCE, suggests that mastering communication skills must occur if students are to move from the position of ‘tourist’, to that of a ‘native’ (the equivalent of doctor employed in a hospital or qualified care provider). Once students master their exams, they have officially passed the first step in being formally qualified. Next, they must prepare to move into residencies where they are able to work with their own patients, and pass the second step of becoming a qualified care giver as set forth by the institution of medicine.

The hierarchy of these qualifications can be seen at Harvard. Here, residents are perceived to have the ability to provide care on their own, even though they are frequently supervised. With the ability to evaluate themselves after real-live patient encounters, they certainly have more autonomy than first and second year medical students. Prior to passing evaluations like the OSCE and CPX, care is viewed passively, not actively participated in. Again, this shows the significance of time in terms of the time it takes before a student can begin to perform care giving on his or her own.

Iowa’s program also illustrates the boundary that exists between an unqualified and qualified caregiver. The educator mentioned the surprise that comes with students’ eagerness to learn how to give bad news. For many, this skill is the primary motivator for students to enroll in medical school. The educator finds that first year students are very eager to learn this skill but reminds them they will not learn it right away as nowhere near ready to perform this task.

Instead, the bad news workshop is strategically placed between years two and three of the program and provides an immersive clinical experience for students. This practice is justified in the fact that students are preparing to start their rotations and have

most likely passed their clinical skills exam, which takes place at the end of their second year. This supports the findings from Harvard that suggest residency is the second step in becoming a qualified care giver. Once the exam is passed and residency commences, students begin to move from a passive ‘sightseer’ to an active, care-ing doctor.

Examining the development of each program including its past, present, and future helps to uncover the organizing forces around it, speaking to guiding principles and objectives that organize particular pedagogical methods, while reflecting on what each program finds important to teach its students. Consistent trends of wanting to provide students with more practice opportunities that are authentic and focus on communication as a foundational skill to care giving emerge as central to the development of programs of care and also to the creation of the care provider.

In the next chapter I will examine the intersections of communication and care to explore how these concepts relate to and influence one another. I will then propose a new curriculum, which responds to the findings from this study that will suggest a new way of teaching medical students in the future. I will conclude with a discussion of the limitations of the present study.

## **Chapter 5: Intersection of Communication and Care**

As a dialogic scholar, I have examined routine practices that occur in medical education programs in an attempt to understand how the structure of the medical school is created, sustained, and continued by and through organizational processes constituted in language. To end here would be an interpretive approach to research. Instead, I would like to propose how medical education might be changed in the future to account for the many stakeholders involved including students, educators, doctors, nurses, patients, and their families.

After analyzing the data collected through interviews, several intersections begin to appear between models of communication and care in medical education. Each program teaches a variety of skills and uses several methods to do so, all to prepare students for their future in the field of medicine. The Communication Continuum in chapter three helps understand how each program understands communication and how these understandings relate to others. Further, each understanding of communication explains how and why schools construct the performance and practice of care in particular ways. Program development and evaluative techniques are just two areas where care practices, their construction, and their instruction are revealed. In the end, it appears that care needs to be practiced in a diversity of contexts and opportunities, in authentic interactions, and is administered by qualified providers.

So how are the concepts of care and communication influence one another?

How can we reconceptualize the ways in which they make themselves manifest in the material, everyday practices of medical school? To begin this discovery process, I first categorize the two understandings of communication that emerge from the data and discuss how these categories are related to models of conversation and dialogue. Then, I explain how the understandings of communication influence different models of care in clinical instruction and interaction. This examination will uncover how alternative discursive practices in medical education have the potential to change the system of care, communication, and the organization of medical school as a whole.

### **At the Crossroads of Communication and Care**

#### **Communication as Conversation**

Within the cybernetic tradition, communication is understood as information processing. Communication as it is understood today originated from this perspective, which helps us understand “how all kinds of complex systems, whether living or nonliving, macro or micro, are able to function, and why they often malfunction” (Craig, 1999, p. 141). Closely related to the transmission model, the cybernetic tradition believes communication is “a mechanism that performs certain functions and that “communication processes can be enormously complex and subtle” (Craig, 1999, p. 142).

Relatedly, the cybernetic tradition helps explain how conversation differs from dialogue in Cayer’s descriptive model. Here, communication as information processing relates to Cayer’s description of conversation as information sharing. It is task-oriented and does not fully account for the human experience. Instead, both conversation and communication as information processing focus on how and why information is transmitted and received.

This view of communication as conversation or information transmission and sharing is reflected in how most programs understand clinical skills instruction. Each school stresses the importance of history taking as a learned skill that is intended to gather and convey particular information. Indiana provides students with a list of questions to ask, paying little to no attention to how those questions might change given the patient, their symptoms, or their desires. Instead, the program simultaneously recognizes the complexity of clinical interaction and then provides tools to simplify and reduce it for students. Similarly, the University of Colorado's acronym ILS simplifies communication's complexity, while performing very particular functions of the medical interview. Each letter encompasses specific skills, which are intended to ease clinical interactions for students. So are students communicating with patients, or simply conversing?

### **Communication as Discussion**

Bohm traces the meaning of 'discussion' back to its root, which is similar to both 'percussion' and 'concussion' and "really means to break things up" (Bohm, 2003, p. 6). It "focuses on analysis, reduction, comparison, contrast, and conclusions based on already existing criteria" (Martin, 2005, p. 84), which often leads to ". . . many points of view . . . where everybody is presenting a different one" (Welsch & Jenlink, 2005, p. 373). As a multitude of ideas are expressed in the context of discussion, they are analyzed and broken which prevents participants from moving beyond their differing ideas. Instead, discussion "leads most often to each person trying to 'win' his or her position" (Welsch & Jenlink, 2005, p. 373).

Discussion is most closely aligned with Craig's (1999) sociopsychological tradition which "theorizes communication as a process of expression, interaction, and influence" (p. 143). Further, this process is influenced by communicator's "psychological predispositions" (Craig, 1999, p. 143), which include attitudes, beliefs, and personality. Its focus on influence and psychology distinguish this tradition from both cybernetic and phenomenological approaches.

As it relates to medical education, UCSF constructs communication as discussion through elements of their program, more specifically, curriculum design. The break down of UCSF's curriculum by organ system reduces communication to pre-assigned categories that relate to the human body. Rather than understanding communication holistically as a dialogical approach would, UCSF constructs the concept in a tailored fashion that blends medical knowledge of an organ system with the communication skills necessary to discuss an illness or health problem within that system. By reducing and breaking communication down to organ system, the curriculum reflects communication as discussion.

### **Communication as Dialogue**

In contrast, the phenomenological tradition understands communication to be "the interplay of identity and difference in authentic human relationships" (Craig, 1999, p. 138). Authenticity, says Craig (1999), "is founded on the experience of direct, unmediated contact with others" (p. 138) where communication is used to "treat each other as persons (I-Thou) not as things (I-It)" (p. 139). This differs from the cybernetic tradition in that it views dialogue as the ideal form of communication, while recognizing its "inherent difficulty" (Craig, 1999, p. 139).

Rather than focusing on information processing, the phenomenological tradition possesses “an impulse to search for common ground among people with differing points of view” recognizing that “supportive relationships are essential to our healthy development as human being” (Craig, 1999, p. 139). While this goal is important, the tradition recognizes that it is hard to achieve, as dialogue is not something that happens on its own. Rather, “sustained, authentic communication between two persons” (Craig, 1999, p. 139) is something that must be a conscious goal for both communicative parties.

The importance of identity and authenticity present in the phenomenological tradition influence the practices and programs at both the University of California and Iowa. UCSF understands the importance of identity as it relates to communication, using its narrative workshop to require students to reflect upon their culture, sexual identity, and experiences with death and dying. This pedagogical method influences authentic relationships with patients as it encourages students to develop a strong level of empathy to better connect with patients. As a result, students and patients are better equipped to find a level of common ground to aid in interaction.

Iowa too reflects a phenomenological and dialogical understanding of communication as it relates to history taking skills. Unlike Indiana, the program at Iowa attempts to teach students how to ask questions when taking a history, rather than providing them with a list of questions to ask. This encourages an authentic relationship with patients because it considers the human experience present in interaction. Rather than treating all patients the same, Iowa’s approach acknowledges that different patients with different symptoms require a variety of techniques to elicit the information necessary to make diagnoses and propose plans of action. The phenomenological

tradition suggests that “the most satisfactory human relationships are characterized by reciprocity and nondomination” (Craig, 1999, p. 140) and both Iowa and UCSF’s programs attempt to equip students with the flexibility necessary to achieve both of these goals.

As discussed above, understanding communication as conversation, discussion, and/or dialogue plays an important role in both the pedagogical and learned practices in medical education. While these conceptualizations are not mutually exclusive, they do play a pivotal role in how medical students engage with patients and understand their role within the organization of medicine. Ultimately, the way communication is conceptualized appears to influence how medical students engage in care practices both in school and clinical interaction.

### **Care as Conversation**

The above understandings of communication provide some insight into how certain models of care become employed in clinical interaction. For example, the model of paternalism constructs the doctor as the information seeker. Doctors ask questions and patients provide answers. As a result, such a model does not account for the nuances of interpersonal relationships as patients are not encouraged to ask questions or participate in decision-making.

Given these characteristics, a paternalistic approach to care can be understood cybernetically where communication is used as a means to “evaluate the reliability of information” (Craig, 1999, p. 142). It is also a particular form of conversation as communicative parties, doctors and patients interact to share information. Communication in this model of care is task oriented and used to elicit enough

information to allow doctors to prescribe a plan of action because as the old adage goes, “Doctor knows best.”

The program at Indiana reflects this model of care through their instruction on the clinical interview. Students are only trained on what questions to ask, rather than how to ask questions or respond to patients. This constructs the student as the information seeker and the patient, whether it be standardized or real, as information provider. By focusing on what to communicate about, rather than how to communicate, students at Indiana learn about communication in a way that encourages care as conversation.

Similarly, the program at the University of Colorado constructs care as conversation through the use of Invitations, Listening, and Summaries (ILS). Because this acronym is used to teach skills rather than technique, students do not learn *how* to employ each of these skills proficiently, but instead learn that these are skills to use. As it is taught, ILS ends up being a doctor-centered approach that focuses on what the doctor should do, instead of what is best for the patient. The absence of teaching how to use these skills results in a lack of flexibility and adaptability in the instruction and construction of care. Ultimately, this results in doctors again being constructed as information seekers who rely upon their patients for answers to their questions.

### **Care as Discussion**

The model of consumerism begins to abandon such a cybernetic view of communication, and instead aligns more closely with both discussion and the sociopsychological tradition where communication is conceptualized as “expression, interaction, and influence” (Craig, 1999, p. 133). Consumerism, as a care model, is characterized by both patients and doctors making decisions regarding care. Patients

begin to advocate for themselves, following Bohm's understanding of discussion where communication is used to promote one's beliefs. In the care model of consumerism, both doctors and patients discuss their beliefs and work together to develop a model of care for both parties. Typically, the patient still relies upon the doctor's knowledge, but possesses more power than in a model of paternalism. Like a business transaction, the doctor operates as seller who must sell a product to an educated buyer who has the resources to seek business elsewhere if necessary.

As it relates to this study's sample, no school teaching care as discussion or focuses on encouraging a consumerist model.

### **Care as Dialogue**

The final care model of mutuality reflects the phenomenological tradition of communication as dialogue. In this model of care, the relationship between the doctor and patient is the most symmetrical because goals, decisions, and agendas are created by both the doctor and the patient reflecting the presences of a common ground. In this care model, both parties have to acknowledge their role in influencing and participating with in interaction, reflecting characteristics of dialogue including collective assumptions, shared meaning, participatory exchange, and mediation. With a phenomenological view of communication, people are treated as people (I-Thou) and understand that it is "important to acknowledge and respect differences . . . learn from others, to seek common ground, and to avoid polarization and strategic dishonesty in human relations" (Craig, 1999, p. 139).

As it relates to medical education programs, Harvard reflects a dialogic perspective with its use of the Kalamazoo Model in medical interviewing. This model

constructs the physician/patient relationship as a partnership which abandons the construction of doctors as information seekers. It strays from consumerism and the sociopsychological tradition by suggesting that both communicative parties are influential in interaction, rather than one person attempting to be more influential than another. When people interact as partners, the relationship becomes more symmetrical and participative decision-making is easier to accomplish.

Like Harvard, UCSF also constructs care as dialogue but does so through different methods. Rather than relying on a dialogic model, UCSF's understanding of care as dialogue is seen through their narrative writing workshop. As stated previously, UCSF hosts their narrative workshop in effort to heighten each student's personal awareness of culture, sexuality, death, dying, and why they wanted to be a doctor. The program believes that increasing self awareness will aid in connecting with patients by recognizing that each person has a diversity of perspectives, beliefs, and understanding about their self and their health. Developing empathy follows the dialogic perspective that understanding others leads to more egalitarian relationships. Therefore, UCSF's pedagogical method constructs care as dialogue because it moves past the differences that exist between people in favor of using such differences to connect in new ways. In this view, differences cease to divide and instead bring people together.

It is clear through these discussions, that communication and care are closely connected. The ways communication is discursively constructed influences how material practices of care unfold in clinical interaction. Research shows that discourse serves a formative function that "creates, sustains, and transforms" (Fairhurst & Putnam, 2004, p. 13) organizing processes. As an organizing site of care and communication, as well as

medicine, the medical school provides a space where alternative understandings of care and communication can be discursively performed, transforming clinical interaction. Therefore, changing the ways communication is taught and understood can potentially change the models of care that come to be employed in the clinic.

The history of the medical school itself reflects the many ways that the organization has discursively changed over the years. Yet, even with such changes it appears that some processes remain the same. For example, Foucault details the role of the medical school in eighteenth century suggesting that patient subjectivity is constituted by and through questions about his/her illness and the information provided about the illness. Based on this knowledge, the patient is subjected to a particular gaze of the doctor to create a plan of action to restore health. While Foucault described this process years ago, it can still be seen in pedagogical practices at medical schools today. Every program interviewed discusses history taking as a primary skill taught in medical education. When learning this skill, students are provided questions to ask to elicit the necessary information for diagnosis. In Indiana's program for example, the student has a list of questions to ask and patients provide answers for each. Iowa's emphasis on the importance of open-ended questions begins to alter this process slightly as a doctor's questions are not targeting specific information from patients, but rather seek more general understandings of the patient's state of health. While programs like UCSF teaches students how to ask questions, rather than which questions to ask, it still positions the doctor as the primary information seeker and the patient as the information giver. Thus, it could be suggested that every school focuses on what the student needs to do in clinical interaction, ignoring the patient's needs and influence.

Given this construction of ‘doctor’, ‘patient’, ‘illness’, and ‘interaction’, it is difficult to change the way communication is understood and practiced if the doctor or medical student is repeatedly positioned as having more knowledge and power in clinical interaction. However, if conceptualizations of communication fail to be altered, changing the ways that care is performed and constructed is also limited. Therefore, if the process of constituting patients is to change, the focus and structure of medical education must change also. To understand how changes might materialize, the following section proposes a new program of medical education that accounts for all stakeholders, considers previous research, intersects both care and communication, acknowledges the long history of the medical school, and ultimately redesigns clinical communication for the future of medicine.

### **Educating a Future of Care-ing Doctors**

Before outlining a future curriculum, it is important to construct a model that would be recognized and legitimized by the Liaison Committee for Medical Education (LCME) to ensure that it is recognized as legitimate and innovative by the medical community. LCME guidelines, combined with the intersections of communication and care, reveal aspects of each program that should be included in a future curriculum. As it relates to the academic environment, the LCME (2010) says students should learn in a clinical environment that permits interaction with students in other health professions in a way that fosters intellectual challenge. Learning should occur actively and independently in order to develop lifelong learning skills which include “assessment on learning needs; the independent identification, analysis, and synthesis of relevant

information; and the appraisal of the credibility of information sources” (“Functions and structure,” 2010).

Besides the learning environment, students should also have ongoing assessments with regard to problem solving, clinical reasoning, decision making, and communication skills which include physician responsibility, communication with patients, families, colleagues, and other health professionals. These assessments must be provided in enough time to address necessary remediation procedures for struggling students and address content requirements for programs. Finally, the LCME says that all programs must teach basic science courses, critical judgment, biomedical sciences, cover all organ systems, and aspects of preventative care. This content should be taught in the classroom, as well as the laboratory in order to provide multidisciplinary opportunities that relate to every life cycle of the human body.

With LCME requirements in mind, I would like to propose a new curriculum based on the findings of my study and the current literature about doctor/patient relationships. As it relates to care, this study uncovered several themes which suggest care needs to be practiced in a diversity of contexts and opportunities, happens in authentic interactions, and is constituted in communicative practices. Therefore, my new program will be guided and influenced by these conclusions.

### **The Future of Evaluating Care-ing Practices**

**Iowa.** Evaluation procedures at Iowa are both unique and helpful in creating a new program. By understanding what is important to students, the educator is able to make changes to better meet students’ needs. Also, when evaluations come from students who have been working in the field with real patients, their feedback helps

educators identify gaps in their learning that inhibit them from fully being able to provide care. Additionally, evaluations can reveal how students understand both care and communication which can help equip them with or improve skills that assist in interacting with many different types of patients.

Another important role of evaluations in Iowa's program can be seen through their use of the Calgary Cambridge Model, which provides a guide to the medical interview. This model suggests that doctors must provide structure and build a relationship with their patient as they conduct the medical interview. The interview is composed of a series of steps which include initiating the session, gathering information, the physical exam, explanation and planning, and closing the session. In each of these steps, the model accounts for both the patient and biomedical perspectives of the presented problem, while encouraging the patient to participate in the process (Kurtz, Silverman, Benson, & Draper, 2003).

Iowa uses this model "not just for teaching, but also for assessment, so every time students get feedback from a standardized patient they are using the components of that model to look at it and take the skills that are laid on in that model and go, 'Oh, did I use screening?'" Using the model as a standardizing tool provides "consistency in both teaching and assessing skills" which is one area that has "been lacking" in medical education as a whole. With that said, the educator hopes to continue using the model to provide more timely feedback to students. Currently, a student will have "a standardized patient encounter and get feedback on how to improve and then not have another one for a month." Instead, the educator would "love if [students] could try it again right away to include those things" they were given feedback about. This would meet the LCME

objective that says evaluations must be given in a timely manner to help meet the needs of struggling learners.

*Contributions to a future evaluative measures.* Based on these evaluative practices and use of the Calgary Cambridge Model, a measure for a new curriculum would be to provide ways that students can openly discuss how the program is or is not meeting their needs as they interact with patients, both real and standardized. Ideally, this feedback would follow an overarching model which would provide consistency in both curriculum development and future amendments. Essentially, the model when used correctly not only provides consistency in teaching and evaluation, but also in the language used by both students and educators. When students provide feedback, it should be reviewed annually and adjustments should be made to ensure all students' needs are being met.

**Indiana.** Both the competency based curriculum and use of the OSCE at Indiana are important in that they provide standards for students with regard to mastering particular skills. Also, methods like the OSCE serve as measure of evaluating Indiana's program as a whole to determine if it is meeting its goals and objectives in equipping students with skills deemed important and necessary for being a doctor. In addition, evaluating competencies help the program gauge how well they are doing in helping students master the eight things they believe every competent doctor should be able to do. Making evaluative measure more rigorous fulfills the LCME requirement, which states evaluations "must be stated in outcome-based terms that allow assessment of student progress in developing the competencies that the profession and the public expect of a physician" ("Functions and structure," 2010).

*Contributions to a future evaluative measures.* When comparing Iowa and Indiana's curriculum, it appears that their primary teaching tenets can be melded together when looking to the future. Rather than simply outlining competencies, a model like Calgary-Cambridge can outline the specific skills students need to be proficient in. Using a model to guide competencies would still allow for them to be measured, providing further consistency in evaluative measures.

**University of California San Francisco.** The standardized exam required by the state of California is unique to UCSF's program and provides an additional checkpoint to ensure that not only San Francisco, but all medical schools in California are meeting teaching objectives. Further, it serves as a practice exam for the boards, which all medical students are required to take. By evaluating students prior to the board, students have the opportunity to perfect skills to ensure they are achieving at least minimal levels of proficiency.

In addition to ensuring that UCSF's program is meeting its objectives and goals, the program is again similar to Indiana in their use of an OSCE. In the past, this exam was not taken seriously at UCSF and students were not expected to be able to complete the exam absent resources and materials to guide them. More recently, the school has found this exam to be very important, as it is a primary place that students are able to provide care on their own in a safe environment that allows for learning and growth under the watchful eye of instructors. To reinforce its seriousness, the OSCE is now given "off book" and "at the end of the first year [there is] a mini-OSCE and a larger one at the end of the second year and those also have to do without notes and [the educator] is doing actual assessment as opposed to being kind of easy on [students]." Giving multiple

assessment that require students to rely upon their skills and knowledge meets the LCME's evaluative requirement that says, "A medical education program must include ongoing assessment activities that ensure that medical students have acquired and can demonstrate on direct observation the core clinical skills, behaviors, and attitudes that have been specified in the program's educational objectives" ("Functions and structures," 2010).

By changing the way the OSCE is evaluated, UCSF has seen changes in other evaluations simultaneously. More specifically, the educator "has noticed that over the years the rating of the course has risen dramatically" and attributes the reason for this change to the fact that it is "expected students learn [material] and come prepared." In short, the program is now "actually doing assessments." Making these changes in evaluative procedures has proved important because they authenticate clinical experience in a way that makes feedback most salient, which the LCME requires. Also, like Indiana, UCSF is hoping to include more "competency assessments" as "that's the direction the school is moving into." Previous evaluative techniques speak to the importance of this change because they show that students are more successful when they are clear on what is being evaluated. Further, in making the OSCE setting more authentic it constructs care as an action that can be performed in safe place where feedback can be provided.

*Contributions to a future evaluative measures.* UCSF's program contributes the importance of exams that simulate authentic interaction as closely as possible. Providing exams creates a standard of measurement to assess students' skills and provide resources when necessary to ensure all students test proficient in areas related to doctor/patient interaction. Using competencies outlined by a guiding model as seen with Iowa and

Indiana, would further outline a standard of measurement for consistently evaluating students. Exams like the OSCE and CPX provide an opportunity for both students and educators to assess how the program is doing in meeting students' needs and preparing them to become licensed doctors. With opportunities to provide feedback, exams and student input would allow each program to make adjustments as needed in order to best educate students as it relates to clinical skills.

**University of Colorado.** The educator at Colorado would like to change what the program does “with recalcitrant learners . . . to give them feedback” as “gaps” exist in the current program. The educator noted that one “wonders how people who don't do well in [clinical skills] do in their professional lives,” yet there are no measures in place to gauge what particular things students struggle with. This statement illustrates that a lack of proficiency in clinical skills impedes a doctor's professional life in providing care to patients. Further, it fails to meet the LCME's requirement for timely feedback which might address the very struggle Colorado is currently experiencing.

*Contributions to a future evaluative measures.* Examining Colorado's curriculum reinforces the previous discussion regarding the importance of implementing a guiding model to outline both competencies and evaluative measures in a program. Doing this would allow Colorado's educator the means to address the needs of ‘recalcitrant learners’ as well as a way to provide consistent feedback to close gaps present in student proficiency. The problems raised by Harvard's educator speak to the shortfalls that arise when programs lack the consistency provided by these tools.

**Harvard.** Harvard's educator suggests that “there is an unspoken sense out there that communication skills you are taught in medical school and then you are fine.”

The LCME requires programs to equip students with skills that would allow them to become lifelong learners, which illustrates the danger in the perceived terminal nature of clinical skills programs. By establishing programs in residency and requiring both surveys and videotapes as evaluative measures, the educator is able to provide evidence for the belief that “communication must be continued beyond medical school and the perfect place to do that is residency.” because as qualified medical doctors, and thus care providers, residents are responsible for providing care to patients, even if it is supervised.

*Contributions to a future evaluative measures.* Again, Harvard’s program further illustrates the need for consistency in both teaching and evaluative practices. In addition, this program suggests that these curriculum changes need to extend beyond medical school and into residency as the commonly held assumption that two years of clinical skills training is sufficient appears false. Following a model and creating a standard for teaching and evaluation would make the incorporation of clinical skills into residency easier given that consistency is built into such practices. By adopting methods that coincide with evaluative measures, educators can begin to use these materials in way that fits their teaching style, while still providing an environment necessary for students to learn and practice clinical skills. Therefore, teaching models and evaluative measures must cease to be confined in medical school and must instead extend into residency to aid future doctors with learning the skills necessary to communicate with patients and both build and foster therapeutic relationships.

### **Summary**

After evaluating each program that participated in this study it appears that the following criteria can improve clinical skills education while also adhering more closely

to LCME guidelines for accreditation. First, adopting a guiding model will help outline the necessary competencies students must learn. Second, evaluative procedures that follow the chosen model will help students by providing consistency between teaching and practice. Third, a guiding model will create better understanding between educators and students by providing a common language with which to talk about clinical skills. For example, if an educator wants to assess how a student begins a medical interview, a model like Calgary-Cambridge labels this as “Initiating the Session” and outlines all pertinent skills in doing so. As a result, the student is clear on what skills he or she will be evaluated on, as well as what skills are necessary in each part of the interview. Lastly, adopting a model that outlines necessary competencies and evaluative procedures should be adopted in both medical schools and residency programs as the LCME states that students should be taught how to become lifelong learners. Teaching clinical skills in a terminal fashion fails to meet this objective and does not provide the resources necessary for students to maintain proficiency with regard to interacting with patients.

### **The Future of Care-ing Pedagogical Methods**

One area where every program falls short according to LCME standards is in regard to communication skills. The LCME says that programs must include specific instruction in communication skills as they relate to physician responsibilities, including communication with patients and their families, colleagues, and other health professionals” (“Functions and structure,” 2010). No program offers opportunities to communicate with patient families, and only few instruct on interprofessional communication. Therefore, as part of a new medical education curriculum, these components need to be added.

Making this first change reiterates that care and its instruction need to occur in an authentic experience. In the future, students should have the opportunity to interact with a standardized patient, alongside their “family”. Not only would this aid in developing communication skills, but could also teach students about issues regarding confidentiality and patient rights. Once students have learned basic skills, I would propose that they be provided opportunities to then work with real patients, including their families to ensure authenticity in clinical skills instruction.

As it relates to colleagues, Indiana provides a model that can assist with this objective while also addressing LCME requirements that not only call for interprofessional communication, but also a learning environment that permits interaction with other graduate students, professional degree programs, and physicians. Their Clinical Skills Center simulates authentic experiences, which allows practice with patient hand-offs and specialty programs. For example, a student can work with a patient over a medication error, which requires the student to call a pharmacy student who is standing outside the room. Together, both students can work through a problem together while also practicing professionalism.

As it relates to authentic interaction, rounds with preceptors are another great place to develop and foster communication skills with colleagues. Students should have the opportunity to relay information to other professionals as it relates to a patient. For example, when doing rounds a doctor might prescribe a course of treatment that needs to be communicated to the nursing staff at the hospital. After monitoring the interaction, the student should be given the opportunity to speak to the nursing staff about this plan. The student should be given the opportunity to answer questions posed by the staff, again

under the watchful eye of a supervisor. This authentic interaction could provide students the ability to receive feedback about interacting with other staff, while also helping them understand the organizing discourse of medicine. Also, these practice opportunities could also help students develop relationships that offer a more supportive environment as they prepare to start residencies. If they begin to meet and know staff at a hospital, it could help make the transition go a little smoother as they continue their medical education journey.

With each of these changes, it appears that a support network also needs to be created to ensure that physicians have a place to go to debrief about the challenges they are facing in the clinic. A large contributing factor to patient dissatisfaction is a result of the many demands doctors face each and every day. These include but are not limited to working long hours, too many cases, short staff, interprofessional conflict, and the lingering fear of medical malpractice. These challenges have material consequences for the way doctors engage with patients and can in fact inhibit or interfere with relationship building. To combat this, I propose that a new curriculum establish groups across the countries that provide a place for doctors to come together and learn from one another. These need to be geographically plentiful so as not to create further stress, and could even be conducted via video technology such Skype. Also, I would suggest that doctors be required to attend these sessions as part of their licensing requirements to ensure that they are reaping the benefit that would come from stepping away from the clinic and into a supportive environment that has the potential to equip doctors with skills that would improve their future clinical interactions. Much like remediation programs in medical

school, this support group would provide a safety net to address issues before patients receive the brunt of the increasing demands on doctors.

In summary, care needs to be practiced in a variety of contexts that provide authentic interaction. While standardized patients are not the purest form of authenticity, interactions with them help to develop a foundation to develop important skills. When combined with real patient interaction, standardized encounters help increase practice opportunities while also recognizing the organizational constraint of time in medicine. Having students interact with real patients in rounds is more time consuming than having them simply watch. Therefore, a balance between standardized and real encounters can offer more practice and a greater variety of cases and contexts.

Not only do contexts need diversity, interactions must be diverse as well. Health is complex and only educating students how to talk with patients does a disservice to them as patients are only one of many people doctors will have to communicate with in one particular case. As models of consumerism and mutuality become more prevalent, doctors must be trained to be adaptable as patients, their spouses, their parents, and their children can now come to a clinical interaction with knowledge and expertise on how to proceed with an illness. Therefore, teaching skills is still important but teaching technique is more so. Rather than giving students a list of questions to ask, students need to learn how to ask questions that both elicit information and meet patient needs.

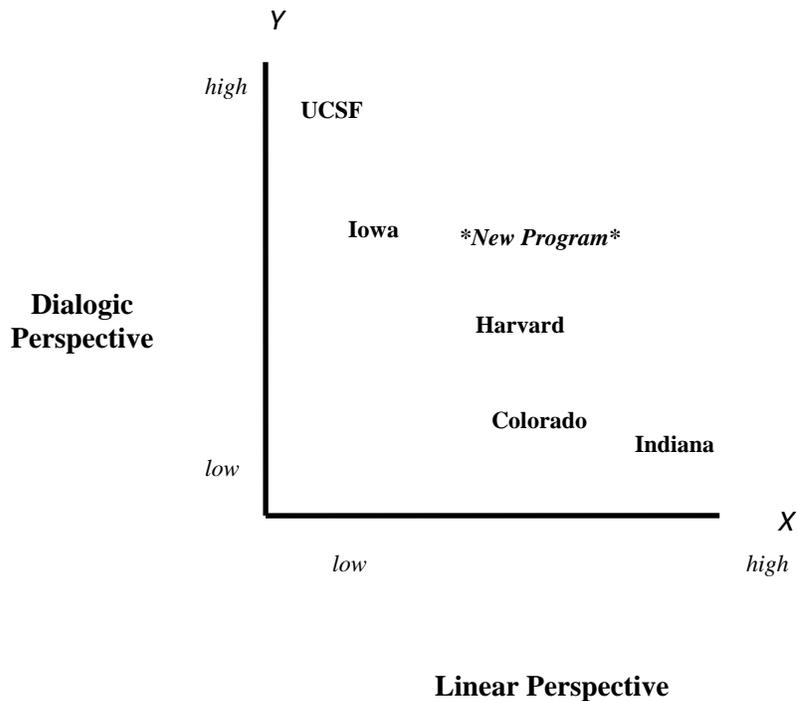
The LCME requirement regarding the need to teach all organ systems and include clinical experience with all life cycles is helpful as it relates to teaching technique over skill. Providing the opportunity to engage in clinical encounters across life cycles is an opportune way to provide students a diversity of contexts. In addition, this objective fails

to hold the patient constant, but instead illuminate the diversity of the human experience. For example, in pediatric care the patient is a child who most likely has other parties speaking on behalf of him or her. A middle-aged patient might be more likely to speak on behalf of him or herself as it relates to illness, but might also have a partner or child whom he or she wishes to discuss a plan of action with. An elderly patient might seek the advice of the doctor whom he or she has known for decades with little to no input from anyone.

While these are merely examples, they illustrate that no list of questions can be used in every encounter to meet the same objective. Instead, students must know how to ask what questions and to whom. Authentic experiences across lifecycles can begin to afford these opportunities. Having a question bank is important, but relying upon the same list does a disservice to patients, their families, and the enterprise of care itself. As the future of medical education unfolds, students need an increase in diverse opportunities that span the life cycle so they can begin to see patients as people whose understandings of health are influenced by a multitude of sources.

**Evaluative and pedagogical contributions to a future curriculum.** When combined with recommendations from the previous section, students must be provided a diversity of contexts that offer authentic interactions with patients that can be evaluated. While practice alone is important, being evaluated provides opportunities for students to learn how to perform skills in new ways, as well as the contexts in which certain skills work best. By offering a variety of contexts for students to learn within and offering standards of measure to evaluate their interactions, students will be better equipped to fulfill their roles as doctors once licensed. Also, a multitude of contexts provides

students the ability to fix mistakes early on in a safe environment where resources are more plentiful. To explain this visually, the communication model map would like this if the my proposed program were added:



Making these changes would embrace both linear and dialogic perspectives of communication, recognizing that either view can be effective depending on the circumstance. Essentially, a future curriculum that uses a guiding model to outline competencies and evaluative measures, while increasing the contexts and number of practice opportunities students have to employ their skills, will work together to construct a more solid foundation upon which each students' future as doctor will be built.

### **The Future of Care-ing Communicative Practices.**

In addition to authenticity and variety, care is constituted in the way students are taught about communication and how they communicate. Increasing both diversity and authenticity will help with communication, but in these experiences it appears that

remediation programs need to be developed more fully. UCSF is the only program that has a comprehensive approach to assist struggling students as it relates to clinical skills. Every program spoke to the importance of proficiency in these skills, the fact that communication is not innate, and that learning communication is an ongoing process. With these beliefs, the material construction of medical education programs fails to acknowledge these complexities. Students will struggle, so therefore they needed to be provided with the resources they need to succeed whether it be more practice, more observation, or one-on-one time with educators. Further, students need to have the opportunity to assess themselves and be assessed as stated by LCME requirements. Harvard's videotape evaluation process can be used as a model as students know what they will be evaluated on prior to an interaction and evaluate themselves in the same way they are evaluated. This combined with UCSF's remediation program would be very beneficial as evaluations would be standard for all students with a program in place to offer students the support and help they need to master communication skills.

An established remediation program combined with an increase of contexts in which to practice could greatly help medical education programs and the enterprise of care itself. Students should be evaluated in real patient interaction, as well as standardized encounters to help achieve proficiency in many contexts. Interacting with a standardized patient presenting with symptoms of a bladder infection is going to require a different skill set than treating a toddler presenting with symptoms of strep throat. Evaluating one encounter a year assumes proficiency in one case constitutes proficiency in another. This assumption does nothing but create a slippery slope that denies students the learning environment they need to excel. Medical schools need to develop lifelong

learning skills. Evaluating one experience that assumes proficiency does anything but that.

### **Limitations and Future Directions**

While this study reveals important findings related to communication and care and suggests ideas for the future of medical education, it does fall short in some areas that must be addressed which include sampling, representation, methods, and the characteristics of interviewees. Each of these factors will be discussed and improvements for future research will then be suggested.

As it relates to sampling, this study offers only a small glimpse of clinical skills programs in the United States. With only five schools it is hard to generalize medical education as a whole. Even still, the data found in this study is still useful in explaining how programs construct both care and communication by and through their programs.

Also related to sampling is the idea of representation. This was proved to be a limitation of this study because each school was represented through the voice of one educator. As a result, this study is unable to account for variables that would influence an educator's perception of the program such as dissatisfaction, length of employment, or role in the program which could have influenced the way they described their respective programs as they did. Because only one person was interviewed, data may be more reflective of the educator, rather than the program as a whole. In the future, it would be helpful to interview multiple educators at each institution to ensure consistency and reliability of data. Doing so would allow the program as a whole to be reflected in the data, and not just educators' views and opinions.

Third, this study could be enriched through further inquiry of interviewee characteristics by furthering the methods used in this study. While qualitative interviewing was useful in uncovering the interviewee's conceptualizations of communication and care, combining this method with participant observation could enrich the data further by comparing how educators talk about their instruction with what they actually do in the classroom. Further, observation could reveal more about pedagogical methods by providing a way to witness how an educator's goals are communicated and modeled by students. As it relates to interviewing, questioning educators about their educational background would help understand more variables that influence the intersection of communication and care. Additionally, combined with participant observation, a researcher could examine how medical educators are not only influenced by their own background, but also how they model the very skills they seek to teach. These dimensions would help provide further answers to the questions set forth by this study, and would also reveal how a multitude of variable influence both learning and pedagogy.

While this study provides a plentiful amount of data concerning medical education, care, communication, and curriculum there are clearly many avenues that can still be explored. Despite the limitations that do exist, the future of a care-ing medical education curriculum must recognize that care is constituted by and through communication in a variety of contexts that foster authentic interaction. The curriculum must favor technique over skill, offer resources students need to excel, provide feedback in a timely manner, and encourage lifelong learning. To provide and achieve each of things would make students more adaptable in their approach and more equipped to

address the fast-paced field of medicine. As Iowa's 20/20 program (2010) says, "Medical knowledge is doubling every three years currently and projected to be doubling every 73 days by 2020" ("20/20 vision"). With such drastic changes, medical education must adapt just as quickly if students are to be prepared to be competent doctors in the changing field of medicine. With limited resources including time and money, the intersections of care and communication illustrate the first place to bring about great change.

## **Chapter 6: Conclusions**

It is hard to watch or read the news today without hearing about health care issues or needs to change. Doctors are forced to take on more cases, nurses are overworked and underpaid, and patients often feel as though their conditions are overlooked or brushed over. To improve these realities for those who engage in and use the health care system, the biggest concern that accompanies such proposals is cost. This project recognized these concerns while understanding the importance of a quality healthcare system that serves all interested parties. It also sought to explore a potential avenue that could help alter the way care is administered in clinical interaction absent the high cost that accompanies insurance reform, specialization, and retraining current doctors. This study is future oriented in that it posits how factors can be changed now to create future results. By examining how medical education influences the way doctors practice medicine, this project investigated how these variables are related and influence one another.

When this study began, sampling became the first challenge which reflected the high demands on medical educators. From a sample of three, I was able to find two more contacts to create the sample of five schools used in this study. After coding the first three schools, clear categories emerged which were then used when coding the proceeding two interview transcripts. The data within each category began to construct answers to the research questions posed by this study. First, how do medical schools in the United States construct understandings of care through their clinical skills/medical

education programs? Second, how is communication conceptualized and developed in clinical skills/medical education programs at medical schools in the United States?

In response to the first research question, interviewees were explicit in explaining how their program understands, teaches, and defines communication. Additionally, examining the methods used to teach particular skills further explained each school's perspective on communication and its importance. To understand how the schools relate to one another regarding their understanding of communication, the communication model map provided a visual representation of how the program at each school aligns with both linear and dialogic perspectives of communication. The map is not intended to put programs up against each other, but rather summarizes the perspectives and definitions of communication as they are understood by each program. In answering the first research question, it became clear that the way communication is taught does indeed have material consequences for the way clinical interactions unfold. The map then helps explain how definitions and conceptualizations of communication influence the way medicine is practiced after medical school concludes.

So, how do schools understand and conceptualize communication? The data reveals that programs are more dialogic in their teaching and instruction of communication when the concept is understood through the lens of communication studies rather than medicine. For example, UCSF was the most dialogic in their program and the way communication is understood is taught through the American Academy of Communication in Healthcare (AACH). This organization is interdisciplinary and overseen by a board of medical doctors as well as PhD's in communication. On the other hand, Indiana adheres more closely with a linear perspective of communication and their

program is coordinated by a medical doctor. Therefore, this sample suggests that as communication is taught and understood from a social science perspective, understandings and constructions of the concept are more dialogic than linear.

Besides categorizing understandings of communication, the communication model map also supports the idea that linear and dialogic perspectives are not in opposition to one another, but instead reflect the need to teach students how to be both flexible and adaptable to meet patient needs. There are medical scenarios that simply do not allow for dialogue, such as a major trauma case. In this instance, a doctor needs to use a linear view of communication to dictate instructions on how to provide care to ensure that patients are well taken care of. To take the time to discover patients wants, needs, and desires would be impossible and would actually impede care. On the contrary, there are other instances where patients and doctors can and should collaborate to make care decisions. For example, if a patient is stable, coherent, and has a condition where time is not a huge factor in how to provide care, doctors and patients can work together as partners in developing a plan action to get well. This can happen in more chronic conditions where doctors may or may not understand the everyday situation of how a condition influences the life of the patient and families. Therefore, the map shows how each interviewed program understands communication and there conceptualizations begin to inform students on how to engage in clinical interaction. By understanding the roots of instruction, it become easier to uncover how and why clinical interactions unfold as they do.

While answers to the first research questions were explicitly present in the data, attempting to understand how care is constructed and understood was more implicit.

Interviewees did not talk specifically about care, even when prompted with interview questions. Therefore, I looked at how clinical skills program fit within a larger curriculum of medical education in order to understand what educators hoped students take away from their clinical skills courses. By examining the way students learn and how they are evaluated, I was then able to understand the way care is understood in medical education.

The interview data revealed three conclusions that were supported by each program. First, care happens in a diversity of contexts. Second, care happens in authentic interactions. Third, care is constituted in communication practices. These conclusions not only reveal how care is understood, but also suggest how and why particular changes can be made to ensure students are equipped and have the support they need once they are licensed doctors. Essentially, understanding how care is constructed and how it relates to communication began to reveal how the concepts intersect with one another and influence the material practices of medicine.

After providing answers to the questions posed by this study, I followed a dialogic position by making suggestions for how medical education might be changed in the future. I used LCME guidelines to inform my curriculum design, recognizing the importance of being an accredited medical institution. These guidelines also support my suggestions for change and help outline new skills and methods of teaching. Essentially, my new program would fall on in the middle of the communication model map and embrace linear and dialogic perspectives equally, allowing students to be flexible and adaptable in employing models of care necessary for each patient they see.

In order to begin this curriculum reform, a planning committee would come together that would involve as many stakeholders as possible. This would include educators, medical students, patients, communication scholars, and current health professionals. The curriculum would be created in a way that would provide more practice opportunities, both with real and standardized patients. Additionally, students would gain experience with patient handoff, interdisciplinary work with students in other specialties, and oral and written presentations. Within these opportunities students would have time to reflect on their cultural, spiritual, and personal variable that influence the way they engage with others, as well as how patients' factors influence interaction as well. Standardized interactions would be more diverse, offering students a chance to speak with patient families, and get exposure to as much diversity in patients and their illnesses as possible. These methods would be used with the hope they would better equip students with adaptability and flexibility as it relates to employing care models in interaction. With an increase and practice and exposure, students will have had more time to prepare and make necessary adjustments before they begin working on their own as doctors.

While this study's sample is small, it does begin to make suggestions regarding the importance of teaching communication in medical education programs. Further, it illustrates how understandings of communication influence the way care is constructed and performed in medical school and beyond. This study shows how interviewing methods can reveal important factors, but also suggests that methods like participant observation in combination with interviewing can provide an even richer dataset.

Theoretically, this study supports the importance of communication theory and its ability to inform other disciplines such as health. By tracing the history of communication models, literature related to communication theory helped understand how and communication and care intersect as they do. Additionally, this project supports the work of poststructuralists like Foucault, who argue the importance of the language and its connection to social reality. Understanding the ways we explain the world reveals how we understand it. This is true in medical school as well. Examining how clinical skills are taught and discussed influences how clinical interactions unfold.

Pragmatically, this study takes a small step toward proposing the ways that medical education curriculum can be changed in future. The intersection of care and communication is one place to start, but not the only place that could use revision. Combining this study with others that focus on the multitude of demands that are present in medical school and the field of medicine itself could help bring about a more comprehensive curriculum reform that extends beyond clinical skills. The LCME helps outline the ways we can change pedagogical methods and classroom experiences, but that is just the first step toward providing the necessary resources to educate the doctors of tomorrow.

Ultimately, this study begins to provide answers regarding not only care and communication, but the role of medical education and doctors themselves. By intersecting communication models with models of care, historical conceptualizations of paternalistic doctors and passive patients are challenged. As a result, the fields medicine and medical education must respond to these changing times if students are to be adequately equipped with the skills necessary to provide care and communicate with

patients. By examining the initial location where such skills are taught and learned, it appears that small changes can begin to make big differences. If we are to remain at the forefront of medical advancement and technology, the importance of clinical education must be recognized beyond the ‘touchy feely stuff’ in order to improve how healthcare is delivered and administered.

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## Appendix I

Dear \_\_\_\_\_,

I hope this note finds you well. I am on the graduate committee of Elise Clement MS in Health Communication. Elise is working on a project related to how medical schools are teaching physician-patient communication.

She is looking to:

1. Recruit 10 medical schools
2. Interview a key medical communication educator
3. Obtain the syllabi for the medical communication coursework

The end result of her project will be to make recommendations on how to move teaching communication forward in the medical curricula.

I am hoping that you would be willing to participate or recommend a colleague that might be a better fit. We would be most grateful for your time, efforts and most of all expertise.

Thank you,

## Appendix II

### **Consent to Participate in a Research Study Colorado State University**

**TITLE OF STUDY:** Communicating Care in Medical Education

**PRINCIPAL INVESTIGATOR:** Kirsten Broadfoot (Kirsten.broadfoot@colostate.edu)

**CO-PRINCIPAL INVESTIGATOR:** Elise Clement (elise.clement@colostate.edu)

**WHY AM I BEING INVITED TO TAKE PART IN THIS RESEARCH?** You have been asked to participate in this study because you teach clinical skills at a University based medical school.

**WHO IS DOING THE STUDY?** Elise Clement, a Master's Student at Colorado State University, is conducting this study under the direction of Dr. Kirsten Broadfoot, a communication professor at Colorado State University.

**WHAT IS THE PURPOSE OF THIS STUDY?** The purpose of this study is to understand how communication is conceptualized in clinical skills programs in medical schools. This study also seeks to understand how models of communication influence models of care that are favored in clinical interaction.

**WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?** This study will take place across medical schools in the US and will involve a one hour telephone interview with faculty in clinical skills programs.

**WHAT WILL I BE ASKED TO DO?** You will be asked to participate in a telephone interview based on a series of interview questions that relate to your job as an instructor, as well as your school's clinical skills program as a whole. The questions will be open-ended to allow you to respond in whatever way you choose.

**ARE THERE REASONS WHY I SHOULD NOT TAKE PART IN THIS STUDY?** There are no foreseeable reasons why you should not take part in this study besides time constraints.

**WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?** It is not possible to identify all potential risks in research procedures, but the researcher(s) have taken reasonable safeguards to minimize any known and potential, but unknown, risks.

**ARE THERE ANY BENEFITS FROM TAKING PART IN THIS STUDY?** The benefit of taking part in this study is to become aware of how clinical skills programs can be improved in the future. The information provided to the research team will be analyzed and suggestions will be made based on findings.

**DO I HAVE TO TAKE PART IN THE STUDY?** Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.



## Appendix C

1. Can you tell me a little about yourself – your education, how you got to be in your position, what your position entails, etc?
2. How do you participate in clinical skills training in your medical school?

### Program Questions:

1. What do you believe to be the role of clinical skills training in contemporary medical education?
2. What kind of communication training do you provide and why?
3. What are the foundational principles (models of care) for the communication curriculum?
4. How is communication training designed and implemented in your program?
5. What texts do you require students to read as a part of this program?
6. Can you describe the text selection process at your institution?
7. What are your pedagogical objectives as someone who is involved in the clinical skills training program?
8. What do you want students to learn as a result of participating in the program?
9. How have these objectives influenced your choice of pedagogical methods in your program?
10. What do think medical students want to learn (student's communication objectives) in their clinical skills program?
11. What communication challenges do students face in clinical interaction?
12. Can you describe how this course and its impact on medical students have changed over the last ten years?

13. If you could change the way the course is taught and experienced now what would you do? Why?
14. Is there anything else you would like to add?



