

Teaching Communicative Competence in Health
Sciences Education: An Analysis of Medical Students'
first Biopsychosocial Interview in a Clinical Setting.

By: Natalie Moller (MLLNAT009)

Supervised by: Associate Prof E Van Pletzen

and

Dr G Gunston

A Dissertation submitted in fulfilment of the requirement for the
degree: M Phil (HES)

Faculty of Humanities

University of Cape Town

December 2016

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

Plagiarism Declaration

“This thesis/dissertation has been submitted to the Turnitin module (or equivalent similarity and originality checking software) and I confirm that my supervisor has seen my report and any concerns revealed by such have been resolved with my supervisor.”

Name: Natalie Moller

Student number: mlInat009

Signature:

Signature removed

Date:

5/08/2016

Acknowledgment

I have learnt that writing can be a lonely and sometimes seemingly endless task made possible solely by those who push, support and encourage one to keep going.

I would like to thank my two wonderful supervisors, Associate Prof Ermien Van Pletzen and Dr Geney Gunston for their continued patience, support, encouragement and belief that I could complete this dissertation. Their guidance has both humbled and inspired me and I feel really privileged to have worked so closely with these two amazing women. Thank you both. I shall always treasure the laughter if not the corrections.

To my students who so generously allowed me to document a small part of their journey towards becoming caring doctors. Your contribution will make me a better teacher and will guide those who follow you. Thank you!

I also need to thank Douglas Sias for the many private lessons in 'handling a computer' and being so willing to help with the 'technology' challenges in preparing this dissertation. I really have learnt so much and thank him for his patience when I needed to write down every last 'click here' or 'change this'. Thank you Douglas!

To my extended family, (Helen in particular), and friends. Thank you for making me 'just finish it' even when times got really bad. Your support never waived and I really needed that. Thank you!

Finally to Ian, Sam and Mike: my undying love always. You are my foundation and inspiration. I love you guys. It is finally complete and normal life returns.

Table of Contents

Acknowledgments.....	iii
Table of Contents.....	iv
Table of Figures, Text boxes, Screen Prints and Tables.....	vi
Abstract.....	vii
Chapter 1.....	1
Introduction	1
Context of study.....	2
Pedagogical Approach	3
The impact of student diversity on teaching communicative competence	3
Research question, aims and objectives.....	4
Chapter 2.....	6
Literature Review and Theoretical Framework	6
Understanding the Biomedical approach	6
The development of the medical curriculum in South Africa following biomedical British models ..	7
A change in thinking towards the biopsychosocial model	7
Communication as key to Patient-centred Care.....	8
Teaching Communicative Competence	10
Theories and tools for analysing communicative competence in the medical interview	12
The first medical interview as part of Medical Discourse.....	12
The first medical interview as socially determined relationship and the role of power	13
The first medical interview and interaction order.....	13
Biopsychosocial aspects of the interview process.....	14
Chapter 3.....	18
Methodology.....	18
Introduction	18
Study Design	18
Study population and sampling	18
Data collection	19
Data Analysis.....	20

Ethical Considerations	22
Chapter 4.....	23
Results.....	23
Establishing Professional Credibility	24
Building rapport	25
Achieving Inclusivity: Questioning for information or questioning to hear the patient	30
<i>Impact of open ended / closed questions</i>	31
<i>Impact of closed question signalling confirmation</i>	31
<i>Impact of questions related to biomedical or biopsychosocial information</i>	32
<i>Impact of medical terminology and multiple questions</i>	34
<i>Impact of awareness of diversity</i>	35
<i>Impact of interruptions</i>	36
<i>Impact of topic control</i>	38
<i>Impact of fluency of questioning</i>	38
Chapter 5.....	45
Discussion	45
Introduction	45
<i>Establishing Professional Credibility through Non- Verbal Self Presentation</i>	45
<i>Initiating the interview and building rapport</i>	46
<i>Inclusivity: Questioning for information gathering and hearing the patient</i>	48
<i>Demonstrating Professional Empathy</i>	49
Recommendations for Teaching Practice	50
Limitations of study.....	53
Conclusion.....	53
References	I
Appendices.....	VI

Table of Figures, Table, Text boxes and Screen Prints

Figure 1	Intersection of components comprising effective communication	9
Figure 2	Dress Code	25
Figure 3	Interview A: Categorisation of questions	32
Figure 4	Interview B: Categorisation of questions	33
Figure 5	Interview C: Categorisation of questions	34
Figure 6	Initial position	41
Figure 7	Determining location	41
Figure 8	Shifting position	42
Table 1	Alignment of concepts from the New Literacy Studies and functional literature	16
Text Box 1	Introductory Phase; Interview A	27
Text Box 2	Introductory Phase; Interview B	28
Text Box 3	Introductory Phase; Interview C	29
Text Box 4	Examples of multiple questions	34
Text Box 5	Impact of linguistic diversity	35
Text Box 6	Example of interruptions to flow of interview	37
Text Box 7	Interview C	40
Text Box 8	Excerpt 1: Interview C	43
Text Box 9	Excerpt 2: Interview A	45
Text Box 10	Excerpt 3: Interview A	46
Screen Print 1	Interview C: 14:52	43
Screen Print 2	Interview C: 14:58	44
Screen Print 3	Interview C: 15:04	44
Screen Print 4	Interview C: 15:24	44

Abstract

Objective: Communicative competence is recognised as essential for establishing an effective doctor-patient relationship. A Primary Health Care –led curriculum places this established relationship at the heart of all interactions and interventions between the patient and the health professional. Medical students at the University of Cape Town are taught in the Clinical Skills Department how to communicate and interact with patients in the pre- clinical years of training using primarily role play. This study examines how medical students transform classroom-based teaching into authentic clinical practice that follows Primary Health care principles in order to evaluate the effectiveness of the Clinical Skills strategy for teaching communicative competence.

Methodology: Video recordings of three authentic clinical interviews conducted by medical students taking their first comprehensive biopsychosocial interview in a clinical area were analysed. This data was supported by scrutiny of the intended learning outcomes of all pre- clinical courses in which aspects of communication competence was taught as well as teaching observations made of the students within the classroom

Conclusion: The study revealed that although the students could structure a biopsychosocial interview the nuances of building a professional relationship with the patient as envisioned in a Primary Health Care –led curriculum proved difficult for them. These findings suggest that using a single pedagogical method in the Clinical Skills department, namely role play, may not be sufficient for teaching medical students how to place the needs of the patient first above their need to learn, diagnose and treat the patient.

Chapter 1

Introduction

Communication between doctor and patient is central to clinical practice. Silverman et al (1998) identify four competencies that they consider essential for all health professionals to master in order to deliver effective clinical practice. These competencies include having the ability to communicate effectively with patients in order to elicit and deliver relevant information, being able to acquire the appropriate biomedical and clinical knowledge, being able to conduct a physical examination and employing problem solving skills in order to formulate an accurate diagnosis. Communicative competence is therefore regarded as a core clinical skill that aids with turning theoretical knowledge into effective practice and establishes the nature of the relationship that forms between health professionals and their patients.

The value of effective and skilful doctor-patient communication as documented by Lloyd and Bor (2009) is associated with benefits for both participants in dialogue. They highlight communicative competence as the foundation for eliciting both the correct and adequate information from the patient in order for the doctor to formulate an accurate diagnosis and upon which an effective treatment plan can be based. They further suggest that skilful communicative practices facilitate the doctor's detection of and response to emotional stress in the patient that will improve patients' overall satisfaction with their healthcare experience. This could further result in patients' improved adherence to the proposed treatment plan and satisfaction for both parties as a result of their encounter. The global recognition of effective communication as a cornerstone for successful healthcare delivery has resulted in the inclusion and implementation of formal communication training in the medical education curricula of many institutions across many countries (Cushing, 2015).

The medical interview is a dialogue conducted between two, often unacquainted, persons, each with the aim of achieving a specified goal. Patients seek help to attain a state of health and wellbeing while doctors aim to both identify and subsequently treat each uniquely presenting problem that the patient seeks resolution for. According to Goodyear-Smith and Buetow (2001), power is an unavoidable aspect of all social interactions and can be used to either empower both parties or misused to favour one party's goal over the other. A thorough awareness of the issue of power when conducting and managing each interview is therefore essential for the health professional to ensure that both parties are satisfied with the outcome.

Given that each party in the medical interview pursues their own agenda and that each party has the potential power to dominate the other, they each also inevitably bring a certain vulnerability to the interview process. The patients' vulnerability lies in exposing personal aspects of their life to scrutiny and interrogation whilst the doctor's vulnerability lies in not accessing enough information to correctly diagnose and treat the patient in the appropriate manner. The doctor uses both theoretical and experiential knowledge to perform these tasks but is dependent on patients' full presentation of their lived experience of all facets contributing to and influenced by the presenting complaint. An open relationship, based on trust, therefore needs to form rapidly on initial meeting in order to facilitate patients' full disclosure of potentially sensitive and intensely personal information. A breakdown in this communication could lead to misunderstanding, frustration and disappointment

on numerous levels for both parties. A high level of communicative competence, both non-verbal and verbal, is therefore necessary for health professionals to encourage patients to speak openly and elicit all the required information for a successful encounter to take place.

Context of study

Founded in 1912, the University of Cape Town's Medical School is the oldest medical school in South Africa and has a tradition of excellence in teaching and research, in the delivery of high quality care and in the internationally recognised competence of its graduates (Hartman, 2014). However, these accolades should be understood within the context of racial segregation and discriminatory access in all aspects of civil society, including the health system, which characterised the political climate in South Africa prior to 1994. In keeping with accepted international professional norms of the time, both the training of medical students and professional practice followed a biomedical, curative approach to healthcare that was reflected in a primarily hospital-care based health service. In addition, particular to South Africa, unequal access to medical training and education as well as unequal access to healthcare and treatment reflected in racially segregated hospital wards offering vastly unequal levels of care, reproduced the dominant racist political and professional norms of the times (Breier and Wildschut, 2006). Furthermore, the medical student cohort of that time did not represent the demographic population of South Africa, being predominately 'white' and 'male'. In summary, the excellence and character of the healthcare available to South Africans and the education of health professionals were "largely determined by three factors: race, income and location" (Kautzky and Tollman, 2008:21). Following government change in 1994, medical schools throughout South Africa responded to the demand for a more community orientated, socially responsive curriculum capable of answering the needs of the entire South African population and of putting patients' requirements at the centre of healthcare. At the same time measures were introduced at training centres and universities to change the demographic profile of the student cohort.

In line with these developments, in 2002 the Faculty of Health Sciences at the University of Cape Town (UCT) introduced its new medical curriculum that has Primary Health Care as a lead theme. The curriculum aims to produce graduates who will provide equitable and holistic healthcare within the South African healthcare system. It is expected that graduates will embrace the qualities of Boelen's "five-star doctor" which is perceived as the best fit to practise and deliver healthcare in our country's communities (Seggie, 2010). From this perspective the graduated doctor is envisioned as both leading and managing health teams that aim to improve the social and health needs of both patients and their communities, by addressing the health issues of patients and communities through consultation with them and by delivering continuous and inclusive physical, emotional and psychological care to patients. Central to this dissertation is Boelen's fifth quality of being an expert communicator able to persuade patients and communities to become partners in their quest for health.

A Primary Health Care orientated practitioner is characterised by looking at patients in totality, seeing patients as individuals with feelings, concerns and expectations about their disease, as well as expectations of their healthcare practitioners. The relationship is not patronising or patriarchal, with doctors holding power and dictating treatment to patients, but is rather patient centred, with the doctor drawing patients into both understanding and accepting responsibility for their own continued treatment and care. It is for this reason that being a good communicator is considered to

be one of the five attributes required to fit this anticipated profile for South African doctors of tomorrow and therefore formal communication training has been introduced into this medical curriculum in the early pre-clinical years of training.

As a clinical educator working in the Clinical Skills unit under the auspices of the Department of Medicine at the University of Cape Town, part of my teaching portfolio involves facilitating and instructing medical students in their preclinical years on ways to master the clinical interview using the Primary Health Care approach. Within this ideology, a relationship of mutual trust between the patient and health care professional should be the basis for all practice. This directly relates to the health practitioners' value system and awareness of power relations and issues of authority that may foster or impede an equal and fruitful partnership developing between patient and health professional (HPCSA, 2008; Hartman, 2014). The envisioned relationship should start on first meeting between the parties, which usually commences with the clinical interview.

The focus of this study is to ascertain whether the Primary Health Care values rooted and taught in the classroom are translated later by medical students into practice when they start encountering patients within the clinical area of a tertiary training hospital.

Pedagogical approach

In the curriculum under consideration, the technicalities of communicative competence, as well as an appreciation of its value and relevance, is originally taught and performed by students in a classroom setting in the years prior to their first interaction with a patient. In the second year of training, medical students are taught to conduct and practise medical interviews in a simulated ward setting within the Clinical Skills unit. The pedagogical method chosen to accomplish this is role play. This form of training continues at intervals throughout the year and it is presumed that students are adequately prepared to move into clinical practice in a hospital setting as soon as they enter their third year of training. No further role play practice sessions are conducted by the clinical skills teaching staff during subsequent years of training.

Role play involves using scripted scenarios without the constraints imposed by a real patient, in order for students to experience both the patient's and clinician's perspectives as they alternately play the part of each (Joyner and Young, 2006). It is presumed that role play would enable the doctor-in-training to learn how to ask questions in a manner that would encourage dialogue and promote a safe environment for patients to disclose the required information. On the other hand it is assumed that through playing the role of the patient, students will develop an understanding of the difficulty patients may experience when having to reveal sensitive and personal information to an unfamiliar person.

The impact of student diversity on teaching communicative competence

The diversity of students at medical schools in South Africa offers unique teaching challenges which highlight the need for adaptation and re-evaluation of communication teaching methods. The historical demographic profile of medical students prior to 1994 has steadily evolved so that instead of being overwhelmingly white and male, as before, the current cohort of students reflect both the demographic diversity of the country as well as the feminisation of South African medical schools (Breir and Wildschut, 2006). According to Hartman et al (2012:6), the Faculty of Health Sciences at

UCT has made “made significant progress in achieving equity of access for students” with the medical programme in particular “approximating the national demographic picture”.

This change in demography means that diversity exists on many levels and this has important implications for teaching students to communicate with patients in medical settings. As the student cohort at UCT is drawn from all the provinces within South Africa, linguistic diversity amongst the students is high. Furthermore, most students’ dominant or home languages differ from the dominant languages of the main patient population accessing public health facilities in the Western Cape, which are primarily Afrikaans and isiXhosa. A complicating factor is that all Clinical Skills training is conducted in English, which is usually not the home language of students either. This complex and uneven distribution of linguistic diversity amongst students and patients may impact on students’ approach to learning communication skills and their behaviour during training. For example they may revert to mechanised learning of key phrases to be used in conversation with patients. This approach may then make it difficult for them to understand patients’ stories or respond appropriately when the interview diverts from their learnt phrases.

A multiplicity of cultures and value systems characterises all aspects of South African society and is evidenced within a diverse student cohort. How students perceive their future role as a doctor is often drawn from early enculturation and experiences prior to entering medical school, for example previous exposure to members of the medical profession or values attaching high social status to being a medical professional. This in turn may impact on the value students attach to the importance and necessity of learning and practising communication skills and thereafter on how they may ultimately interact with their patients. For example, students may place value on the biomedical approach to healthcare over the biopsychosocial approach embedded in a Primary Health Care led curriculum. From within this ‘culture’ they might view and use the first medical interview not as a means for understanding and drawing the patient into disclosing information, but rather as an exercise for collecting the correct information needed to formulate a diagnosis.

Finally, inequality of resources, varied levels of schooling, and different social and cultural values relating to urban/rural communities further contribute to the diversity of the student population. These differences offer both opportunities and challenges to teaching. For instance, some students emerge from schooling without advanced proficiency in English, but a good understanding of community issues. Such students would struggle with aspects of communication in English, but may be better prepared to relate to patients’ contexts, cultural values and experiences. Many well-resourced schools place greater value on scientific enquiry over cultural aspects of education. Some students trained in this way would transfer this educational approach to their medical studies, ending up valuing a biomedical rather than a psychosocial approach and even feeling discomfort with cultural and psychosocial aspects of their studies. Such complex variation in the student body impacts on the pace at which individual students practise and master communicative competence within the group as well as the cultural value placed on aspects of learning to interact with patients.

It is against this context characterised by complexities of transformation and diversity that this study formulates its research question, aims and objectives.

Research question, aims and objectives

The main focus of this dissertation is to assess whether the current pre-clinical teaching of communicative competence using role play adequately prepares a culturally diverse student body to

conduct a medical interview within a clinical setting serving an equally diverse patient population. More specifically, the study assesses whether students manage to transfer and maintain the values underpinning the Primary Health Care philosophy of the curriculum through which they are taught when they conduct their first medical interviews in a clinical setting where the technical scientific side of clinical medicine comes into play.

The central question that guides subsequent analysis in this study is therefore:

Do the communicative practices of medical students at the University of Cape Town, conducting their first interview with a patient in a clinical setting, reflect the values of patient centeredness that are embedded in a Primary Health Care-led curriculum and that are taught during pre-clinical communication training?

The aim of the study is to evaluate the effectiveness of the Clinical Skills division's strategy for teaching communicative competence. It looks into whether classroom-based learning is transformed into patient centred clinical practice as is envisioned in a Primary Health Care-led curriculum.

Objectives for this study are to:

- Outline the learning objectives and teaching practices related to teaching communicative competence in the Primary Health Care led curriculum of the study context, and formulate a thematic framework for assessing communicative competence in practice.
- Analyse through scrutiny of both verbal and non-verbal modes of communication a number of clinical interviews performed by third year medical students on their first interaction with a patient in a tertiary hospital setting.
- Assess whether students manage to construct and maintain a partner relationship with their patients. This will be done by analysing whether students achieve specific objectives taught and required of them by the Primary Health Care-led curriculum when they conduct their interviews in a clinical setting. This includes:
 - Establishing professional credibility through self-presentation and positioning
 - Initiating the interview and building rapport
 - Achieving Inclusivity in dialogue
 - Demonstrating professional empathy.
- Recommend changes to current teaching practice based on the difficulties experienced by students as exposed by analysis of the interviews.

Chapter 2

Literature Review and Theoretical Framework

Three areas of literature are chosen for review for this study. Firstly, literature will be reviewed that builds up an historical understanding of the movement away from the biomedical tradition of medical intervention and the reasons for the introduction of the biopsychosocial approach to understanding patients and disease. This overview explores some of the reasons for the transformation from a powerful elitist ideology to the current, more inclusive and sharing ideology on which the medical curriculum rests at UCT. Secondly, medical educational literature is reviewed to determine what methods of instruction for teaching communicative competence are generally used in medical training institutions in order to prepare medical students for clinical practice, in particular the practice of conducting the medical interview. The perceived strengths and weaknesses of each method are examined in order to compare these pedagogical methods with that chosen for teaching in the context of a Primary Health Care-led curriculum in which the study is based. Thirdly, the work of a number of sociolinguistic theorists in the field of New Literacy Studies are presented to formulate the theoretical framework for this study and to define the theoretical tools that will be used to analyse the medical interview data collected.

Understanding the biomedical approach

The biomedical approach to healthcare has its roots in Louis Pasteur's germ theory of disease (Johnson, 2012) and in the Cartesian division between mind and body, the premise of which is that the physical and non-physical are two separate and individual phenomena (Alonso, 2004). Wade & Halligan (2004) describe this as a reductionist approach to healthcare, which views health as the absence of disease, and disease itself as being directly related to a faulty genetic makeup, an injury or an infection which manifests through signs and symptoms in the patient. Neither the patient, nor the patient's circumstances, provides any explanation for succumbing to disease, and the patient becomes a passive recipient of treatment simply acquiescing to what is prescribed. Accordingly McCollum and Pincus (2009) reason that under this approach, the patient relies entirely on the actions and decisions of the health professional who collects information from the patient, determines which tests are needed to confirm a diagnosis and implements treatment in order to achieve a healthy outcome. The model of the doctor-patient relationship that this approach sets up, as suggested by Goodyear-Smith and Burtow (2001), mimics that of an adult-child relationship. The power resides with the doctor, who has the ability to discard information given by the patient as irrelevant and who relies only on information that can be scientifically verified or tested against an existing standard and upon which the diagnosis and prescription of treatment to be followed by the patient will be based.

This prevailing ideology is clearly illustrated in an interview with Dr Paul Beeson in 1999 who, reflecting on his medical training, describes how "certainly no teacher, at any time, reminded us that patients are people, with differing life situations and backgrounds.... indeed, they almost ignored the patient as a person, acting though the patient was simply a specimen for teaching" (quoted in Lee, 2000:73). He goes on to describe a meeting with Dr Soma Weiss in 1939, whose attitude introduced him to a very different ideology, that of the biopsychosocial: "his attitude towards a patient during a

teaching visit impressed us all. When he came to the bedside, he would take time to introduce himself and explain what he and those with him were doing, it was clear that he was considering a medical problem affecting the life of one human being” (quoted in Lee, 2000:75). Although this was not an approach to the patient that was widely adopted at the time, it was an ideology that would gain energy and emerge as an alternative model to the biomedical standpoint.

The development of the medical curriculum in South Africa following biomedical British models

Seggie (2010) reflects that the majority of medical schools in South Africa were established in the last century and imitated a Scottish pedagogy that was predominately followed by medical schools established in British Commonwealth countries. Abraham Flexner, for instance, envisioned the medical practitioner as a scientist who would treat each patient encounter as “an exercise in scientific enquiry” (Seggie, 2010:9). Following the Flexner report in 1910, medical schools throughout the English-speaking world, including South Africa, developed curricula that valued and supported a bio-scientific model for understanding illness.

The curriculum that emerged resulted in students being overwhelmed with learning basic science facts, with limited translation of these facts into use or relevance within the clinical field. There was no or minimal recognition of the patient as an individual with a unique life story and background or how this may impact on the course of illness. Research output was the gold standard against which medical faculties were evaluated, which resulted in teaching students and caring for patients being considered subordinate to the former (Seggie, 2010). The South African medical profession reflected Goodyear-Smith & Buetow’s (2001) description of the medical profession as an example of a paternalistic system with a predominately male workforce having high social status, exclusive knowledge and having the ability to make decisions on their patients’ behalf. Barry and Edgeman-Levitan (2012) determined that this prevailing health care environment excluded the majority of patients and their families from discussion, participation or management of their own healthcare.

A change in thinking towards the biopsychosocial model

Borrell-Carrio et al (2004) describe the thinking of the late clinician George Engel who, in 1977, would offer an alternative model to the prevailing biomedical approach to healthcare. This would become known as the biopsychosocial model for healthcare delivery. Engel did not deny the role that scientific research had played in improving health outcomes for patients, but he rejected the idea of such a narrow view of causality of disease that had resulted in patients being seen as mainly objects for study, as dehumanised and disempowered, with their subjective stories not worthy of importance. He postulated that for clinicians to understand and effectively treat their patients, they needed to understand the social and psychological aspects of disease for each individual patient, as well as the biological factors. Engel wanted to promote an essential ideology that empowered both doctor and patient and introduced a caring and empathetic human side into the practice of medicine (Borrell-Carrio et al 2004). This view found official expression in the declaration subsequent to the 1978 international conference on Primary Health Care in Alma-Ata, when the World Health Organisation (WHO) affirmed that health, as a fundamental human right, was a state of physical, mental and social wellbeing and not merely the absence of diseases or infirmity (Declaration of Alma-Ata, 1978).

In 1994, following the appointment of the first democratically elected government in South Africa, Primary Health Care was adopted as the lead ideology for transformation of the existing health system. This approach to healthcare provision acknowledged the World Health Organization's goal of attaining better health and equitable health care for all (WHO, 2013). The implementation of a revised medical curriculum at the University of Cape Town in 2002 recognised Primary Health Care as a lead theme across the teaching curricula and sought to promote the relevance of Primary Health Care principles to every patient encounter in all health care disciplines and across all settings (UCT, Primary Health Care Directorate). To achieve this kind of care, the patient's needs and wishes should motivate all interactions and care delivered (i.e., it should be patient centred) and should be supported by the manner (verbal and non-verbal) guiding the approach taken by the health professional in all dealings with patients. Integral to this change in underlying ideology in support of the new curriculum was a corresponding change in teaching content and methods, and an introduction of a new set of values and a focus on patients (their families and communities) for staff and students.

To support the change in curriculum ideology across medical schools in South Africa, Breier and Wildschut (2006) enumerate adaptations to teaching methodology that are prescribed by the Health Professionals Council of South Africa (HPCSA) to include a decrease in the presentation of factual, didactically taught knowledge in favour of more practical, stimulating and contextual teaching e.g. more clinical scenarios with the patient as the "focus of learning" (Seggie 2010) or simulated skills training. They concur that Public Health Care should be a guiding theme that is extended throughout the entire curriculum. Of significance for this study is that there should be an emphasis placed on good communicative competence and training which explicitly supports enhanced sensitivity to language, cultural, racial and gender differences presented by the patient population.

Communication as key to patient centred care

In the 2008 World Health Organisation World Health Report, patient centeredness or putting the patient as the focal point of all care is considered to be pivotal to the delivery of effective health care. The report further details how curative or evidence-based medicine, in combination with caring or patient centred care, together constitutes safe and effective health care. According to Barry and Edgeman-Levitan (2012), the term patient centred care stresses the importance of the health professional understanding the experience of illness for each patient on an individual basis and responding appropriately to those individual needs. For Illingworth (2010), patient centred in the context of the medical consultation means a consultation process that is driven by the patient's agenda with the doctor facilitating and encouraging the process. Patient centred care therefore carries according to Epstein and Street (2011), a particular ethos, that is, a moral implication for the health professional, based on a deep respect for the patient as a unique individual and the obligation to care for each patient on their own terms. Patient centred care originates from the healing relationship that develops between the doctor and patient. Its aim is to improve clinical practice by building a caring relationship between the two parties, a relationship that accommodates and is not restricted by the demographic, social or economic differences between doctor and patient; a relationship that is built on dialogue through sharing experiences and sharing information (Engel, 1997; Bensing, 2000 & Epstein et al, 2010). Throughout each interaction and intervention, skilful, sensitive and effective communication functions as an important medium through which the caring

relationship between doctor and patient is established, as well as a vehicle through which the health professional's ethos of care is conveyed.

Communication between health professional and client, between team members, between health professional and family and between health professional and community, supports and precedes almost all medical interventions. Hulsman (2009) describes medical communication as the base on which medical care is layered and by implication therefore is one of the clinician's most important skills. Kurtz (2002) confirms the notion of communication competence being a basic clinical skill, with formal communication skills training at all levels of medical education being implemented at institutions worldwide.

Kurtz (2002) identifies three types of communication skills that need to be taught and integrated into a communication skills programme within a curriculum. They are content skills (what questions to ask, formulating a differential diagnosis to guide further questioning and the medical knowledge base from which the doctor works), process skills (how the questions are asked, how the interaction is structured and how rapport is built with the patient) and perceptual skills (the interviewer's response to the patient, awareness of distractors in context and the interviewer's own possible prejudices or biases). As can be seen in Figure 1, effective communication can be found at the intersection of content, process and perceptual skills. Combining the interpersonal elements of content and process skills with the intra-personal qualities of perceptual skills promotes the patient centred collaboration or partnership between doctor and patient envisioned within a Primary Health Care system (Figure1).

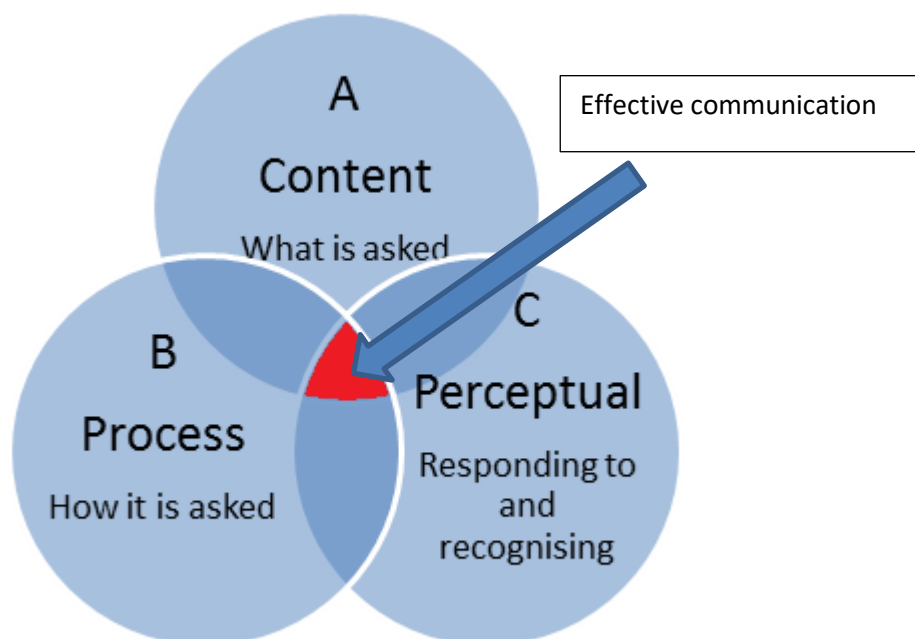


Figure 1: Intersection of components comprising effective communication

While, according to Kurtz et al (2003), the traditional medical history interview requires the student to obtain a framework of information that will assist with formulating a differential diagnosis (the *content*), communication models focus on the *process* of collecting information. Medical students often disregard the communications tools they have learnt and use the traditional method geared towards formulating a diagnosis as a guide not only for establishing *content* but also for how to ask

questions as well (the *process*). The interview is in such cases used as a method of solving a problem rather than for building a relationship with the patient whilst getting to an understanding of the problem.

Teaching communicative competence therefore needs to involve combining interpersonal and intrapersonal skills in a meaningful and precise manner that will encourage the student to utilize all these skills effectively and simultaneously in consultation with the patient. Makoul and Schofield (1999: 192) advise that teaching should include not only the relevant skills but also “an understanding of the nature, context and ethics of the doctor-patient relationship” that will encourage students to develop a range of strategies that will allow each patient encounter to be led by the context and will be individually responsive to the patient’s being. According to Makoul and Schofield, “This flexible approach reflects the reality of both medical practice and human communication (1999:193).

Teaching communicative competence

The literature suggests that many medical schools use varied combinations of cognitive input, modelling and practice of skills when teaching communicative competence. The component of the teaching, however, that is constant throughout all studies is the need for the students to practise the key skills as they learn. According to Aspergren, (1999:565) “learning by doing is more effective than by instruction” whilst Kurtz (2002:S25) concisely states that “knowledge by itself does not translate directly into performance”. Maguire and Pitceathly (2002) furthermore suggest that cognitive input should not only include attainment of content skills but also evidence of practices that improve or hinder communication. They add that students should be given evidence of good communicative practices in clinical settings that will improve both doctor and patient satisfaction.

In the context of this study the change from a biomedical to a biopsychosocial approach to health care necessitated a change in both teaching and student learning. The biomedical approach followed a behavioural approach to learning where an emphasis would be placed on the content or facts that needed to be obtained to formulate a diagnosis. The students thus learned what factual information they needed prior to moving into the real situation. The biopsychosocial approach values student learning about the individual needs and response of the patient in addition to content and an experiential learning approach is adopted. This allows the students to learn and develop knowledge, skills and values by direct experience outside a traditional classroom.

Two methods for teaching doctor-patient communication dominate the literature: the use of role play and the use of standardised patients. Joyner and Young (2006) describe role play as a teaching strategy that allows students to think about a situation and to try out specific behaviours and emotions as they experience the roles of doctor and patient by playing them out in turn. Students therefore have an opportunity to practise dealing with potentially real-life situations without having to deal with problems and limitations that real patients bring to the context. At the same time they learn to appreciate the needs of both clinician and patient. Nestel and Tierney (2007) describe role play as a form of simulation that acknowledges the social context of learning as the participants relate to each-other. The advantages of using role play as a strategy is that few resources are required other than those needed for regular teaching activities and it allows students to understand the complexity of taking a medical interview. However, role play can meet with resistance, anxiety or even scepticism by the student body as it may be perceived as “acting” or make-belief, and not serving a real purpose. A further disadvantage is the possibility that the student either underplays or

overplays the 'patient' role, thereby either just presenting information to the 'doctor' without being asked for it or making it impossible for the 'doctor' to extract the information (Jackson & Back, 2011).

The second approach to training involves a standardised patient who is described by Wallace (1997:6) as a "person who has been carefully trained to take on the characteristics of a real patient in order to provide an opportunity for a student to learn or be evaluated on skills first hand". Cleland et al (2009) suggest that the use of trained standardised patients for teaching communication skills offers a controlled realism to teaching events that might not be present in other forms of practice. Through training the standardised patient can be prepared to present a broad scope of disease, thereby widening the scope of the students' experience. From a teaching perspective the standardised patient offers ready availability when required for teaching events and can be trained to give individual, immediate and direct feedback to students following each interaction from the 'patient's' perspective on the effectiveness of the encounter. Each student-standardised patient interaction undertaken therefore offers students an opportunity to relate to a 'patient' as an individual with a history, physical signs and with unique emotional, social and personality characteristics in a safe environment.

Cleland et al, (2009) categorise the disadvantages of the use of standardised patients as relating to the cost of training them (personnel and time) and the cost of employing these individuals. They further acknowledge the problem that students may think that the standardised patient lacks authenticity since they are trained to reveal information, are co-operative, show no aggression and do not hide information that may be critical for formulating a diagnosis and treatment plan.

A third method that supports students' learning but appears less frequently in the literature is the use of real patients as teachers for junior students. Bleakley and Bligh (2008:89) strongly advocate for this as an authentic patient-centred approach to learning with the patient-student relationship being articulated in terms of a "collaborative knowledge production, involving close reading with the patient as text, through dialogue". Spencer et al (2000:851) concurs that "medical education without patients would be an extraordinary concept" and that patient contact should start as early as possible. Following a review of the literature pertaining to the advantages of using real patients in a teaching role, Wykurtz and Kelly (2002) determine that early clinical contact with real patient provides context to students' learning and reduces student anxiety whilst instilling the confidence needed to interact with real patients. Potentially relevant to this study is their conclusion that early contact with real patients deepens students' understanding of the impact disease may have on patients' lives and therefore positively impacts on students' attitudes and behaviours whilst increasing their respect for their patients (Wykurtz and Kelly, 2002).

In a systematic review of literature pertaining to how medical students are taught to interview patients, Keifenheim et al (2015) conclude that there is no single preferred teaching method that comprehensively covers all aspects of communicative competence. They state that "encounters with patients are highly complex events and no simple approach can do justice to all possible processes and challenges in such interactions" (2015:10). The context of each teaching environment combined with each unique patient encounter determines how teaching communicative competence is managed (Keifenheim et al, 2015). This study tries to evaluate the effectiveness of role play in preparing a diverse cohort of students, within the South African context, to perform a comprehensive biopsychosocial medical interview in a hospital setting.

Theories and tools for analysing communicative competence in the medical interview

The focus of this study is to attempt to surface and assess whether the ethos underlying the first medical interview between student-doctors and a patient align with or deviate from the communicative competence striven for in a Primary Health Care-led curriculum. As discussed earlier in the literature review, the ethos carried by the doctor into each encounter with a patient may embrace a predominantly biomedical or alternatively a biopsychosocial approach to health care. In a Primary Health Care led curriculum the principal concept of patient centeredness should be exemplified in the relationship that forms between the patient and the doctor during their first encounter, which usually takes the form of a medical interview. As shown before, the foundation of this relationship is built primarily upon language as it is enacted and spoken (Engel, 1997; Epstein and Street, 2011 and Bensing 2000). It is presumed that close analysis of this first interview should reveal the type of relationship that comes into being between the student doctors and their patient, and by extension, the underlying ethos that governs the interview would be surfaced. For clarity the term 'ideology' is used throughout to refer to the overarching theme of patient centeredness that is embedded in a Primary Health Care-led curriculum, while the term 'ethos' will be used when referring to the fundamental values that can become visible through behaviour and verbalised through the spoken word and that are carried into authentic practice. In this study, the New Literacy Studies' notion of language as social practice will be used to analyse the interpersonal relationship that comes into being between the medical student and patient during the medical interview.

The first medical interview as part of medical Discourse

James Paul Gee contends that language and the use thereof cannot be examined in isolation but needs to be seen both in combination and as part of accompanying actions and interactions, as well as ways of thinking and believing that collectively define relationships and social structure (Gee, 1996). He describes Discourse (using a capital D) as embodying socially accepted ways of behaving, interacting, valuing, thinking, believing and speaking (Gee, 1990). Discourse therefore encompasses more than just the language or words used by individuals when interacting with each other but also the behaviour, mannerisms, dress, tools, and actions that further constitute the interaction. A particular Discourse can identify one as a member of a social group and make roles within the group visible and identifiable (Gee, 1990). Language plays an important role in building identity or roles within a context and is always "integrated with and relative to social practices constituting particular Discourses (Gee, 1990: 5; Gee 2008). Focus on particular language in use, as will take place in this study, constitutes analysis of discourse (with a small d) (Gee 2008). Students' utterances and interactions while learning to interview patients make up the discourse that is analysed in this study as actual socially embedded instances of the medical Discourse that they are expected to acquire. Pertinent to this study is Gee's notion that to acquire secondary Discourse involves interacting with people who do not share common experience or knowledge, whilst taking on an identity that differs from that within one's primary Discourse (which is learnt 'at home' or from birth). The students in this study are seen as moving into medical Discourse which they acquire as secondary Discourse. The particular type of medical Discourse that they need to acquire in the study context is imbued with a Primary Health Care ideology and has a set of social practices inherent to this Discourse. Acquiring this Discourse can be achieved through watching role models and through practice in clinical settings. Learning occurs as students perfect the ways of thinking, acting and being required for

competent practice as a Primary Health Care professional. In this dissertation, the medical interview is seen as an integral component of this type of Primary Health Care medical Discourse that comprises communicative practices that students will need to acquire in order to achieve fulfilling interactions with patients in a clinical setting.

The first medical interview as socially determined relationship and the role of power

Like Gee, Fairclough's Social Theory of Discourse (Fairclough, 1992) argues that both the construction and use of language is a form of social practice. According to Fairclough, different types of discourse, or language in use, set within different social domains or institutions (such as medical practice), may become ideologically invested and this contributes to the construction of social identities and social relationships between people (Fairclough, 1992). He proposes that language allows access to the ethos shaping how people act in relation to others and therefore also becomes a means to making visible, understanding and interpreting such an ethos. Fairclough explicitly presents the traditional biomedical interview as a particular form of social practice that assigns power to one party over another (Fairclough 1992). He uses the term 'force' to describe how control over or power in language usage may define how interpersonal relationships are constructed within social practice. He describes 'force' as the actional component of language usage through which a possible dominant social power may both be enacted in practice and revealed through analysis. Control of the agenda during an interview, control of turn-taking, exchange structure, posing questions, the types of questions formulated and the topic of discussion all point to interactional control in dialogue (Fairclough, 1992).

In the context of this dissertation, the focus will be on the social identities that medical students construct as apprentice doctors in their first medical interview with a patient. Following the thinking of Fairclough, an assessment will be made of whether their interactional ethos correlates with or deviates from the Primary Health Care ideology of the curriculum through which they are being taught. The biopsychosocial model of healthcare is underpinned by a relationship based on trust and understanding developing between student-doctor and patient during medical interviews (Epstein et al, 2010). This is diametrically opposite to the traditional biomedical approach of the doctor as socially powerful, holding exclusive knowledge and being the primary and sole decision maker in the relationship (Goodyear-Smith and Buetow, 2001).

The first medical interview and interaction order

Language, although dominant, does not function on its own as mode of communication. Gestures, posture, positioning and gaze also constitute part of the relationship that comes into being between subjects and should therefore also be treated as communicating meaning (Scollon and Scollon, 2003). Each facet of an interaction offers a mode of communication that may either support or appear in conflict with the verbal language component. Sissons (2013) describes how advances in recording technology have facilitated audio and video data collection that has opened the path for multimodal analysis of interactions as they occur.

The works of Ron and Suzie Wong Scollon highlight how human bodily position will always contribute meaning concurrently with language as social interaction occurs (Scollon and Scollon, 2003). They describe how the concept of the 'interaction order' which refers to the many ways that people interact with each other, is made visible through semiotic resources such as interlocutors'

“personal front” and “interpersonal distances”. They posit that through the reading of the complex typology of an interaction order, the power or authority of one party over another may be revealed. Personal front refers to the clothing and equipment necessarily and/or purposefully carried by an individual that allows for the identification of a socially determined role. The second semiotic resource examined in this study is the interpersonal distance within which a specified form of social interaction occurs.

Theory into practice: the Biopsychosocial interview process

So far, literature from the New Literacy Studies and multimodality has been reviewed to reveal various aspects of the interview process that may hinder or enhance the process of building a relationship between the student-doctor and patient. Another type of literature which has a more practical, functional training focus will now be introduced to flesh out some of the theoretical points drawn from the New Literacy Studies literature.

According to Mash (2006) establishing a good doctor-patient relationship by initiating and maintaining rapport whilst gathering information are hallmarks of effective communication in the consultation. In similar types of literature related to building rapport, Talley and O’Connor (2010) suggest that putting the patient at ease is the foundation for eliciting correct and adequate information from the patient. Mash (2006) identifies aspects of practice that will help building rapport such as eliciting the patient’s name and greeting accordingly, naming and identification of roles, ensuring patient readiness and privacy, removing barriers to communication and ensuring the patient’s comfort. Epstein et al (2008) advocates that both the preparation for a consultation and clarification of the intentions for the consultation to the patient demonstrates respect, interest and concern for the patient. Lichstein (1990) concurs that a clear, confident, honest and caring introduction communicates respect as a unique individual to the patient. The relevance of the fore-mentioned aspects of communicative competence for building a professionally caring relationship with patients is emphasised by Uber et al (1995, quoted in Ulrich et al, 2004:13) who demonstrate that patient confidentiality and privacy is frequently breached by health professionals talking in spaces where they could be overheard by other patients and persons. In a study by Barlas et al (2001, quoted in Ulrich et al, 2004:14) 5% of patients admitted to withholding medical information from the health professional due to privacy concerns. Lack of privacy for the patient therefore has the possibility of suppressing the patient’s voice during a medical interaction. The importance of establishing a clear and open dialogue with the patient is further advocated in the Health Professional Council of South Africa’s guidelines for good practice (2008) where “truth and truthfulness” is considered the basis for building trust when developing a professional relationship with patients.

Maintaining rapport ensures that the need of the doctor to gather information throughout the interview process does not overwhelm the needs of the patient to be heard and to fully participate in all aspects of care. Larivaara, Kiuttu and Taanila (2001) characterise a doctor centred interview as one that is led by the doctor who tends to use mainly closed questions, who interrupts the patient’s words, concentrates on biomedical information and makes the decision about what information is important and necessary. They contrast this approach with a patient centred interview characterised by aspects of communication such as the use of single questions, open ended questions, the use of

clarification and summarising by the doctor as an indication to the patient of active listening and acknowledgment of emotional and social issues as relevant information. Epstein and Street (2011) suggest that although the effect of an inclusive communication technique might only indirectly affect the patient's health outcome, the more immediate outcome for the patient of feeling known, respected, involved and engaged will strongly support the patient's improved adherence to the health plan, self-care and psychological wellbeing. Acknowledgment of the patient's perspective by the health professional is, according to Mercer and Reynolds (2002), a key factor in improving the doctor patient relationship.

As far as the concepts drawn from Scollon and Scollon (2003) are concerned, a concept like 'personal front' can be explained by aspects of dress and habit, for example the stethoscope that distinguishes a health professional from support staff. The significance of what Scollon and Scollon (2003) call health professionals' 'personal front' can be seen in by for instance Epstein et al (2008) and Lill and Wilkinson (2005) who focus on the professional credibility achieved through the manner of dress and approach used by a doctor when setting up an interview environment with a patient. Although this is not the most significant aspect of the doctor-patient relationship, they indicate that 'personal front' can make a difference in determining the success of this relationship. Au, Khandwala and Stelfox (2013) further describe how professional attire may quickly influence patients' and their family members' perception of the health professional's competency, trustworthiness and suitability. These perceptions may in turn directly affect, in a positive or potentially negative manner, the establishment of a mutually satisfactory relationship and the building of rapport between patient and health professional. A study by Newman, Wright, Wrenn and Bernard, (2005) has further shown the importance of 'personal front' in areas where the doctor is in training or where episodic, not long term, care is delivered (as is the context for students on entry into the clinical area). An aspect of dress that was shown to be important to patients and their families for establishing professional credibility according to Lill and Wilkinson, (2005) and Au, Khandwala and Stelfox (2013) was clear display of modes of identification. This is further supported by the National Patient's Charter that the patient has the right to be treated by a named health care professional (Western Cape Government, 2015).

The importance of 'Interpersonal distance' (Scollon and Scollon 2003) in the interview process can likewise be exemplified from practical, functional literature. According to Epstein et al (2008) the physical positioning adopted by the doctor is essential for ensuring patient comfort to engage without straining, for maintaining eye contact between parties and for putting the patient at ease in preparation for conducting a comprehensive medical interview. In a study by Swayden et al (2012), patients perceived that when their doctor sat during the interview more time was spent together and thus reported a more positive interaction experience and a better understanding of their condition.

Table 1 below attempts to align the conceptual framework drawn from the New Literacy theorists with the more practical functional tasks presented by writers like Mash (2006), Epstein et al (2008), Lichstein (1990) and Larivaara, Kiuttu and Taanila (2001).

Table 1 Alignment of concepts from the New Literacy Studies and functional literature

Concepts from New Literacy Studies	Tasks when Interviewing from functional, practical literature
Acquisition of Secondary Discourse in this case medical Discourse	Practising the discourse features of a comprehensive biopsychosocial medical interviewing: <ul style="list-style-type: none"> • Building a professionally caring relationship by ensuring confidentiality and privacy • Removing barriers to communication • Eliciting the patient’s name and greeting by name • Identification of roles • Clarification of true purpose for conducting the interview
Linguistic Force : Open or closed questions Control of topic and topic change Turn taking and interruption Specialist or lay terminology/information	Use of discourse features that support a patient centred interview <ul style="list-style-type: none"> • Mainly single and open ended questions • Use of questions of clarification by doctor • Allowing patient to control topic and be heard • Few interruptions by doctor • Use of summarising and questions of clarification • Active listening by doctor • Use of lay terminology; asking questions eliciting biopsychosocial as well as biomedical information • Acknowledgment of emotional and social issues as relevant information
Personal front	Presentation of discourse features that establish professional credibility <ul style="list-style-type: none"> • Mode of Dress • Wearing stethoscope, clear display of modes of identification (name tags) • Creating confidence in patient (and family) by establishing impression of competency, trustworthiness and suitability
Interpersonal distance	Use if discourse features that minimise patient discomfort Physical positioning that ensures patient comfort (e.g. the doctor is sitting down, signalling

	undivided attention and intention to spend time) Achieving inclusivity and empathy by maintaining eye contact, physical positioning and touch
--	--

Patient centred care is a pivotal concept in a Primary Health care-led curriculum that places emphasis on instilling values such as empathy, respect and understanding for patient autonomy into the education of the future graduates of the South African health system (PHC Directorate, UCT). However there is no literature on how medical students at UCT on initial entry into the tertiary hospital system translate these values from the classroom into an authentic clinical area. In addition, many students voice the difficulty experienced when conducting such an interview when they enter into clinical practice. This study therefore attempts to draw together the many individual aspects of communicative competence required to perform an effective medical interview and to examine whether and how students taught within a Primary Health Care framework demonstrate communicative competence by utilising all or some of these features in an interview aiming to take a clinical history from a patient within a clinical setting.

Guided by the conclusion of the systematic review by Keifenheim et al (2015), the objective of this study is to evaluate the effectiveness of role play, as the chosen method of classroom instruction at UCT, in preparing a diverse cohort of students, within the South African context, to perform a comprehensive biopsychosocial medical interview in a hospital setting. It provides a baseline measurement, often lacking in studies (Keifenheim et al, 2015), from which further studies may emerge.

Chapter 3

Methodology

Introduction

In the previous chapter, through a review of literature, the ideological change underpinning the medical curriculum at UCT was discussed. This change calls for students to demonstrate, through language and behaviour, how a specific type of professional relationship is built with patients. Possible analytic tools from theorists within the New Literacy Studies were further identified that could be used to reveal the values carried into an authentic clinical setting by medical students. This chapter presents the methodology used to analyse both behavioural and verbal texts presented by students interviewing patients within a hospital setting.

The aim of the study is to determine the effectiveness of the current teaching strategy within the Clinical Skills Unit in preparing students to conduct a patient centred interview that incorporates both the need to gather medical information with the requirement to understand and acknowledge the patient's unique context and problems. It is assumed that analysis of students' verbal and non-verbal communication skills will reveal how they transform teaching into clinical practice.

The data for this study were taken from three video recordings of three different groups of medical students conducting a medical interview with patients. The data are supported by scrutiny (but not detailed analysis) of the learning outcomes for courses that taught aspects of communicative competence to medical students before they were taught in the Clinical Skills programme. Teaching observations of the researcher in her position as Clinical Educator within the Clinical Skills Unit were further used to interpret possible findings.

Study Design

A descriptive and explorative qualitative study, using linguistic and visual semiotic analytic tools adapted from theorists of the New Literacy Studies, was undertaken to explore how three groups of students performed in their first medical interview with a patient in a clinical setting. The study proposes that these students were being inducted as apprentice doctors into a Primary Health Care orientated medical Discourse taking a biopsychosocial approach to health. The study sets out to assess whether the values that the students learnt during the first two years of the Primary Health Care-led curriculum were being expressed or reflected through their language and behaviour during the interview.

Study population and sampling

At UCT, due to large student numbers, 50 third year students per day attend Clinical Skills training on three consecutive days of the week. The total population of students available to participate in the study over three days was therefore 150. Each total cohort per day self divides into approximately 15 groups of three to four students. Each small student group is then allocated to interview a patient identified by the clinical educators. The patients to be interviewed by the student groups as part of the Clinical Skills training are usually sourced from the clinical areas by the clinical educators

prior to the students arriving in the training centre. The patients are chosen based on their presenting problem and possible clinical signs that the students might find during the physical examination. No attempt is made to match linguistic ability of students with the home language of the patient. The small student groups are given a ward, the name of their patient and the bed space number by a clinical educator before they proceed to find and interview their allocated patient.

All 150 students commencing the third year MB ChB programme at UCT in 2014 were eligible to participate in the study and the total cohort was informed about the study before they divided into smaller groups and the patient details were handed out. All students (150) gave verbal consent to be filmed while conducting their interview. However, only one patient per day was asked to give consent to participate in the study (a total of three patients) and therefore only the interviews of the students allocated to these three patients were recorded for the study. A process of convenience sampling therefore took place for this study. The researcher did not participate in the handing out the patient allocations to the students to ensure that there was random allocation of the groups to the patients participating in the study. The set-up of the video recorder was managed by the researcher prior to the arrival of the group of students at the patient's bedside. A total of three video recordings were completed, each on a consecutive day.

A total of 10 students divided into three small groups participated in this study. The demographics of the three small groups were as follows. There was one group of four students, composed of one male and three female students, and two groups consisting of three female students each. The larger group had two students in the group who were fluent in the two other dominant languages within the Western Cape, namely Afrikaans and isiXhosa, beside the language of tuition, which is English. The two smaller groups had members who were fluent in English and Afrikaans only.

Data collection

The data collected for this study were informed by the change from a biomedical to biopsychosocial approach to healthcare informing medical curricula throughout South Africa (as documented in Breier and Wildschut 2006 and Seggie 2010).

The data for this study were collected through video recordings of the three interviews conducted by the small student groups allocated to the patients participating in this study. In order to capture an in-depth and composite representation of students' first clinical interviews as they were being conducted, video recordings were made as these interactions occurred within the clinical setting of a tertiary training hospital. Video recording was deemed to be less intrusive than observation by the researcher who was also the clinical educator of the students doing the interview. Consideration was given that the presence of the educator-researcher might inhibit the flow of questions posed by the students or alternatively that the students might look to the educator-researcher for advice, guidance or affirmation during the interview. It was therefore felt that the use of a video camera would minimise the potential of the observer effect or a possible modification of behaviour in the students in response to the presence of another person in the room. The three video recordings were taken on three consecutive days and were labelled sequentially as A, B and C for analysis.

Once taken, the three video recordings were transposed into an MP3 format to allow for transcription of the verbal component of the interaction (Appendix 1). This was carried out by an external agent, primarily working in a legal practice and with no medical knowledge or connection to the Faculty of Health Sciences at UCT. The transcript enabled subsequent fine grained linguistic

analysis of the verbal component of the interaction to be undertaken. Verbal utterances that were deemed to be too indistinct for transcription were transcribed more fully by the researcher using a combination of the visual component of the video recording as well as the researcher's knowledge and experience of being directly involved in the teaching of this section of the course to decipher indistinct passages (Appendix 2).

The recorded length of each of the three interviews varied from 20 to 35 minutes per recording and therefore full analysis of all verbal and behavioural aspects were not feasible for the scope of this dissertation.

Data Analysis

Analytic tools drawn from theorists of the New Literacy Studies were identified for in depth analysis of both verbal and visual aspects of the interview data. These tools were then used to identify lines of tension between the taught learning outcomes supporting a Primary Health Care led curriculum and students' actual performance within a clinical setting. Analysis therefore took place within the context of courses that preceded the course from which this study originates. These courses taught and gave students the opportunity to practise aspects of communicative competence in the classroom (UCT, Faculty of Health Sciences, Undergraduate Programmes, 2015). The intended learning outcomes of these courses therefore provided supplementary knowledge to the Clinical Skills training course and are used to inform data analysis. A second body of knowledge that informs data analysis are the observational notes made by the researcher in her role as Clinical Educator teaching communication skills to medical students. These offered insight into the communication practices that were taught within the classroom and were presumed to be transformed into authentic practice within the clinical area.

The learning objectives attached to teaching communicative competence in the Primary Health Care-led curriculum provided a starting point for constructing thematic domains within which the analysis of interview data took place. These learning objectives state that each student needed to learn how to

- Establish rapport with the patient
- Uncover information that related both to the process of disease and to the impact that the disease process may be having on the patient's total being, physically, emotionally, psychologically and socially
- Start acquiring an appropriate questioning technique that would be understandable to the patient whilst at the same time encouraging the patient to have the confidence to speak freely (UCT, Introduction to Clinical Skills, MBChB 11-111, 2015 and Talley and O'Connor, 2010).

From these learning objectives four thematic domains were deductively constructed within which verbal and visual aspects of students' communicative performance were assessed in their first interviews with authentic patients in a clinical setting. The domains paralleled the phases and specific tasks required for conducting a medical interview as taught to medical students in the Faculty. These phases and tasks include initiating the interview, gathering information and overall

establishing a good doctor-patient relationship (Mash 2006). The domains that emerged were the following:

- Establishing professional credibility through self-presentation using non-verbal semiotics resources
- Initiating the interview to build rapport
- Achieving inclusivity in dialogue through the construction and management of the interview
- Demonstrating professional empathy through appropriate response to the emotive aspect of illness.

Verbal and non-verbal communicative practices that were taught in the classroom to build a professional relationship were used to assess the type of relationship between the students and patients. These were:

- How students chose to position themselves in relationship to the patient
- How students identified themselves within their new socially determined role (as apprentice doctors)
- How rapport was initiated and established with the patient
- How the interview was constructed and executed
- How both parties participated and contributed to the dialogue
- How students responded in dialogue to exposed personal highly emotive aspects of the patients' life.

Using the fore-mentioned aspects of communicative practice as a guide, concepts and analytic tools drawn from theorists of the New Literacy Studies were applied to the visual and verbal interview data. In the section that follows the main analytic tools that were applied to the interview data to assess students' communicative performance in the four domains are identified.

At the broadest level of analysis, Gee's concept of secondary Discourse as a way of being that needs to be acquired and that leads to the formation of new identities (Gee, 1990) was used to describe students' move from the classroom, where they mainly assume a student identity, into the clinical setting, which requires that students adopt a new set of identities as apprentice users of a Primary Health Care based medical Discourse, taking a biopsychosocial approach to healthcare. Critical Discourse Analysis was used to describe the discourse features of students' attempts at conducting biopsychosocial clinical interviews in a clinical (as opposed to classroom) setting. The Scollons' (2003) concept of personal front was further applied to describe the semiotic resources used and displayed by students as novice members of the medical profession.

A further concept by Scollon and Scollon (2003) namely that of interpersonal distance was applied to the data to describe how the students physically positioned themselves in relation to the patient in preparation for the interview. Students' body language was scrutinised to identify their ease or insecurity with the process unfolding. The maintenance of eye contact, the use of touch and attentiveness to their patient were non-verbal elements used to analyse student-patient interaction. Verbal analysis complemented analysis of the visual data focusing on Fairclough's (1992) notion of the actional aspects of speech that may set the tone and direction of the interview that follows.

Throughout the body of the interview, aspects of the dialogue that possibly demonstrated the 'force' of speech were identified (Fairclough, 1992). These moments were read as indicative of the

management of, sharing of or maintenance of a form of social power by one party over another. Linguistic features such as use of open questions that encouraged patients to talk, clarification as a method for understanding and acknowledging the patients' words, interruptions in speech by one party over another and the content of questions were examined. Each aspect of visual and verbal analysis was examined in the context of the learning objectives and teaching materials of the Primary Health Care curriculum that prepared students to conduct this first medical interview. Analysis was used to determine the type of relationship built up by the students in their first interaction with a patient. In particular analysis sought to uncover whether students managed to maintain and reveal the values and the principles that reflect the biopsychosocial approach of the taught curriculum.

Ethical Considerations

A full verbal explanation of the reason for this study and the right to participate or refuse participation in the study with no repercussions of any form was given to all participants (patients and students) before written consent for involvement was obtained. The total cohort of 3rd year students gave verbal permission but only those groups allocated to designated patients signed a written consent form. As students of UCT further consent for student participation in a study was obtained from the University as required. All signed consent forms are being held securely by the researcher.

Patient participation and the collection of visual data raised further ethical issues. The video recordings required that careful consideration be given to the placement of the camera and security of the material during and after recording. The video recorder was placed at the head of the patient's bed to secure a lengthways view of the bed that would minimise undue physical identification of the patient during the interview and would ensure the greatest degree of patient privacy. With patients positioned reclining against pillows placed against the head of bed, only their voices are heard in recording which further ensures anonymity during filming. A view of the students around the patient's bed was captured and has been used as the visual data for analysis. All student participants were informed that should visual record of moments in the interview be used in the discussion of the study for enhancing the clarity of explanation, all distinguishing characteristics of participants would be digitally obscured so that identification of individuals would remain concealed. The video recorder was started by the researcher prior to the students entering the patient's bed space and one student was asked to discontinue the recording once the interview was concluded and before any physical examination of the patient took place.

On completion of the recording, the transposition of the tapes from the original format into an MP3 format took place in the researcher's presence before the initial transcription of the verbal clinical interviews. These are held personally and securely by the researcher. On transcription all names as given during the introductions were removed to ensure anonymity for all participants. Furthermore when recorded data in the form of visual representation is presented in analysis as illustrative of results for this study, all distinguishing features are obscured to ensure anonymity for all parties involved.

Formal ethics approval for the study was granted by the Human Research Ethics Committee of UCT, Faculty of Health Science (HREC Ref: 723/2013).

Chapter 4

Results

Course materials and learning objectives from the first two years of the medical curriculum clearly indicate that the relevance and worth of good communicative competence in building a satisfactory doctor-patient relationship is taught and practised in classroom and Primary Health Care clinic settings throughout the students' first two years of training. In the first year of training, learning outcomes such as developing an understanding of empathy and its role in interactions with generic (not health specific) clients, understanding how to prepare for and initiate a generic interview with a client, understanding how to conduct the exploration and termination phase of an interview, recognition of and appropriate response to non-verbal behaviour and understanding the concept of confidentiality in health guide students' development of communicative competence in the core course, *Becoming a Professional*. This is followed by a second core course in the first year, *Becoming a Health Professional*, which includes an introduction to the Primary Health Care approach and the key principles that support such an ideology in the latter part of year one. At this stage in training the focus is on understanding the life situation of patients and responding to patients.

In second year students enter the Clinical Skills Unit where the biomedical component of the medical interview is added so that students can take a comprehensive biopsychosocial medical interview. Learning objectives for Clinical Skills include conducting a clinical interview in a confident and professional manner, understanding the importance of confidentiality when dealing with patient information, acknowledging and responding appropriately to sensitive patient information, interrogating the patient's primary presenting problem, obtaining a complete medical and family history and taking a comprehensive psychosocial history by identifying the patient's coping style, support, interests, personality, strengths and fears. Role play amongst peers is the only pedagogical method used for practising interviewing techniques within the Clinical Skills Unit.

In her role as clinical educator, the researcher was in a good position to observe the behaviour of the students conducting role play exercises in their second year of study in the Clinical Skills Unit. Her main findings were that students seemed to struggle to create or maintain a sense of authentic doctor-patient relationships during role play and that they tended to interpret the aim of role play at this stage as having to reach a biomedical diagnosis rather than to establish a relationship with the patient. It was noted for instance that students tended to interact with each other as peers and there was often a seemingly light hearted approach to asking questions, with many students simply 'ticking off' all the medical points on the scenario sheet as the aim of the exercise. The questioning appeared rote and impersonal with the student 'doctor' mechanically reciting prepared questions and the student 'patient' answering equally perfunctorily. The art of phrasing questions clearly and succinctly was often taken lightly and not perceived as critical in helping to ease the possible tensions of an anxious or fearful patient. The 'patient' in the role play often appeared to simply read off large parts of the scenario provided. This usually led to a story leading to quick completion of the task and superficial engagement with potential problems set by the scenario. There was also minimal concern for any emotional issues that may underlie the case, as usually the 'patient' failed to act out such complexities. It was further noted that students tended to revert to 'textbook' medical terminology throughout their practice sessions, since in role play the 'doctor' and the

'patient' had a shared vocabulary and understanding of technical terms such as 'hypertension'. The student acting out the 'doctor' therefore made no attempt to think of simpler ways of rephrasing or asking questions as 'patients' and 'doctors' understood each other fully. It was also noted that role play exercises were often completed within 5-10 minutes, with students assuming that they had mastered the technique of carrying out a comprehensive biopsychosocial interview. As will be shown later, these teaching observations were incorporated into analysis of the interview data.

The learning outcomes that were pertinent to teaching communicative competence supported the formulation of the domains through which the video recorded interview data were analysed. These domains were designed to mirror phases of the interview namely preparation, initiating, and exploring, whilst the domain pertaining to the verbal or visible display of empathy was a common feature across all the phases of an interview. The domains formulated for the purposes of this study were:

- Establishing professional credibility with patients through physical personal appearance and the use of semiotic resources that form part of the medical Discourse.
- Initiating the interview, setting the tone and establishing rapport with patients through interpersonal physical positioning and introductory remarks.
- Achieving inclusivity in dialogue by encouraging patients to speak freely and acknowledging their stories.
- Appropriate display of professional empathy as demonstrated through both physical and verbal responses to emotional or sensitive issues raised in conversation with the patient.

In the description of findings which follows, the interviews conducted by the three groups are labelled A, B and C. When excerpts are used to illustrate similarities or differences in practice, the interviews are consistently identified in this manner. Since the main aim of the dissertation is to evaluate students' transfer of training and concepts encountered in the classroom and the Clinical Skills Unit to a clinical setting, a description of the prior teaching practice will be given before a description of the students' actual practice as recorded in the clinical area. This will allow for analysis of the possible lines of tension or alignment between prior teaching and how the students transform teaching into authentic clinical practice. As previously stated all teaching and role play practice related to conducting a comprehensive medical interview occurs during the students' second year of tuition. At the start of third year they begin to conduct interviews with patients in a clinical setting.

Establishing professional credibility

As indicated in the literature review, establishing professional credibility is not achieved solely through the language used or knowledge shared by the doctor in consultation. It is enhanced by non-verbal modes of self-presentation to the patient. First impressions are often enduring and therefore the study analysed students' visible presentation of themselves even before they started seeking medical information from patients. This aspect of analysis relied on detailing the semiotic resources presented by the students in their interaction with patients even before any verbal exchange occurred. Ron and Suzie Wong Scollons' (2003) concept of personal front was the analytic tool used to describe the type of social identity presented by their manner of dress and the semiotic resources they carried into this new environment of the clinical setting. The students' use of semiotic resources further gives a sense of how they are attempting to become members of a

community and a Discourse, in that using these resources becomes part of what Gee describes as being, acting and becoming actors in a socially determined Discourse of becoming a doctor (Gee, 1990).



Figure 2: Dress Code

During their first and second year of training students are taught that there is a dress code for staff within the clinical areas. The reason given is that “...inappropriate clothing may offend patients....and result in a lack of confidence in the care offered.... as well as negatively affecting the public image of the health care system” (*Introduction to Clinical Skills*, 2015:7).The code prescribes that medical students should wear a clean white jacket over their clothes.

In all three video recordings, the students are clearly identifiable as members of the medical profession (Figure 6). All wear the short white jackets synonymous with medical apparel for more than a century and seen as an accepted standard of medical professionalism. There is an embroidered emblem on the left hand side of the jacket and the words UCT Health Sciences are clearly visible below. A personal identification card is visible with a large 3 denoting the year of study and the UCT emblem. In video A, all four students visibly ‘wear’ their stethoscopes around their necks whilst in videos B and C only one student in each group displays her stethoscope. Each student carries a pen and paper which they use throughout the interview.

Building rapport

Building rapport with the patient starts as the interview commences with introductory remarks which often set the tone for the full interview that follows. Although medical students as apprentice doctors have the socially accepted power to enter the personal space of patients in order to start gathering information any interaction with patients benefits their need for learning more than it does the patient’s need for the restoration of health. This section of analysis examines how the students initiate building rapport with their patient. Elements such as the establishment of environmental privacy for the consultation, the manner of greeting and how respect and transparency are evidenced through both speech and behaviour were analysed to reveal how the students position themselves in their new role as medical students interacting with real patients. Ron and Suzie Wong Scollon’s (2003) concept of interpersonal distance in dialogue is further used to analyse how the position adopted around the patient may inhibit or build rapport.

During teaching sessions in their second year of training, emphasis is placed on the introduction to the patient as the foundation on to which the rest of the interview is built. Students are encouraged to greet their patients by establishing their name and by shaking hands or by a simple touch if the patient is too ill. Once students have ascertained their patient’s name they are encouraged to address the patient by name throughout the interview. They are further taught to ensure and respect the confidential nature of the information that they gather and to explain why they need the information from the patient (*Introduction to Clinical Skills*,2015:18). Confidence, quiet friendliness, respect and honesty in communication are qualities that are singled out as important for building rapport with the patient. The importance of ensuring environmental privacy (for instance by drawing the curtains around the patient’s bed) is not explicitly foregrounded during teaching as it is

presumed to be built into the students' understanding of confidentiality as affording privacy for the patient and as excluding others in the vicinity who are not directly involved in the interaction. In the students' prescribed reading this aspect of patient care is understood as attending to the physical needs of the patient by the doctor before information gathering starts (Mash, 2006).

In the three recorded interviews, the student groups generally adopt similar positions around the bed. In interview A the four students position themselves with two students on either side of the bed, with the closest student within arm's reach of the patient. In interview B all three students stand in line on the same side of the bed (on the patient's left hand side) whilst in interview C two students stand on the left of the patient's bed and one on the patient's right. All the students' bodily positions fall within the Scollons' concept of personal distance or the "distance within which we feel we must engage in some kind of social interaction with the other person" (Scollon and Scollon, 2003:54). This positioning within a close proximity to the patient acknowledges their intention to interact with their patient despite them having never met before. The students adopt a close to intimate distance to each other which suggests that they are a united front, they all have the same goal, they know each-other and what they need to achieve in this encounter. All students choose to remain standing for the interview despite the presence of chairs in close proximity.

Analysis of the position adopted by students and of the introductory moments of the interviews shows very different styles of starting the interview and students have mixed success at establishing rapport with the patient. The group conducting interview B appears to be the most successful at starting to build rapport with their patient when compared to the hurried and impersonal approach taken by the other groups who appear to struggle to achieve this task, as will be seen in the results described below.

The students from Interview A enter the patient's bed space when it has already been partially enclosed by the curtains around the bed. Each student softly greets the female patient (without any attempt to shake her hand) and they quietly adopt positions around the bed before the dialogue commences. The entrance of the students into the defined bed space of the patient and the full closure of the curtains as the interview starts group the students and patient into a specific interaction unit separate from the rest of the people in the ward area. Having positioned themselves within a personal distance from their patient the students have set up what Scollon and Scollon call a "people processing interaction unit" (2003:62) that requires one party to give an account of themselves while the other party has the social power to define an outcome for the former. Two of the four students (identified as A and B) position themselves on the patient's left hand side while the other two position themselves on the right of her bed. The conversation is initiated by Student A (Text box 1).

INTERVIEWER: Morning Mrs X. So we are medical students here at the University of Cape Town, we just came in today, just asking a couple of questions about ..Sorry I will just close this (*the student closes the curtain fully around the patient before proceeding with introduction*) just asking a couple of questions about what brought you here and also to just do a general exam, is that ok? And then obviously whatever we discuss today will stay between us and obviously our relevant lecturer and then just to introduce ourselves, my name is A..

INTERVIEWER: My name is B...

INTERVIEWER: I am C.....

INTERVIEWER: And I am D

Through the use of the word “so” to start her verbal introduction, Student A appears to be indicating to the patient the reason for them being at her bedside and the relevance it might have for her as the patient. The use of the word “just” in “we just came in today” suggests that they merely came in to hear her story. This may be a way of underplaying the medical aspect of their visit. The continued use of the word in “just asking a few questions” and “just do a general exam” may be an attempt to minimise the possible invasive impact that these actions might have on the patient, both mentally and physically. The interview thus starts off with the student apparently not wanting to dominate. However, there is no indication what value this interview might have for the patient and with the fast pace of statements by the student the patient’s voice remains silent. Student A continues to run quickly through the preliminaries, for instance with the

Text box 1: Introductory phase; Interview A

statement “...then obviously whatever we discuss today will stay between us”. She is stating this as a routine fact and seems to presume that the patient understands, tacitly accepts and acquiesces to this fact. No time is given for the patient to ask a question, agree or disagree. The student clearly becomes dominant over the patient in this part of the interview.

During this introductory phase of the interview, Student A clearly maintains eye contact with and talks directly to the patient whilst positioning her body facing towards the patient. Student B is hidden behind Student A and appears to be distracted and looks uncomfortable with the position he finds himself in. In the space of the first 45 seconds of the video he only glances twice at the patient but five times at the video recorder and then his eyes search around for some information (possibly the name of the patient which is displayed above the bed) which he focusses on and then records on his paper. His body position faces directly on to the bed and has no inclination towards the patient at all. These two students clearly display contrasting images of the comfort they feel at the position that they find themselves in.

As students' introduction of themselves to the patient forms the basis for the rest of the interview it is therefore important to examine a further dimension of the data, namely the time taken to perform this phase. Who directs and manages this part of the interview may suggest how control over the conversation is being established in the first moments of the interview. In 50 seconds

INTERVIEWER: Good morning sir.

INTERVIEWEE: Good morning doctor.

INTERVIEWER: My name is.A..(The student holds out her hand and shakes her patient's hand) I am a medical student and you are?

INTERVIEWEE: I am MrX

INTERVIEWER: My name is.....B (The student moves forward and shakes the patient's hand)

INTERVIEWEE: It is nice to meet you

INTERVIEWER: Yes. It is nice to meet you.

INTERVIEWEE: Thank you very much it is a pleasure.

INTERVIEWER: Thank you.

INTERVIEWER: My name is.... C (Student reaches across to shake patient's hand)

INTERVIEWEE: Please to meet you

INTERVIEWER A: Mr...X just like to tell you that what we are saying, asking you today will kept confidential. It will only be used for reporting to other doctors this case, the situation so don't worry we are not going to be telling anyone else about this

INTERVIEWEE: Ja, so....

Student A moves swiftly through the introductory remarks before each of the other students introduces themselves by name. The patient makes no audible comment throughout this time. Looking at this introduction there appears to be a lack of any personal touch. It is formal in statement of intent and appears to be rather hurried as student A continues to talk even though other members of her group are closing curtains and are not fully focusing their attention on the patient. It appears to signal that the student wants to move on and get what they need from the interview. The control of the introductory remarks appears to be firmly part of the student's agenda at this point in the interview. The evidence cited in the analysis of the introductory remarks of the students conducting interview A all mount up to an impression of the students establishing a position of authority over the patient at this stage.

The students in interview B walk to the patient's bed space in the ward but make no effort to screen their patient's bed off by drawing the curtains. Whether this is because there appeared to be no-one else in the immediate vicinity or they had simply forgotten cannot be determined through looking at the video recording.

Text Box 2: Introductory phase; Interview B

One of the students starts the interaction by acknowledging the patient with a sign of respect, addressing him as "Sir" before asking what his name is (Text Box 2). The patient returns this deference by using the title 'doctor' when returning the greeting. The student immediately states that they are medical students, which indicate their possible right to be at the bedside of the patient and to speak to him, but it does not really clarify what they will be doing for him. In this video each student shakes the patient's hand as they introduce themselves and acknowledges that 'it is nice to meet you' (the patient). The patient responds to this by thanking the students and despite their different roles, saying it is a pleasure to interact with the students. It is clearly evident that an

understanding has been built in these first steps of the interaction despite the lack of privacy afforded to the patient.

The length of time taken to perform these introductory remarks, namely 57 seconds, and the personal introduction to the patient by the students on an individual basis, before explaining about confidentiality, adds to a less formal, more empathetic feel to this introduction. The expectation created is that participatory dialogue between the patient and medical students is likely to follow. In this introduction the patient's voice shares equal time with those of the students.

The students position themselves all on the patient's left hand side as he is sitting in bed and all incline their bodies towards him. Combined with the warm handshakes (averaging 5.3 seconds in length), a picture of interested and empathic medical students as engaged listeners is emerging.

INTERVIEWEE: How are you?

INTERVIEWER: Good thank you. My name is....A ,and this is....B and this C .We are third year medical students and we would like to know if it is okay with you, (Student B looks around and moves to close the curtains around the bed space)if we just ask you a few questions. Are you comfortable with us speaking in English? Okay so anything that we discuss or anything that we talk about will remain confidential. Do you understand that? So m'am how can I call you today?

INTERVIEWEE: Linda.

INTERVIEWER: Linda.

In interview C (Text box 3) the patient starts the interview very quietly with a whispered "how are you" before one of the students says "Good thank you". The student then moves straight into introducing herself and her colleagues by name, identifying themselves as medical students and asking if they could ask the patient questions. In a brisk manner the student mentions confidentiality and asks "Do you understand that?" This short, rather terse question has the potential to intimidate a patient into giving an affirmative answer as the student speaks confidently and fairly fast. This interview is evidently taking place in a busy ward area as other patients and staff members are clearly visible on the video screen. Student A starts and continues the introduction while her colleagues close and adjust the curtains to exclude others in the

ward. The student then goes on to say "So m'am how can I call you today?". The student does not ask what the patient's name is and simply seems to ask for a single name by which to address the patient. This could be interpreted as disrespectful, especially as the patient is considerably older than the students. The patient presents her first name and seems to be pressured into continuing with the interview and answering the questions asked. By asking "how can I call you today?", the students seems to revert to behaviour associated with the role play exercise when students conjured up temporary names while playing the patient role.

The introductory remarks for interview C take only 40 seconds and are carried out by one student. Once again the introduction is carried out even though not all students have their full attention focussed on the patient (Student B is closing the curtains). The clipped, short sentences once more suggest that the student wants to move rapidly on with the main body of the interview. This overwhelms the need for building rapport during the introduction. The student appears to be

Text Box 3: Introductory phase; Interview C

putting the agenda of the task ahead of the patient's needs with a clinical, impersonal and rather mechanically recited rendition of the requirements for an introduction.

A noticeable omission by the students in interview C (as in interview A) is that they make no effort to shake or touch the patient's hand during the introductory statements. Unlike the introduction in interview B this introduction appears to make a more clinical or distant approach to taking the patient's history and lacks the warmth that could lead to a potentially satisfactory outcome, as seen in interview B.

A common feature in all three interviews is the verbalisation and acknowledgment of the need to keep all information divulged by the patient confidential. One group mentions that the information will only be discussed with "obviously our relevant lecturer", a student in the second group prematurely assumes an identity as a doctor by stating that the information will be shared "with other doctors" and the third that the information will be all "kept confidential" implying that it would remain between the interacting parties only. What the students do not explain is that the information is discussed in a small group tutorial led by a clinician in order to learn how to use the information to start the process of clinical reasoning to reach a working diagnosis.

Achieving Inclusivity: Questioning for information or questioning to hear the patient

Inclusivity refers to the opportunities given throughout the interview to the patient to speak freely in response to questioning that simultaneously allows students to gather the information they need. It gives patients the opportunity to communicate their own unique story whilst being questioned. The interviewer can then pick up clues from the information that is being articulated and direct further questions as needed. The assumption underlying inclusivity is that mutual trust should exist between patient and medical staff and that patients have the fundamental right to participate fully in getting their health needs met.

During Clinical Skills training sessions in second year, the students were encouraged to have a conversation with their patient rather than to interrogate them. Leading questions and "putting words in his/her mouth" are discouraged whilst using open ended questions, the importance of active listening, paying close attention to non-verbal cues that the patient gives and clarification of information heard is advised (*Introduction to Clinical Skills*,2015:18). As the patient's problems need to be explored, facilitation skills such as nodding, echoing the patient's words and repeating what the patient has said, are suggested to encourage the patients to speak freely and confidently (Mash, 2006). The interview process is further structured in training into definite phases as a mechanism for helping the students gather all the information they need to reach a comprehensive understanding of the patient's problem. Specific tasks related to the phases of the interview were introduced in practice. These tasks are identified as:

- Exploring the patient's problem, referred to as the Primary Presenting Problem (PPP)
- Understanding the patient's context through eliciting information about his or her past medical history (PMH) as well as through his or her family history (FH)
- Making an attempt to understand patients' perspective through eliciting their beliefs, concerns, expectations and feelings related to their problem. This information relates to the

Psycho-Social (Psy/So) aspect of the medical interview that is integral to a patient centred consultation (Mash,2006; *Introduction to Clinical Skills*,2015).

It is stressed to students that each phase of the interview contributes equally to conducting a comprehensive and balanced interview. It is explained that some questions tend to be geared towards gathering biomedical information whilst others are posed to develop an understanding of the patient's perspective and psychosocial situation.

Analysis of how the interview is managed and by whom it is controlled may reveal a power variance between the participating parties. Alternatively it may demonstrate how a mutually acceptable dialogue between equal partners may emerge. Fairclough illustrates how control over an interaction can be demonstrated in linguistic features of the interview. The sub-sections below will analyse elements of the interviews in order to indicate whether inclusivity of the patient has been achieved. Some of these elements are the use of open ended or closed questions that encourage or inhibit dialogue, acknowledgement that the patient's story has been heard, the type of question used as well as the content orientation of questions, whether interruptions occurred and who did the interrupting. Through analysis of these aspects of communication an indication of control over the interview and the extent to which the patient has been included may be determined.

Impact of open ended / closed questions

During the initial classification process in analysis, it was assumed that an open ended question would encourage the patient to speak freely whilst a closed question would elicit a brief response from the patient. A breakdown of the proportion of open ended questions versus closed questions is given below. The assumption that closed questions necessarily signal less inclusivity will be revisited at various points later in the results section where more nuanced analyses of the use of open ended and closed questions will be presented.

In interview A the patient was posed 55 open-ended questions out of a total of 213 questions asked throughout the interview. In a straightforward reading this suggests that 26% of questions asked offered the patient the opportunity to present her story in her own words.

Interview B apparently offered a slightly higher number of opportunities for the patient to formulate answers in his own way. 60 open-ended questions were asked out of a total of 165 questions asked during the interview (approximately 36%).

Interview C seemingly offered the patient the greatest opportunity to verbalise her story, demonstrated by the students posing 52 open-ended questions out of a total 122 questions (approximately 43%).

Impact of closed question signalling confirmation

Although the percentage of open-ended questions appears relatively low in all interviews, a further layer of analysis looked at the number of closed questions posed by the students that aimed at confirming that what they had heard from the patient was correct. This is tacitly acknowledging that what the patient said is important and needs confirmation. The importance of the information shared, and the student's acknowledgment of it as important by asking for confirmation, gives authority to the patient's voice and story. Thus what this further analysis of closed questions reveals

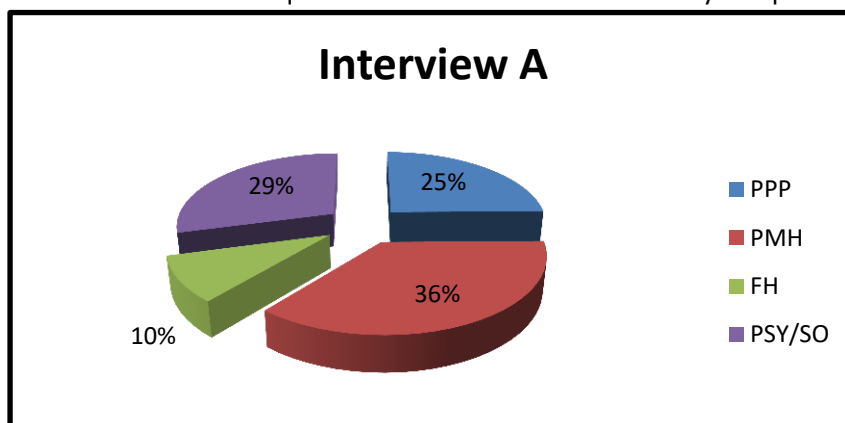
is that closed questions geared towards soliciting confirmation do not exclude or dominate the patient (as was assumed initially) but can function inclusively.

Interview A demonstrated 63 closed questions that were used to confirm that the information that the students had heard was correct. In combination now with the number of open ended questions the percentage of questions throughout the interview that invited and heard the patient's voice rises to 118 questions out of a total 213. 55% of the interview therefore gave some authority to the patient's voice. Interview B added 47 closed confirmation questions to the 60 open ended questions, therefore raising the percentage of questions in which the patient's voice was heard and acknowledged to 65% of the total interview. Interview C offered the least total number of questions presented to the patients, but 62% of the interview offered opportunity for the patient's voice to be heard and acknowledged.

Impact of questions related to biomedical or biopsychosocial information

A further aspect of the interview that was considered important for inclusivity was to determine the number of questions that the student asked relating to the biomedical component of the interview. This was then placed against the number of questions asked about the patient's life conditions and how the disease may affect the patient and his or her family. As mentioned before, questions relating to the latter could serve as an indication that the students were valuing the emotional and psychological impact that disease had on the patient and therefore understood the impact that this might have on any subsequent treatment or medical intervention. The biomedical component of questioning was read in this analysis as an indication that the students were trying to problem-solve following a more traditional bio-scientific approach, and attempting to diagnose why the patient was in hospital even if this was not a stipulated outcome for this encounter. Inclusivity would assume a biopsychosocial approach, where the students would balance their need to collect biomedical information (for diagnosis) with their desire to learn about and understand the needs and individual context of the patient. As is taught in a Primary Health Care led curriculum, a balanced distribution of questions would therefore not allow either aim to overwhelm the other.

In interview A 25% of questions related to the reason why the patient came to the hospital, i.e. the



primary presenting problem (PPP). The largest component, 36% of questions, related to the patient's past medical history (PMH), whilst 10% related to the patient's family medical history (FH) (see Table 1). 71% of questions therefore related to gathering bio-medical data or trying to problem-

Figure 3: Interview A: Categorisation of questions

solve whilst the remaining 29% were psychosocial questions (Psy/So) about the patient's life and the impact that the disease has on her life now and in the future.

Interview B, suggests a different picture to that of interview A. Table 2 demonstrates a strong

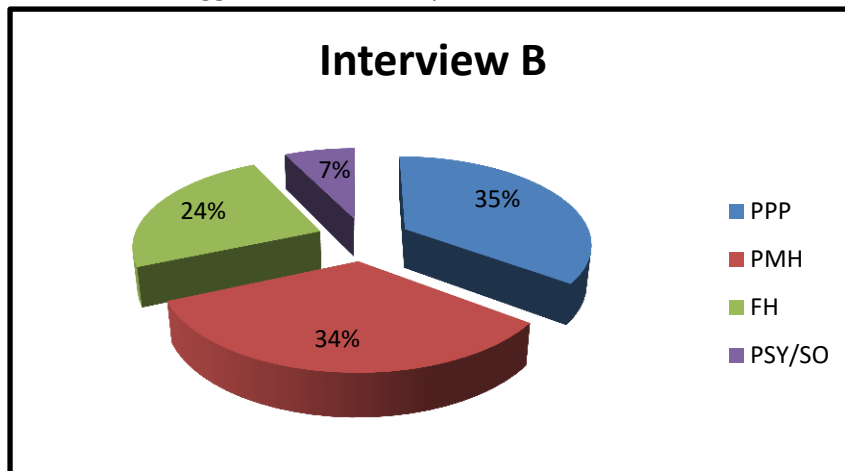


Figure 4: Interview B: Categorisation of questions

leaning towards the biomedical component of the interview with only 7% of questions related to the psychosocial dimension of the interview. This may be read either as the students seeing the interview as predominantly a problem-solving or diagnosing exercise and therefore directing the questions to this perceived primary task.

Alternatively the students may not place value on understanding the patient's life story and learning about how the disease process may have impacted on his life. A third option for consideration is that the students in this group felt more comfortable with factual questions and did not have the confidence to ask questions that could potentially raise emotions that they would have to cope with. However this rather decontextualized analysis of the type of questions asked proved problematic in this interview and does not capture the actual nature of the interaction. What actually happened is that the students allowed the patient to speak without interruptions at the start of the interview and thus they had already gained considerable insight into how his life had been disrupted by the disease process. Comments from the patient such as (in original transcript of HDV0008: Line26-27) "it was very sore, I was crying because of the pain" and "If I lay on the bed I lay still, if I just make a move I feel like I am dying. That is real" (Line 40-41) clearly illustrates right at the start of the interview how debilitating this disease was for the patient. How it affected his family is revealed in lines 39-40 (00:04:10) when the patient says "For that six months the tablets did not help. I could not walk. I must ask my boys, my wife to help me to the toilet even to move me." What cannot be assessed is how much of the emotional side of the interview the students absorbed during this initial recounting of his history and therefore did not ask about at a later stage. Looking at the video during this period of time (00:04:00 – 00:04:30) an assessment can be made of how often the students wrote down a comment or acknowledged the patient's story through body movement (e.g. head nodding). Such gestures were interpreted as the students recognising the importance of the patient's information and therefore implicitly understanding how the disease overwhelmed their patient's life. In this 30 second period of video recording the students collectively made six separate entries of the patient's words into their notebooks while there were also two definite "head nod" acknowledgments of his story. Without access to the student's written notes, it is difficult to interpret these gestures as signs that the students were hearing the patient's pain. These gestures do however add to a possible picture of the students hearing the patient's story. However at no time during the interview do the students refer back to the obviously devastating effect that this intense pain and the subsequent course of the disease process had on the patient and his family's life.

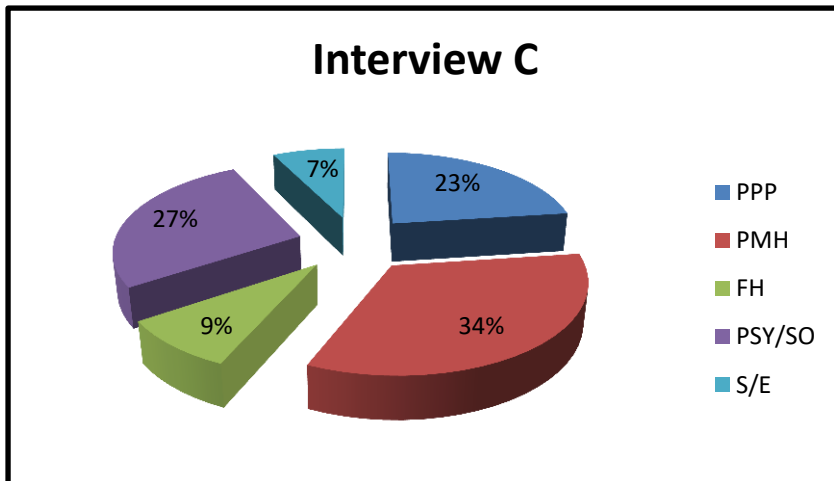


Figure 5: Interview C: Categorisation of questions

Interview C offers a similar picture to that offered by interview A (See Table 3 below). However the students in this group do offer another type of questions not mentioned earlier, namely questions of systemic enquiry (S/E). These are specific questions asked to exclude any other symptoms in another bodily system that the patient might not consider

important to talk about but which might have an impact on how this presenting problem is managed. As these questions are medical in nature they were included as part of the biomedical component of the interview. As in interview A, approximately one third of questions is directed towards understanding who the patient is and how this current illness has impacted on her emotional and social well-being.

Interview A (original transcript: HDV 0006: 55) “and do you take supplements or multivitamins?”

Interview B (original transcript: HVD 0008: 165) “do you cough ever, cough now or do you start coughing or shortness of breath”

Interview C (original transcript: HDV 0012: 37) “And did they manage to fix it, did they say what you had?”

Text box 4: Examples of multiple questions

Impact of medical terminology and multiple questions

This aspect of analysis looked at the content that was included by the students in each question. Consideration was given to how often two questions were melded into one (examples as shown in Text box 4) and secondly how often the student used medical terminology in the question

(examples as shown in Text box 5). During training students are explicitly instructed to ask simple questions and not to use medical terminology so that patients can understand what information they are looking for (*Introduction to Clinical Skills, 2015:7*). When several questions are melded into one question the possibility exists for the patient to deny or affirm both questions by responding to the part that is of concern whilst simply ignoring the other half. The patient may not understand what information is being asked for and important aspects of the story may be missed or wrongly interpreted. Using medical terminology may be the students’ way of doing, talking and being a part of a biomedically inclined medical Discourse (as described by Gee). However, it excludes the patient from the conversation. These terms are unfamiliar and place a barrier to the free flow of conversation and understanding between the parties. Terms such as hypertension or diabetes, although familiar to students through training, are often referred to as “high blood” or “sugar siekte” within the general population. Even a word such as “chronic” might be incorrectly interpreted as no specified time frame is mentioned. In situations such as these, use of medical

terms has the possibility of overwhelming patients and therefore excluding them from full participation in the interview process.

The use of these types of questions varied considerably between the groups. The group conducting Interview A offered only three instances of 'merged' questions and only once did they directly use medical terminology. The students conducting Interview B posed 14 'merged' questions to their patient whilst six questions incorporated the use of medical terminology. Group C asked the most 'merged' questions, namely 16, but did not use medical terminology during the interaction.

Impact of awareness of diversity

As mentioned previously, linguistic, cultural and social diversity is present both within the student cohort as well as between the students and patients. This aspect of analysis looks at which aspects

INTERVIEWER A: So what brought you into hospital? What was the matter? (Open)

INTERVIEWEE: Can I speak Afrikaans? (The student is evidently thrown off guard by this request and looks somewhat bemusedly at her colleagues. Student B standing next to her appears to throw his hand up which could be translated as either acknowledging her request, frustration at the request or irritation that this interview was now a problem due to not understanding the patient) um...um chest pain.

INTERVIEWER: Chest pain? (Closed/confirmation)

INTERVIEWEE: mm but not here.. in Vredenberg Hospital.Ja, in Saldanha.

INTERVIEWER: And then what- did they refer you from Vredenberg Hospital to us? (Closed)

INTERVIEWEE: Ja.

INTERVIEWER: Okay. (Confirmation)

INTERVIEWER: Mevrou kan meer sê in Afrikaans as u wil en dan kan ek vertaal vir hulle. (Open)

INTERVIEWEE: Aah-ek het in die nag so drie uur wakker geword en die pyn het my wakker gemaak.Dit was so swaar amper soos wat lê op my bors, so was hy.

of diversity are exposed during the interview.

Consideration is given to how students approach, use or miss moments where linguistic, cultural or social diversity may impact the type of professional relationship that is being built with the patient.

In interview A (Text box 5) the student commences with an open ended question and asks the patient: "What brought you into hospital, what was the matter?" The patient after a pause asks "Can I speak in Afrikaans?". The student looks to another colleague for confirmation who appears to softly repeat the question in Afrikaans for the patient. She then offers a brief answer in English "I had chest pain". The student presses on asking clarifying questions in English in order to draw out more information whilst the

patient continues to respond fairly tersely. The student is pushing her agenda at this point to get information at the expense of the patient's comfort. The patient's voice appears to be secondary to

Text box 5: Impact of linguistic diversity

the student's need to seek information. At this point another student, who has recognised that the patient is struggling to articulate her story in English, quietly but assertively breaks into the conversation and speaks to the patient in Afrikaans saying "Mevrou kan meer sê in Afrikaans as u wil en dan kan ek vertaal vir hulle." The use of the word 'meer' or more in English shows that the student recognises the possible wealth of information that is being withheld because of language difficulties and offers the patient the opportunity to tell her story in more detail in her language of choice. By giving the patient the right to speak in her mother tongue the patient voice is given the freedom to be fully heard. The patient responds with an affirmative exclamation and starts to give information much more freely and easily. The importance of recognising the right of the patient to speak in her mother tongue and understanding the depth of information that this may reveal is clearly illustrated in this short interaction. The students now continue to attempt asking questions in Afrikaans or English whilst their colleague translates as needed. Sharing of authority has resumed with the patient's voice being clearly heard. Awareness of diversity has led to a more inclusive interview at this stage. Although using this excerpt and the student's translation of what the patient says is adequate at this early stage in dialogue as it is factual, the emotive part of conversation has the potential to get lost in translation as will be seen in the section on empathy.

In interview B, following the initial opening question, the patient clearly recognises the weight his words carry as information the students need to gather, and starts presenting his story with the statement "Okay I will tell you now". The patient's voice is clearly heard as having the authority to give or withhold information. The students now allow their patient to speak uninterrupted for one minute and thirty six seconds. They encourage his voice by maintaining eye contact or nodding as they each write down aspects of his story as they hear it. Following three short clarifying questions about the information that they have heard, the students then allow the patient's voice to be heard for a further four minutes and forty one seconds as the patient gives a detailed and informative description of the course of his disease and the impact it had on him and on his family. By silently encouraging the patient to speak openly and without interruption, the students have allowed the patient to reveal many aspects of the disease process that might have been missed by using closed questions and that can now be probed for additional information as needed to obtain a comprehensive history.

The students conducting Interview C also start, following the introduction, with an open question. Although their patient appears more reticent to speak, the students use verbal acknowledgment to encourage her to speak freely. In the video recording it can be seen that Student A who is asking the questions has her body tilted towards her patient, maintains steady eye contact with her patient and five times during this brief interaction nods her head to acknowledge hearing and understanding her patient whilst twice recording in her notes something that the patient had said. These actions seem to 'prompt' the patient to speak, by tacit acceptance of her words, and granting her the space to continue talking.

Impact of interruptions

Although the above evidence leans towards the notion that the patient's voice is being clearly heard thus far, in order to gain a more comprehensive picture, the number of incidents where either the student interrupted the flow of the patient's voice or where the patient broke up the student's voice was considered.

An interruption in this analysis was recorded during transcription of the video recording as one party breaking into the speech of the other, either to add new information, correct the flow of information or to answer the question before it had been fully articulated. At the time of the interruption the action was interpreted as power by the interrupter to put their evaluation, translation, or knowledge into the forefront of the conversation and thereby control the dialogue for that moment.

Text Box 6 is used to demonstrate how an interruption to the flow of conversation may reveal which

INTERVIEWER: Before you, had this pains for the six months, how long, where, where did you get the pains? (Open, Technique, Probing)

INTERVIEWEE: It started about six months ago because it was about June

INTERVIEWER: Yes. Do, did your ankle, did it pain during the day, during – when during the day did it pain? (Open, Technique, Probing)

INTERVIEWEE: It was the whole day, day and night, twenty four hours. There was no stop in that pain.

INTERVIEWER: So it last for a long time. How long? (clarification for student)

INTERVIEWEE: Last for about how? Can you explain to me? (Clarification from student)

INTERVIEWER: I mean if you had the pain (Closed)

INTERVIEWEE: Ja.

INTERVIEWER: How many minutes or hours (interrupted by patient)

INTERVIEWEE: There was no minutes, no hours, straight, continues, it was a continuous thing. Don't stop. Was pain, that was trying to stop but just continue. There was no stop to that pain.

party is taking control of the interview process at that moment. In this extract, taken from interview B, Student A (The interviewer) is trying to determine both for how long the patient has had the pain and the exact location of the pain. In response to being asked multiple questions, the patient chooses to focus on the time frame rather than location of the pain, thereby controlling the information revealed. Student A struggles to articulate what information she is looking for and the patient asks her to clarify what information she needs. Rather impatiently the patient interrupts Student A as she tries to articulate her need to get a time frame for the

Text box 6: Example of interruptions to flow of interview

duration of the pain experienced by the patient, who forcefully describes the continuous character of the pain. Student A tries to push her agenda and control the patient's flow of words but is once more interrupted as the patient chooses to translate the question posed as "how did it" as a time frame not a possible description of the course of the pain as wanted by Student A. Student A then rephrases and repeats her question, attempting to understand the character of the pain. This extract can be seen as a struggle for control of the interview as Student A continues to quantify the information the patient presents whilst the patient attempts to reveal the debilitating effects and depth of the emotional stress of the continuous pain. Looking closely at the video recording at this point of the interview, the bodily position of Student A and her colleagues remain inclined towards

the patient and they all maintain eye contact with their patient. This picture appears to illustrate that the students are acknowledging the value of the patient's knowledge as important to their learning as they have maintained the position of attentive listening as the patient both interrupts their questioning and speaks. This brief extract reveals a potential line of tension between an analysis based solely on verbal dialogue and one including analysis of visual signs. Read solely through the verbal transcription of the dialogue, interpretation would suggest that there is a struggle between the parties for control of the interview at this stage in the interview. However when the verbal interaction is combined with visual aspects of communication, a picture of students acknowledging the patient's story is clearly observable.

What appeared in analysis was that the patients in all interviews used interruptions at stages in the interview and thereby demonstrated their implicit awareness of their role as holding essential knowledge required by the students. In Interview A the patient interrupts the students 11 times and a further twice to correct the translation that one student is giving to her colleagues. An example of such an interruption is taken from lines 28-30 (original transcript: HDV 0005) when the students asks, "And how did it feel when you were having the heart attack? Did you only have the chest pain or were?". At this point the patient interrupts the student's question to say "had pain in my arm." The patient clearly anticipates the question the student is going to ask and confidently answers before it is expressed.

Interview B demonstrates 13 interruptions by the patient whilst interview C only shows 3 interruptions by the patient to the flow of conversation. What was interesting was that except on one occasion in interview A the students never interrupted the patient's flow of words. In all these instances the patient's voice could assert itself over the student voice.

Impact of topic control

Fairclough (1990) highlights topic control as an actional component of speech that through analysis can demonstrate how social power may be exercised in conversation. In all the interviews the students controlled the flow of the interview by determining when to complete or introduce new topics. By this regulation of both the direction and pace of the interview it could be interpreted that control of this interaction lay with the students. However, as the patients had been chosen for the students by their clinical educator for interview and they were therefore were aware that the students were conducting their first medical interview, topic control does not singly demonstrate a control of the interview nor determine fully which voice dominated the interview. There is also the consideration that the patient, knowing that the students were novice, might allow them the control and planning of the direction of the interview.

Impact of fluency of questioning

For completion of this section of analysis, the fluency of the student's questioning technique was considered. Confidence and efficiency is projected through mastery of clear, understandable and secure phrasing of questions. Understanding each other is the foundation of a good doctor patient relationship.

The number of times the student used repetition of words in a question or rephrased a question multiple times in a single sentence was examined. The following excerpts from two of the interviews illustrate instances like these.

Interview A: Line 9: “So what brought you into hospital, what was the matter?”

Interview B: Line15: “So firstly I would just like to ask **why, why** you in hospital?”

Interview B: Line28: “So this was **on over happened** in six months?”

These brief statements from the initial introductory period of the interviews explicitly demonstrate the students’ inexperience when asking questions. During the comparison of the three interviews, it is noted that the students conducting interview B rephrased approximately 21% of their total questions asked whilst students conducting interview A rephrased approximately 12% of questions with the students conducting interview C coming in with the least number of questions rephrased namely only 9% of total asked. However when one looks at each interview comprehensively the number of times the student needed to clarify for the patient what they were asking equally suggests the possibility of miscommunication and misinterpretation of questions and answers occurring. For example in Interview C , line 154, the student asks “.. when did you stop with the contraceptives” and the patient clearly not understanding asks “When did I?”. The student then asks a simpler question “Did you take contraceptive pills before?” to which the patient responds affirmatively. This demonstrates the need for the students to practice phrasing questions appropriately for their patient’s understanding. Interview A offered 12 questions that needed to be presented to their patient so that she could understand what she had been asked previously. Added to the initial 12% of rephrased questions asked the percentage of incidents where possible student inexperience can be demonstrated rose to 17% of total questions asked during the interview. Using the same classification interview B now showed an increase to 30% of questions demonstrating a form of insecurity in questioning technique by the students. Interview C followed the trend with an increase to approximately 21% of questions asked.

This section has looked closely and objectively at categories of questions as indicative of giving one party more control over another. However, in authentic practice analysis of only the verbal component of an interview might be insufficient as an indicator for understanding and interpreting what is occurring in practice. The following example demonstrates how both verbal and visual information is needed to draw a composite picture of an interaction.

INTERVIEWER: So let me just clarify, when you say the pain here by the back, where exactly?
(Closed, Clarification)

INTERVIEWEE: Let me show you.

INTERVIEWER: So in your lower back. (Closed, Clarification)

INTERVIEWEE: Ja, lower back.

INTERVIEWER: Okay. So it is normal for your to experience period pains for about three days, but it went on for five days and actually that's when you came to Groote Schuur (Closed, Clarification)

INTERVIEWEE: Ja.

INTERVIEWER: Okay. And when about was this?

INTERVIEWEE: It was last week Wednesday.

INTERVIEWER: Last week Wednesday, okay, have you ever had this before, has it happened to you in the past? (Clarification, Closed)

INTERVIEWEE: First time

INTERVIEWER: Okay. So the – just do you want to tell me first about the shortness of breath or the pain in the back? Because I would like to know a bit more about both. (Open)

INTERVIEWEE: The shortness of breath,

INTERVIEWER: Ja. When did that begin? (Acknowledgment, Closed)

INTERVIEWEE: The short of breath starts in that period of severe pain

INTERVIEWER: So you only experienced the shortness of breath with the lower pain in the back?
(Closed)

INTERVIEWEE : Yes

INTERVIEWER: Okay. So the shortness of breath can you tell anything that makes it better?
(Open)t

INTERVIEWEE: Sorry?

INTERVIEWER: What makes the pain better, when you sit down, or when you slow down? Is it only when you are walking or are you short of breath sitting? (Clarification for patient, Closed)

INTERVIEWEE: Mostly when I was walking.

Text box 7: Interview C (Lines 16-40 in original transcript HDV 0011)

The extract above follows a pattern of question asked by one party (Interviewer) and answered by another (Interviewee) which is suggestive of the latter giving an account of themselves to the former. The use of successive closed questions requiring precise answers adds to the emerging picture of the interviewer requiring information to suit their need above anything the interviewee might want to add or clarify. On first reading the power gradient appears to suggest that the interviewee is simply acquiescing to the need for biomedical information from the interviewer. However at the sixth question the interviewer appears to hand over some of the control of the interview by allowing the choice of topic to be determined by the interviewee. The transfer of complete control is however tempered by the statement that both topics will need to be explored thereby suggesting that the power over the course of the interview is being shared not given over completely to the interviewee at this stage. Once the interviewee has chosen the topic, the interviewer takes control again by determining what information must be presented. Reading the verbal component of this interaction as a single entity, I would suggest that the techniques related to traditional medical interviewing are taking place in this interview and that the needs of the patient are secondary to that of understanding the biomedical component of disease in this patient when read in isolation from observation of the visual component of communication.

When one looks at the visual component of the data a different viewpoint, a somewhat gentler picture of sharing power rather than the need of one party to dominate the other, now layers itself upon the verbal component. The students have adopted standing



Figure 6: Initial Position

positions around their patient that traditionally is an accepted way of interviewing a patient reclining in bed and that gives the medical personnel both a height advantage and the choice of determining a personal distance in relation to the patient. This formation depicts an interaction unit termed a people-processing encounter where one party gives an account of themselves in order for a more powerful party to determine an outcome for them (Scollon and Scollon, 2003) and once more suggests that the power is firmly positioned with the interviewer. However two aspects of this interaction appear to contradict this sole power gradient. The close proximity of the interviewer to the patient, her inclination of her body towards the bed and her constant eye contact with the interviewee suggests attentive and respectful listening (Figure 3). Watching the interviewer's hand gestures and movements, the closed questions can now be read as exposing the inexperience of the students to understand the information given and using clarification to ensure that the information is fully understood. The second aspect is revealed when the visual recording shows the student trying to determine on her own body where the exact location of the pain occurs (Figure 4). At this moment, the patient takes control of the interview and in order to clarify for the interviewer exactly where the pain was says: "let me show you". The student acquiesces, turning her back and allowing the patient to touch her back in the correct position of the pain (Figure 5). This moment in the early stages of the interview contradicts the recognisable and socially accepted mode of behaviour determined in a people-processing encounter and rather demonstrates a more intimate conversational encounter that focusses on talking



Figure 7: Determining location

This moment in the early stages of the interview contradicts the recognisable and socially accepted mode of behaviour determined in a people-processing encounter and rather demonstrates a more intimate conversational encounter that focusses on talking

between a small group of people (Scollon and Scollon, 2003). This moment of intimacy demonstrates the potential for the emergence of a shared collaboration between the participants in this interaction that supports the goal of satisfying differing agendas but putting the human interactive role of medicine at the centre of all care. By reaching out to touch her interviewer, the patient breaks the tradition of being subservient to the interviewer whilst, by turning her back to be touched the student on turn acknowledges the importance of understanding the information held by the patient.



Figure 8: Shifting position

Having suggested that through her behaviour the student demonstrates her acknowledgment of the importance of the role the patient plays in making this a successful interaction, what cannot be determined from this interaction is the role that gender or race might play in allowing the patient to touch and the medical student in turn to be touched. The need to feminise the student cohort has resulted in greater female enrolment at medical schools throughout South Africa, with female enrolments outnumbering male by 2003 (Breier and Wildshut, 2003). What contribution this makes to a gentler more empathetic approach to patient care is beyond the scope of this dissertation. Similarly, consideration is not given to the racial or cultural profile of the student cohort in comparison to that of the general patient demographic profile

within the Western Cape.

Demonstrating Professional Empathy: Recognition of the impact that the disease process has had on the patient's life

The fourth domain chosen for analysis is how the students react to the human and emotional side of the story presented by the patient. Empathy in the medical interview refers to the students' ability to sense, identify and respond appropriately to their patient's emotions, fears and concerns. It can be evidenced in both verbal and visual signs in moments in the interview in which the student acknowledges or ignores the impact of disease on patient's life. Uncovering, understanding and acknowledging the individual patient's perspective on the disease process distinguishes a healthcare professional following a Primary Health Care approach to health care. The empathetic healthcare provider who listens attentively, hears what the patient needs and responds appropriately has the patient as the focus of all care and interventions in contrast to a biomedical approach to health care where the primary focus is on discovering the biological cause of disease.

Empathic communication is essential for establishing a good doctor patient relationship and is incorporated in the role play practice through the introduction of a potential sensitive issue into all classroom scenarios. It is assumed that verbalising such information may prove difficult for the student 'patient' or to respond to if the student is role playing the doctor. Examples of sensitive issues include disclosing an HIV status, revealing a form of abuse or issues related to sexuality. In their clinical skills handbook the students were advised to observe the patient's non-verbal cues carefully and to be sensitive to the patient's mood and non-verbal responses (*Introduction to Clinical Skills*, 2015:18).

Three extracts from the interviews have been identified to illustrate whether the students managed to recognise and relate to the patient when the influence of the disease clearly impacts on the patient's life and emotional wellbeing.

INTERVIEWER: Is there, is there any reason why, do you have bad memories of the previous one?

INTERVIEWEE: Ja. (The patient becomes very emotional at this stage and starts to cry as she briefly verbalises her fear that a further operation may be needed to correct her heart valves)

INTERVIEWER: Are you okay to continue? (The patient is not seen on the recording so it is assumed she gave physical consent) So in terms of your expectations for this hospital, what are you hoping to get out of this?

INTERVIEWEE: I beg your pardon?

INTERVIEWER: In terms of this hospital visit, what were you hoping to get out of it? A cure or?

INTERVIEWEE: A cure.

INTERVIEWER: So would that be a cure rather through medication rather than operations? Am I correct in saying this?

In an extract taken from Interview C, the patient becomes emotionally distressed and starts to cry as she is confronted with a question about her fears and expectations related to her current problem (Text box 9). Up to this point the students have maintained good eye contact and have engaged well with their patient. At this stage however there is the first rather long silence and through their body language the students start to show visible discomfort at the situation in which they find themselves. The four screen prints below demonstrate how the students' discomfort is manifest in their body

Text Box 8: Excerpt 1, Interview C (Lines 188-196 in original Transcript: HDV 0011)

language. The screen prints are captured over a period of 30 seconds. A brief explanation of the students' action follows each of the appropriate screen prints.



Screen Print 1 (14:52)

In screen Print 1, which is drawn from the early part of the interview, both students have positioned themselves so that their bodies incline towards their patient. This can be read as acceptance or empathic concern for the patient. Both maintain steady eye contact with their patient as they listen to her story. This occurs before she became emotional and starts to cry.



Screen Print 2 (14:58)

Following the patient becoming emotional, the student on the left in Screen print 2, taken at 14 minutes 58 seconds into the interview, who is closest to the patient tilts her body away and presents her shoulder to her patient. She also breaks eye contact and glances towards the camera as though looking for help. Her partner on the right also loses eye contact and focuses on her notes. Her body position remains relatively unchanged, but she is shielded from immediate contact with the patient by the other student. They both show discomfort with the patient's emotions.



Figure 8: Screen Print 3 (15:04)

In Screen print, the student on the right, maintains her silence as well as her body position inclined away from her patient. Her focus is held by her notes and she is avoiding eye contact with the patient. The other student looks to her as if for guidance on how to continue the interview.



Figure 9: Screen Print 4 (15:24)

One of the students not seen on the video recording then resumes questioning after asking the patient if they can continue. As can be seen in screen print 4, the student on the right shifts the inclination of her body, once more tilting towards the patient and eye contact is re-established. The other student remains obscured and focuses on note-taking.

The second extract taken from Interview A (Text box 10) looks at verbal utterances made by

INTERVIEWEE: Laas jaar June, maar ek het nie teruggekom nie. Ek moes teruggekom het, maar ek het nie. Ek was te bang doctor!

INTERVIEWER: June last year she was diagnosed

INTERVIEWEE: I was too scared. (This comment is said softly in an aside as the student translates for her colleagues)

INTERVIEWER: And then did you ever before in last year, before you were diagnosed, did you experience any shortness of breath, like, you would do something and you would feel like you were short of breathe?

INTERVIEWEE: Ja, ja.

INTERVIEWER: And then what sort of activity, what did you experience shortness of breath sitting down doing, were you just doing normal things around the house.

students when the patient's concerns and fears are verbalised. The patient opens this extract speaking in Afrikaans and verbalising that she did not come back for a follow-up because she was too scared "Ek was te bang doctor!" The student who is competent in speaking Afrikaans now partially translates the patient's words for her colleagues "she was diagnosed in June last year". She does not however mention the patient's reason for non-return to the hospital or identify any emotion in the translation. The patient interjects softly now in English, "I was too scared". By reverting to speaking in English the

Text Box 9: Excerpt 2, Interview A (Lines 1111-129 in original transcript: HDV 0005)

patient is emphasising her fear about returning to the hospital and trying to make the students understand how important this is to her. Unfortunately the students simply pick up with asking more biomedical questions and the moment passes with little recognition of the emotion or the patient's concerns being acknowledged or even recognised. The patient goes on quietly answering the questions. This illustrates a case where the ability to understand and respond in the patient's own language did not necessarily lead to greater empathy in the students.

As this appears to be a crucial moment in the interview where the patient's voice was lost in the student's need to collect and understand biomedical information for the purpose of diagnosis, this interview was further scrutinized for other moments where the patient as a person may become secondary to the voice of the students as emerging doctors.

In the final extract the patient identifies her young nephew as having a heart problem (See Text box 10). She uses the word 'bang' (scared in English) three times in the first paragraph and states he is asking many questions about her stay and the reason for her admission. Other than asking how old her nephew is, the interviewing student does not pick up or respond to this obvious concern the patient verbalises. The student now becomes forceful in setting her 'medical agenda' by insisting "u moet vir hom sê hy moet". There is no negotiation in the use of the word "moet" (must in English). It

appears to be the patient's obligation to inform her nephew that he has no choice but to go back to the doctor.

INTERVIEWEE: (indistinct 00:09:07) is net die - my oudste suster se seun, hy het ook 'n hartprobleem. Maar hy is baie bang, hy is baie bang en hy is – my suster het my nou die aand gebel en gevra - gesê hy is nou baie bang wat ek lê nou hierso. Sy auntie is nou hierso en hy, hy baie,hy vra baie nou wat gaan aan.

INTERVIEWER: Hoe oud is hy nou?

INTERVIEWEE: Hy is ses en twintig.

INTERVIEWER: So hy is nog baie, baie jong. U moet vir hom sê hy moet gereeld na die dokter toe gaan... (Interrupted by patient)

INTERVIEWEE: En hy het 'n brief gekry by – van die Kaapse hospitaal maar hy wil nie.. (Interrupted by student)

INTERVIEWER: Hy moet gaan want dit is baie goed as u dit vroeg vind, kan u dit uitsorteer, maar as u wag dan is dit (Interrupted by patient)

INTERVIEWEE: Hy wil nou eers kyk wat hulle met my aanvang en dan...

The patient interrupts the student to say her nephew does have a letter from a hospital but he does not want to go. Before she can finish her sentence to possibly furnish a reason for his reluctance to attend, her response is interrupted by the student insisting that he should attend the hospital. The student presents her argument, increasing the pressure on the patient, by starting to state a possible consequence for the

Text Box 10: Excerpt 3, Interview A (Lines 108-120 in original transcript: HDV 0006)

young man should he not attend the hospital. The patient now interrupts the student to complete her narrative by stating her nephew is waiting to see what happens to her before making his decision to attend hospital or not. This appears to curtail the student's insistence that the patient's nephew be seen at the hospital and routine questioning resumes. In this extract the patient's and her nephew's concerns appear to be secondary to the student's strong belief that the only correct way is for him to follow the dictate of the hospital. The doctor-centred voice of the student is clearly heard here above that of the patient.

This chapter has drawn on both course materials and classroom observations to lay the foundation for the analysis of video recorded interview data that shows medical students conducting their first medical interview with a patient in an authentic clinical setting. As has been revealed the introduction of the biomedical component of a comprehensive biopsychosocial interview is introduced in the second year of training prior to the students interviewing patients in a clinical setting. Whether and the extent to which the students have managed to amalgamate the biomedical component of a medical interview with the generic and empathetic interviewing skills taught in their first year of training will be discussed in the following chapter.

Chapter 5

Discussion and Conclusion

Introduction

From the start of training, medical students in the Faculty of Health Sciences at the University of Cape Town are immersed in a curriculum that has a Primary Health Care focus. In this curriculum, the overarching principle of delivering patient centred care should be enacted through displayed values of empathy and respect for the patient whilst ensuring patient autonomy. This approach to healthcare delivery is emphasised at all levels of training, with the aim of instilling a particular philosophy of healthcare (UCT, Primary Health Care Directorate). In their third year, medical students enter the clinical area of a tertiary level training hospital and start interacting with hospitalised patients. This research study analysed the first biopsychosocial medical interview that trainee doctors conducted with a patient.

The principal aim of the study was to establish whether students in their third year of training managed to establish a professional yet caring relationship with a patient, governed by the values of respect and empathy, in a tertiary setting on first contact. In this chapter, the results presented in the previous chapter are used to assess students' performance and evaluate the effectiveness of their prior training, in particular the use of role play as a teaching method for preparing students to conduct a comprehensive biopsychosocial medical interview with a patient.

The structure of this chapter will mirror that used in chapter 4. Literature that highlights the importance of each aspect of the interview starts the conversation. Discussion will then centre on areas of alignment or disparity between the techniques taught, the process of teaching and the students' performance in an authentic clinical setting. Changes to current teaching practice will be recommended to conclude the discussion.

Establishing Professional Credibility through Non- Verbal Self Presentation

According to Ron and Suzie Wong Scollon (2003), an interaction order is established and is identifiable through non-verbal ways of being between parties who find themselves at the same place and time. The interaction order is made visible through the semiotic resources used by individuals to construct a particular social interaction. In this study the concept of personal front was examined to determine how this non-verbal aspect of communication may contribute to establishing professional credibility when setting up the medical interview. Personal front was described through the dress code adopted by students as well as through the display of visible signage or equipment carried into the interaction. It is further argued that by visibly displaying the 'tools' of the medical profession, including material objects and aspects of medical Discourse, the students are attempting adoption of a new identity, a new profession, that requires a new way of being, acting and doing (Gee 1990).

The results revealed that all three groups of students in this study complied with the requirements for establishing professional credibility through their presentation of a socially recognisable personal

front as a health professional (in training). The visible display of artefacts such as stethoscopes, dress, name tags and writing tools to record the interview contributed to the student doctors' professional credibility and potentially instilled confidence in the patient. It is noted that the patient in Interview B mistook the students for doctors, addressing them as such before they introduced themselves. The students' physical appearance had therefore projected to the patient the impression of professional credibility. These results concur with findings presented elsewhere (Lill and Wilkinson 2005; Newman, Wright, Wrenn and Bernard 2005; Epstein et al 2008; Au, Khandwala and Stelfox 2013) that the significance of a health professionals' personal front contributes to establishing professional credibility as well as plays a role in influencing patients and their family members' perceptions of a health professional's competency, trustworthiness and suitability.

Initiating the interview and building rapport

The results show that there is variation in how well the different groups of students managed aspects of initiating a medical interview. The data demonstrates moments where students appear to have forgotten the teaching they had undergone (e.g. they do not shake hands). There are however more serious omissions in their interaction with patients that may point not merely to superficial lapses of memory on the part of the students but rather to the inadequacy of the teaching methodology chosen to prepare the students for clinical practice.

The first area of pedagogy that causes concern is students' tendency to transfer environmental limitations and other aspects of peer interaction experienced during role play uncritically into the authentic interview with a patient in a clinical setting. During training by role play, environmental privacy is an aspect of the interview process that is mentioned but not performed. Due to the large student classes the students talk directly to each other, on a one-to-one basis, and interact within touching distance of the next pair. Disclosure of information during role-play may thus be easily overheard by adjacent pairs and is not explicitly identified as a problem that may, in the clinical field, affect what information the patient is prepared to share or chooses to withhold. By failing to provide privacy to their patient in a clinical ward setting, the students conducting interview B demonstrated how failure to recognise and transform the physical limitations of role-play could translate in an authentic clinical setting to a loss of professional credibility and could potentially suppress the patient's open disclosure of information. A further example of students' tendency to transfer role play behaviour uncritically to clinical practice occurs when a student does not ask the patient what her name is, but rather enquires "How can I call you today". During role-play students make up their names so are often asked for their names in this way, to which they often respond "call me XXX today". The authenticity of speaking to a patient is lost at this moment.

A second deficit in training is clearly revealed by the change from a one-to-one interview experienced during role play to speaking to the patient in a group of three or four students in a clinical setting. Attentiveness, eye contact and appropriate body language are aspects of teaching that are stressed during role-play as demonstrating respect for the patient and encouraging an open and trusting dialogue. According to Larivaara, Kiuttu and Taanila, (2001) these behaviours are the hallmark of a skilled interviewer. The challenges presented by working as a group in clinical practice is not considered during training. It proves to be more difficult for everyone in a group to maintain respectful attention towards the patient at all times. Behaviour is much more complex to coordinate in groups than when individuals face each other. The visual data revealed many moments in practice where not all the students gave their full attention to the patients, for instance some

students were busy closing curtains whilst introductions were being made by their peers. Some students furthermore did not interact optimally, choosing positions where they were blocked or concealed from the patient's view. In this case the training provided during role play becomes more complex to apply in practice.

The third aspect of concern relates to the concept of patient confidentiality. Although all three groups of students in this study informed their patients that any information revealed during the interview would remain confidential as is taught and practised during role play, the full depth of this concept has either not been fully explored in teaching or fully understood when applied in authentic clinical practice. The commitment to confidentiality prohibits the disclosure of information to others without the patient's consent and implies explicit and transparent disclosure to the patient should any of the information be used or shared with others at a later time. Howe and Anderson (2003) suggest that concern about how their information will be used for student learning is a major barrier for patients wanting to take part in helping students' learning. Transparent dialogue builds trust and the patients have a right to know for what reason the information they supply is being used as in this instance it is not going to benefit them from a medical point of view. Denying patients the right to know how information will be used means that the right of the medical student to learn from patients supersedes the patients' right to privacy when discussion of their life stories occurs away from their immediate vicinity. The voice of medicine dominates in this case the real life world of the patient and is contrary to the principle of patient centeredness.

The introduction to the patient is critical in setting the foundation for a satisfactory relationship to develop and it follows that statements of intent should be explicitly verbalised and fully transparent. A moment in the interviews where the patient's right to autonomy is compromised is demonstrated when all three groups of students fail to fully disclose the purpose of their role at the patient's bedside. Being interviewed and examined repeatedly by groups of students in the different years of clinical training has an impact on the patients' physical, mental and emotional well-being. Although all the groups introduce themselves as medical students they do not explain that this was their first attempt at taking a medical history. They do not indicate that although this interaction will not benefit the patient in the current situation, this history will aid their learning to become skilled and competent physicians in future. The patient would then know that no new medical information would be forthcoming for them during this encounter but that they were assisting future doctors in training. The importance of explaining to the patient the significance of this interaction needs to be explicit in order to give the patient autonomy over both their words and their body especially as the benefit of this interaction lies firmly in the students' domain. The verbalisation of their position as medical students without immediate role clarification hints even at this early stage in training, that the right of medicine often supersedes the right of the patient. This is a situation noted by Marracino and Orr (1998) when they consider the possible assumptions made by students when they neglect to fully identify their role or clarify their intention when interviewing patients.

The values that support a comprehensive introduction in order to build a mutually satisfying relationship appear to be lost at times during the short introductions performed by the students. Although all three groups did cover many actual aspects of introduction, more substantial and nuanced effort at building a relationship with the patient is not always apparent in the interview data. At least part of the problem, as indicated above, can be found in the types of training that preceded students' performance of an interview with a real patient.

Inclusivity: Questioning for information gathering and hearing the patient

This domain of analysis looked at the data globally to determine the structure of the interview and whether one of the parties in the interview became dominant or controlling. This study applies Fairclough's (1992) notion that the force or control over an interaction may be revealed through analysis of textual data to determine how interactional control is managed or maintained. Analysis of the types of questions asked, interruption to speech, change in topic and question domains was undertaken to probe whether verbal performance during the interview may be suggestive of a particular underlying ethos guiding the interaction. As previously stated, the change to a Primary Health Care led medical curriculum places patients' needs at the heart of all medical interactions and interventions. The curative orientation of the doctor to cure should not overwhelm the need of the patient to be heard and to fully participate in all aspects of care. Inclusivity in dialogue therefore rests on the understanding that for the interview that starts a medical process, to be meaningful for both parties, the goal of one party or the voice of one party should not overwhelm the other.

In all three interviews the students at times used a combination of question types and facilitated an open dialogue by giving the patient the time and encouragement to speak freely without interruptions. They similarly shaped their interview at times to allow the patients' perspective on their disease to be revealed and acknowledged by asking questions related to the disease process in combination with questions related to patients' lifestyle and the concerns that patients may have. At various points of their interaction they successfully use a combination of techniques to draw the patient into conversation and seem to have started the journey of combining both the scientific and humanistic approach by seeing the patient with the disease as important, not only the disease process itself (Lappen, 2011). A noticeable omission in the questioning by all the student groups was to elicit from the patient what medical information the patient had or found out about the nature of the disease. Drey and Papen (2004: 314) suggest that "Patients' own information seeking practices, their actions and reactions towards information, are central to understanding people's involvement in their own healthcare".

To speak freely and openly implies that both parties understand and are understood by the other. The importance of both fully understanding and being understood in conversation is crucial in the medical interview scenario where the health outcome for an individual depends on comprehension and open dialogue. This brings to the fore the relevance of language and cultural comprehension in a multilingual and multicultural country such as South Africa. In a study conducted at the University Of Cape Town to demonstrate the clinical benefit of communication in the patient's home language, Deyi and Xhalise (2014) illustrate that patients find it difficult to express the details of their illness to the health professional if they speak a different language. Language barriers often restrict the patient from giving a detailed account of the history of their illness. They refer to the loss in depth and richness when conversation was conducted through a translator and show how misunderstanding can have the potential to lead to a misdiagnosis. Where language was not a barrier to communication, the patient was more involved in the conversation, the patient opened up conversation more easily, discussion flowed more simply and trust appeared to develop more quickly. These obstacles to communication described above are clearly illustrated in interview A where a language barrier initially restricted the flow of conversation until a student who could converse with the patient in her home language intervened and facilitated a more open dialogue.

However, the possibility of losing richness in translation is clearly evidenced later on in the same interview when the student factually but only partially translates the month and year of diagnosis for her peers but omits to translate the patient's fear of returning for a follow-up visit. This information, which is crucial for understanding and insight into limiting aspects of the patients' health seeking behaviour, is lost to the majority of the student group.

Although the teaching of languages is not included in the context of the Clinical Skills department, the importance of language in gaining information from and the trust of the patient is an important facet of doctor–patient interaction. Language tuition is a vital component of the medical curriculum at UCT and starts in the second year of training. However, the integration of language during clinical skills training and practice occurs only twice a year for a single session at a time and coincides with the teaching of clinical examination. The students are instructed to ask their patients to follow certain requests e.g. “Please turn your head” or “I am going to feel your tummy” etc. Role-play as a means of practising history taking does not incorporate a language component and is taught exclusively in English and without consideration of the possibilities of miscommunication that may result from language or cultural variation. There is also no cognisance of the cultural or societal sensitivity that the patient might bring to the conversation.

Demonstrating Professional Empathy

As indicated in the literature review, clinical empathy is described by Mercer and Reynolds (2002) as a form of professional interaction based on skills or competencies rather than based on a subjective emotional experience. They go on to recognise that the cognitive aspect of empathy calls the healthcare professional to engage with the patient's perspective, beliefs, values and experiences but does not call for over-identification or ‘feeling’ for the patient's suffering on an emotional level.

The emotive domain was the one aspect of the patient centred interview that proved most problematic for all groups of students. Moments in the patient's story that dealt with emotion (physically shown or verbalised) were often ignored, not verbally acknowledged or blocked through the use of gestures or bodily positioning. What is very obvious in behavioural aspects of the students' interaction with their patient is that they have not yet mastered the art of empathetic listening or understanding the depth of patients' emotions and feelings. As has been shown through the interview data, they responded in various ways when patients became emotional, positioning their bodies away from the patient, showing their distress when having to deal with a patient's request to speak in her own tongue or verbally overwhelming the patient's fears and voice in a dogmatic and authoritative manner.

Empathy in speech is enacted through both understanding the patient and being understood in return. In order to understand each other the student doctor and the patient must be able to converse in a common language. The importance of language acquisition in a multilingual society is reinforced throughout this study as promoting patient centred communicative competence without restriction or limits to open communication developing. Without competent linguistic ability there exists the danger that patients are seen without a context and since only minimal information can be collected when there are serious linguistic barriers, patients are transformed back into being seen simply as diseases to be cured. In such a context the student doctor reverts to relying on and collecting only biomedical information for diagnosis and the formulation of a treatment plan. The traditional biomedical approach is adopted during questioning at the expense of a biopsychosocial

approach. Communication in the patient's home language or language of choice is seen as a critical element for building rapport. However, a multilingual interview can clearly lead to frustration as evidenced by both parties in Interview A (The student throws up his hand and the patient is not able to verbalise her story comprehensively).

The tendency of students' medical voice overwhelming the voice of the patient in the instances above may point to inexperience in dealing with life issues or over-enthusiasm at being within the clinical field for the first time. Cushing (2015) does suggest that the possibility of questioning raising an emotional response in patients is a general concern for medical students. This aspect of the interview does nevertheless encapsulate the art of medicine rather than the scientific dimension and the two dimensions should work together to recognise the uniqueness of the disease process for the individual patient rather than ignoring or blocking the emotion and reverting to scientific medicine as the cure and answer to all complaints, worries, fears and the process of disease.

Recommendations for Teaching Practice

The discussion has shown up a number of areas where students have not yet internalised all the nuances that are embodied in the execution of a comprehensive biopsychosocial interview. This section will develop some recommendations on how to strengthen teaching and learning practice in order to facilitate the students' movement from the classroom into the clinical area. Throughout this section, the researcher draws on a combination of classroom observation and the data of this study to outline specific areas where the students interviewing skills may be enhanced by changes in teaching strategy. Until the move into clinical practice in the third year of the curriculum under discussion, medical students have not conducted a comprehensive medical interview with a patient. As described before, the sequence of learning interviewing skills takes place over two years. Generic and psychosocial components of the interview process are taught in first year whilst the biomedical component is added in the second year of training. Together this training should result in students understanding and being able to carry out an inclusive biopsychosocial interview. Within the Clinical Skills Unit, in a pedagogical setting, students are taught to ask questions covering certain domains (e.g. the primary presenting problem, past medical history, psychosocial information), how to formulate questions (e.g. open vs closed, using lay terminology, not medical jargon) and the approach to be used (e.g. respectful, empathetic). When doing their first interview, in a clinical setting, students start moving away from a student identity and start entering a professional work setting (the clinical area) where they will need to assume the role of members of the medical profession, performing the complexities of medical Discourse proficiently. Dall'Alba and Sandberg (2006) refer to a model of professional development devised by Dreyfus and Dreyfus that suggests that movement from novice to expert professional occurs in stages. Using this staged model it is assumed that students as novices moving into a clinical practice environment follow explicitly taught rules in order to achieve their goal. In order to reach the desired level of professional competence embodied in a Primary Health Care ethos the students will thus now need to interact as frequently as possible with patients followed by personal and guided reflection on how and what information is collected or omitted. Continued situational-dependent practice is essential for improving proficiency in communicating with patients (Dall'Alba and Sandberg, 2006).

The data suggests that role play as the single pedagogical method for instructing medical students on how to conduct a medical interview may not be adequate in preparing them to take a

comprehensive biopsychosocial history. Although the groups have all structured the interview to cover the domains required for a medical interview (biomedical and psychosocial questioning) and equally have managed to formulate questions adequately (a mix of open and closed questions) the evidence appears to demonstrate that they follow a formal and mechanised approach to performing the interview. They have demonstrated that they are following certain explicit rules of instruction, namely developing sections of content and attempting to formulate questions adequately. However, a Primary Health care led curriculum calls for the patients' needs and wishes to be the focus of all medical interactions and interventions and for the health professional to respond appropriately to uniquely individual facets of communication with patients. The data appears to demonstrate however that a caring approach to the patient appears to be secondary to the need to gather information even at this early novice stage in the students' professional development.

The pedagogical setting that prepares the students for this first real interaction presents certain logistic factors that call into question the effectiveness of role play as the sole pedagogical method. Teaching large numbers of students precludes extensive individual feedback which is vital after role play practice, as will be discussed further below. Although this pedagogical method in this context has allowed the students to learn how to structure an interview, it has not offered them the opportunity to both recognise and experience the complexities and sensitivities needed when conducting an interview with a patient. The nuances of building a caring yet professional relationship is therefore not clearly visible in the data at this early stage of clinical training and student performance. Instead students primarily demonstrate their ability to structure questions to gather information covering certain domains.

Although the physical aspects of practice that will improve both patient comfort and assist in building rapport (e.g. shaking hands, ensuring privacy or conducting an interview whilst seated rather than standing over the patient) can be incorporated into the pedagogical setting, instilling an attitude remains a challenge for clinical skills teaching. During role play students use scenario scripts constructed by the clinical educators that are explicitly written to contain potentially sensitive information such as, for example, the 'patient' having to reveal an HIV status or the impact of disease on family life. Despite this there remains amongst students an unawareness, ignorance or inexperience in dealing with the emotive dimension of gathering information in authentic practice. As mentioned previously, through lack of experience in both clinical practice and life experiences, students are unable to imagine and portray realistically in role play the emotive or psychological effect that disease could have on both the individual and the life of a family. Role play does not appear to be an adequate method for inculcating the required attitude that supports placing the needs of the patient at the centre of all care.

Role play on its own further fails to foster an understanding of the rights of the patient when clinical interviews are conducted primarily for students' learning and not focussed on the patients' needs. The concept of giving the patients autonomy over their bodies and voices through honest disclosure of information about the purpose of the interview is not visible in the data yet is foundational in establishing the proposed relationship. The patient's right to safeguard personal information alongside the right to informed consent covers the right to have the reasons for all procedures or interactions explained honestly and comprehensively. At this critical moment in dialogue and initiating rapport the needs of the doctors in training supersedes the patient's right to participate fully in the health care journey. As practised in a pedagogical setting, role play therefore does not

appear to establish or reveal the challenges of establishing an appropriate ethical foundation for a student-patient interaction.

Developing an empathetic attitude remains, as demonstrated, a difficult process to achieve through role play and is not realistically reproducible within the classroom as many students may not have been exposed to the harsh realities of a disease process on individuals, their families and the general community. Role play appears to foster the need in the students to formulate a diagnosis for the collection of symptoms the 'patient' presents to the 'doctor'. The finesse for picking up, acknowledging and understanding the cues that the real patient might present that indicate emotional or psychological stress directly related to the disease is not sufficiently developed in the role play context. Role play does not therefore offer students an opportunity to respond to emotional issues. Bleakley & Bligh (2008) suggest that teaching patient centeredness, as encapsulated in a strong patient-doctor dialogue and an empathetic dealing with the patient, cannot be taught by a teacher or a peer. By its very term the concept can only be learned, encountered, lived and practised through dealing directly with patients. More attention therefore needs to be given to learning about the patients unique conditions in collaboration with the patients themselves. Role play may therefore in this respect inhibit real patient-centred learning and a possible solution is to combine roleplay with exposure of the students to selective patients in the clinical areas earlier in their training. Role play would then become the platform on which to practise the formulation, technique and language of questioning whilst patient-centred dialogue would be taught through interaction with real patients and the unique stories they bring into the clinical area. The use of role play in combination with another learning experience may offer the best solution to teaching the students how to respond appropriately to emotional or contextual issues presented by the patient. The possible introduction of the students into a clinical area earlier in their training to speak to and interview patients primarily for understanding the issues, concerns and contextual struggles each unique patient experiences is suggested. This could be followed by a deeper in class discussion around how the students felt when hearing the patient's story and this might foreground the importance of understanding the distinctiveness of each patient encounter. The student would learn from the patient and the patient would be recognised as central to the practice of medicine

In the body of the interview each group of students structured their questions as taught and practised to cover all the domains of information needed. The needs of both parties appeared to be satisfied: the student to hear the patient's voice whilst collecting information and the patient being allowed to verbalise a unique story. However two areas of concern that need to be followed through in teaching practice is the role of language in a culturally diverse country such as South Africa and secondly more emphasis needs to be placed on managing the varied and linking facets of behaviour and speech when dealing with sensitive and emotional issues as may be revealed patients.

The language component of the interview is already an integral part of the medical curriculum but is only practised in partnership with the language tutors and the Clinical skills tutors during the physical examination of a patient. A closer collaboration between the clinical skills and language department in the classroom is recommended to overcome the difficulties of not understanding the patient or being understood by the patient. Incorporating language into the role play scenarios will increase the student's exposure to and understanding of the languages predominately heard in the Western Cape. Using students who are mother tongue speakers in the different languages as patients or doctors will allow for peer teaching through translation, correction and a deeper

understanding of different dialects, languages and cultural meaning. This approach will allow students to practise their questioning technique and phrasing whilst simultaneously increasing their exposure to several languages or unfamiliar dialects in a safe and non-threatening environment.

Limitations of study

Due to the constraints of a minor dissertation, only three groups of students (10 students in total) out of a total cohort of approximately 210 students participated in the study. Although the results may present a picture of the achievements, possible errors or difficulties in communication experienced by these students, these findings do not cover all problems experienced by the entire student group. A more comprehensive study of a larger cohort of students would need to be undertaken to determine common difficulties that occur across the student body as a whole.

A further limitation of this study is that the students did not participate in a focus group after their interviews. The translation of their actions and words is therefore based on my interpretation as read through the lens of being their clinical educator preparing them for practice in a clinical setting. A more comprehensive study would require that the students' input be added to fully interpret and understand their actions and words.

This study was conducted during the students' first visit to a patient in a clinical setting and their enthusiasm for operating in an authentic medical setting may have impacted on their performance during their first clinical medical interview. Although they generally attempted to follow the guidelines that were given them during role play, a longitudinal study would add to discovering how the students maintain or improve their communication skills based on a biopsychosocial model. Alternatively such a study may demonstrate how they possibly convert to a more biomedical model as is intimated in a study by Haidet et al (2002) that shows that attitudes amongst later-year students are significantly less patient centred than the attitude of students in their earlier years of training.

Practical considerations that are relevant for future studies include assessing the suitability of the clinical area for filming and positioning of the video camera. The noise generated by daily activity in a large open area overwhelmed the voices of the participants in dialogue many times, thereby making transcription of video recordings difficult or even impossible at times and resulting in loss of sections of dialogue. The positioning and use of a single video camera also restricted the researcher's view of all the students at all times as when they were positioned on either sides of the patient's bed. The students on the same side of the bed as the video camera were rarely seen on camera and their actions are therefore lost to analysis and only their words have been examined.

Conclusion

Medicine draws on the scientific community to analyse, diagnose and successfully treat illness, making use of technological advances and relying on advanced research methods to advise, choose and administer the most appropriate and effective treatment plan for the patient. Conversely, at the centre of all diagnosis and treatment is the human patient, unique in all aspects of existence as well as in reaction to disease process, diagnosis and response to the treatment plan. The art of medicine draws on the human sciences in order to understand, respond to and hear each individual patient's needs and wishes for their own life. Medical students need to learn how to balance these two

opposing but complementary aspects of their profession in order to make the contact with the patient fulfilling for both parties.

Role play is at present the chosen pedagogical method for students to practise communication skills within UCT's Clinical Skills unit. Within a context of large student numbers, student diversity, limited numbers of clinical teaching staff and departmental financial constraints it was deemed to be the best way to prepare students to be able to communicate competently with patients in authentic clinical settings. The results from this study indicate that role play offers adequate training for learning an introduction technique, for the formulation of types of questions, practising questioning technique and for posing understandable questions. It fails however in teaching medical students how to recognise and respond to emotional or contextual cues presented by the patient. It also creates the risk of teaching the student doctor voice to dominate the patient voice, especially in a culturally diverse and multilingual country such as South Africa. It may also give students the sense that it is acceptable practice to conduct conversations in only one language (English), to rely on technical medical terminology when speaking to patients and to assume that they will always be understandable to people in different contexts.

Although role play will remain the most feasible method for teaching communicative competence in the foreseeable future, this study highlights some of its limitations in preparing students to move into authentic clinical settings. Further research into alternative methods to augment this method of teaching will be needed to ensure that medical students are adequately equipped to perform a comprehensive biopsychosocial interview.

The philosophy of placing the patient at the centre of all medical interactions and interventions demands that all practice should reflect patient centeredness. This in turn requires a constant review of both the teaching and the methods chosen to teach so that improvements reflect a curriculum that values an inclusive Primary Health Care approach to health care.

References

- Alonso, Y. 2004, *The biopsychosocial model in medical research: the evolution of the health concept over the last two decades*. Patient Education and Counseling. 53: 239-244.
- Aspergren, K. 1999. *BEME Guide No.2: Teaching and learning communication skills in medicine-a review with quality grading of articles*. Medical Teacher. 21(6): 563-570.
- Au, S., Khandwala, F., and Stelfox, H.T. 2013. *Physician Attire in the Intensive Care Unit and Patient Family Perceptions of Physician Professional Characteristics*. Journal of the American Medical Association Intern Med. 173(6): 465-467.
- Barry, J.M., and Edgman-Levitan P.A. 2012. *Shared Decision Making- The Pinnacle of Patient-Centered Care*. The New England Journal of Medicine. 399(9): 780-781.
- Bensing, J. 2000. Bridging the gap. *The separate worlds of evidence-based medicine and patient-centered medicine*. Patient Education and Counseling. 39: 17-25.
- Bleakley, A. and Bligh, B. 2008. *Students learning from patients: Let's get real in Medical Education*. Advances in Health Sciences Education. 13: 89-107.
- Boelen, C. *The Five –Star Doctor. An asset to health care reform?* World Health Organisation. Geneva, Switzerland. Available http://www.who.int/hrh/en/HRDJ_1_1_02.pdf [2015, March 18].
- Borrell-Carrio, F., Suchman, A.L. and Epstein, R.M. 2004. *The Biopsychosocial Model 25 Years Later: Principles, Practice and Scientific Inquiry*. Annals of Family Medicine. 2(6): 576-582.
- Breier, M. and Wildschut, A. 2006. *Doctors in a Divided Society. The profession and Education of Medical Practitioners in South Africa*. Available: www.hsrcpress.ac.za [2014, April, 20].
- Cleland, J. A., Abe, K. and Rethans, J-J. 2009. *The use of simulated patients in medical education: Association for Medical Education in Europe Guide No 42*. Medical Teacher. 31: 477-486.
- Cushing, A.M. 2015. *Learning patient-centred communication: The journey and the territory*. Patient Education and Counseling. 98: 1236-1242.
- Dall'Alba, G. & Sandberg, J. 2006. *Unveiling Professional Development: A Critical Review of Stage Models*. Review of Educational Research. 76(3): 383-412.
- Deyi, S. and Xhalise, T. 2014. *Integrating isiXhosa into clinical skills to address the linguistic landscape of the Western Cape*. Available: <http://heltasa.org.za/wp-content/uploads/2014/09/HELTASA-2013-Integrating-isiXhosa.pdf>. [2015, August, 21].
- Dray, S. and Pappen, U. 2004. *Literacy and health: towards a methodology for investigating patients' participation in healthcare*. Journal of Applied Linguistics. 1(3): 311-332
- Engel, G.L. 1997. *From Biomedical to Biopsychosocial. Being Scientific in the Human Domain*. Psychomatics. 38(6): 521-528.

- Epstein, O., Perkin, G.D., Cookson, J., Watt, I.S., Rakhit, R., Robins, A. and Hornett, G.A.W. 2008. *Clinical Examination*. 4th Edition. Edinburgh. Mosby. Elsevier.
- Epstein, R.M., Fiscella, K., Lesser, C.S. and Stange, K.C. 2010. *Why the Nation Needs A Policy Push On Patient-Centered Health Care*. *Health Affairs*. 29(8): 1489-149.
- Epstein, R.M., and Street, R.L. 2011. *The Values and Value of Patient-Centered Care*. *Annals of Family Medicine*. 9(2): 100-103.
- Fairclough, N. 1992. *Discourse and Social Change*. Cambridge. Polity Press.
- Gee, J.P. 1990. *Social Linguistics and Literacies: Ideology in Discourses*. 1st Edition. London. Falmer Press.
- Gee, J.P. 1996. *Social Linguistics and Literacies: Ideology in Discourses*. 2nd Edition. London. Taylor and Francis.
- Gee, J.P. 2008. *Social Linguistics and Literacies: Ideology in Discourses*. 3rd Edition. London. Falmer Press.
- Goodyear-Smith, F. and Buetow, S. 2001. *Power Issues in the Doctor–Patient Relationship*. *Health Care Analysis* 9: 449-462.
- Haidet, P., Dains, J.E., Paterniti, D.A., Hechtel, L., Chang, T., Tseng, E. and Rogers, J.C. 2002. *Medical student attitudes towards the doctor-patient relationship*. *Medical Education*. 36: 568-574.
- Hartman, N. 2014. *The Primary Health Care Approach and Restructuring of the MB ChB. A Case Study at the faculty of Health Sciences, University of Cape Town*. Lambert Academic Publishing. Saarbrücken, Germany.
- Hartman, N., Kathard, H., Perez, G., Irlam, J., Gunston, G., Janse van Rensburg, V., Burch, V., Duncan, M., Hellenberg, D., van Rooyen, I., Smouse, M., Sikakana, C., Badenhorst, E. & Inge, B. (2012). *Health Sciences undergraduate education at the University of Cape Town: A story of transformation*. *South African Medical Journal*. 102(6): 477-480.
- Howe, A, and Anderson, J. 2005. *Learning in Practice*. *BMJ* 327: 326-328.
- HPCSA. 2008. *Guidelines for Good Practice in the Health Care Professions. General Ethical Guidelines for the Health Care Professions*. Available: http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf [2015 April 16].
- Hulsmam, R.L. 2009. *Shifting goals in medical communication. Determinants of goal detection and response formation*. *Patient Education and Counseling* 74: 302-306.
- Illingworth, R. 2010. *What does ‘patient-centred’ mean in relation to the consultation?* *The Clinical Teacher*. 7: 116-120.
- Jackson, V.A. and Back, A.L. 2011. *Teaching Communication Skills Using Role-Play: An Experience-Based Guide for Educators*. *Journal of palliative Medicine*: 14(6): 775-780.

- Johnson, S.B. 2012 *Medicine's paradigm shift: An opportunity for psychology*. Available: <http://www.apa.org/monitor/2012/pc.aspx>. [2015. February, 22].
- Joyner, B. and Young, L. 2006. *Teaching medical students using role play: Twelve tips for successful role plays*. *Medical Teacher* 28(3): 225-229.
- Kautzky, K. and Tollman, S.M. 2008. *A Perspective on Primary Health Care in South Africa*. Available: www.hst.org.za/uploads/files/chap2_08.pdf. [2015. March 15]
- Keifenheim, K.E., Teufel, M., Ip J., Leehr, E.J., Zipfel, S. and Hermann-Werner, A. 2015. *Teaching history taking to medical students: a systematic review*. *BioMed Central Medical Education*. 15:159. DOI 10.1186/s12909-105-0443-x.
- Kurtz, S. 2002. *Doctor-Patient Communication: Principles and Practices*. *The Canadian Journal of Neurological Sciences*. 29(Suppl. 2): S23-S29.
- Kurtz, S., Silverman, J., Benson, J. and Draper, J. 2003. *Marrying Content and Process in Clinical Method Teaching: Enhancing the Calgary-Cambridge Guides*. *Academic Medicine*. 78(8): 801-809.
- Lappen, J.R. 2011. *History-Taking and Interview Techniques and the Physician-Patient Relationship*. *Glob.lib.women's med.* (ISSN: 1756-2228); DOI 10.3843/GLOWM.10411.
- Larivaara, P., Kiuttu, J. and Taanila, A. 2001. *The patient-centred interview: the key to biopsychosocial diagnosis and treatment*. *Scandinavian Journal of Primary Health Care* 19: 8-13.
- Lee, R.V. 2000. *Changing Times: Reflections on a Professional Lifetime. An Interview with Paul Beeson*. *Annals of Internal Medicine*. 132: 71-79.
- Lichstein P.R. *The Medical Interview*. In: Walker, H.K., Hall, W.D., and Hurst, J.W. (Eds). 1990. *Clinical Methods: The History, Physical and Laboratory Examinations*. 3rd Edition. Boston: Butterworths. Chapter 3. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK349/>
- Lill, M.M., and Wilkinson, T.J. 2005. *Judging a book by its cover: descriptive survey of patient's preferences for doctors' appearance and mode of address*. *BMJ*. 331: 1524-1527.
- Lloyd, M. and Bor, R. 2009. *Communication skills for Medicine*. 3rd Edition. London. Churchill Livingstone Elsevier.
- Maguire, P. and Pitceathly, C. 2002. *Key communication skills and how to acquire them*. *British Medical Journal*. 325: 697-700.
- Makoul, G. and Schofield, T. 1999. *Communication teaching and assessment in medical education: an international consensus statement*. *Patient Education and Counseling*. 137: 191-195.
- Marracino, R.K. and Orr R.D., 1998. *Entitling the Student Doctor: Defining the Student's Role in Patient Care*. *Journal of General Internal Medicine*: 13(4): 266-270.
- Martin, D. 2003. *Martin's map: a conceptual framework for teaching and learning the medical interview using a patient-centred approach*. *Medical Education*: 37: 1145-1153.

Mash, B. *How to communicate effectively in a consultation*. In: Mash, B., and Blitz-Lindeque, J. (Eds). 2006. *South African Family Practice Manual*. 2nd Edition .Pretoria. Van Schaik.

McCollum, L., and Pincus, T. 2009. *A Biopsychosocial Model to Complement a Biomedical Model: Patient Questionnaire Data and Socioeconomic Status Usually Are More Significant than Laboratory Tests and Imaging Studies in Prognosis of Rheumatoid Arthritis*. Available: <http://cdn.clinicalkey.com/rss/issue/0889857X.xml>. [2015, February, 20]

Mercer, S.W. and Reynolds, W.J. 2002. *Empathy and quality of care*. British Journal of General Practice. 52: S9-S13.

Nestel, D. and Tierney, T. 2007. *Role-play for medical students learning about communication: Guidelines for maximising benefits*. BioMed Central Medical Education. 7(3).

Newman, A.W., Wright, S.W., Wrenn, K.D., and Bernard, A. 2005. *Should Physicians have Facial Piercings?* Journal of General Internal Medicine 20: 213-218

Scollon, R. & Scollon, S.W. 2003. *Language in the Material World*. London. Routledge.

Seggie, J.L., 2010. *MBChB curriculum modernisation in South Africa- growing doctors for Africa*. African Journal of Health Professions Education 2(1): 8-14.

Silverman, J., Kurtz, S.M. and Draper, J. 1998. *Skills for communicating with patients*. Abington, Oxon: Radcliffe Medical Press.

Sissons, H. 2013. *Transcribing Multimodal Interaction*. The Encyclopaedia of Applied Linguistics. Blackwell Publishing Ltd. DOI: 10.1002/9781405198431.wbeal1219 [2016. February 23].

Smajdor, A., Stockl, A. and Salter, C. 2011. *The limits of empathy: Problems in medical education and practice*. Journal of Medical Ethics: 37: 380-383: DOI 10.1136/jme.2010.039628.

Spencer, J., Blackmore, D., Heard, S., McCrorie, P., McHaffie, D., Scherpbier, A., Gupta, T.S., Singh, K. and Douthgate, L. 2000. *Patient-oriented learning: a review of the role of the patient in the education of medical students*. Medical Education. 34: 851-85.

Swayden, K.J., Anderson, K.K., Connelly, L.M., Moran, J.S., McMahon, J.K., and Arnold, P.M. 2012. *Effect of sitting vs standing on perception of provider time at bedside: a pilot study*. Patient Education and Counseling 86(2): 166-171.

Talley, N.J. and O'Connor, S. 2010. *Clinical Examination*. 6th Edition. Sydney. Churchill Livingstone. Elsevier.

University of Cape Town, Faculty of Health Sciences, Undergraduate Programmes. 2015. Available: <http://www.health.uct.ac.za/fhs/apply/undergrad/overview> [2015. November 25].

University of Cape Town, *Introduction to Clinical Skills*, MBChB 11-111, 2015.

University of Cape Town, Primary Health Care Directorate. Available : <http://www.primaryhealthcare.uct.ac.za/> [2014 June20]

Ulrich, R. and Zimring, C. 2005. *The Role of the Physical Environment in the Hospital of the 21st Century: A Once-in –a Lifetime Opportunity*. Available: <https://www.healthdesign.org/chd/research/role-physical-environment-hospital-21st-century>. [2015 August 12].

Wade, D.T. and Halligan, P.W. 2004. *Do biomedical models of illness make for good healthcare systems?* British Medical Journal. 329: 1398-1401.

Wallace, P. 1997. *Following the Threads of an Innovation: The History of Standardized Patients in Medical Education*. Caduceus. 13(2): 5-28.

Western Cape Government, 2015. *Patients' Rights and Responsibilities*. Available: <https://www.westerncape.gov.za/general-publication/patients-rights-and-responsibilities> [2015, June 24].

WHO, 1978. *Declaration of Alma Ata*. Available: http://www.who.int/publications/almaata_declaration_en.pdf [2014 May 13].

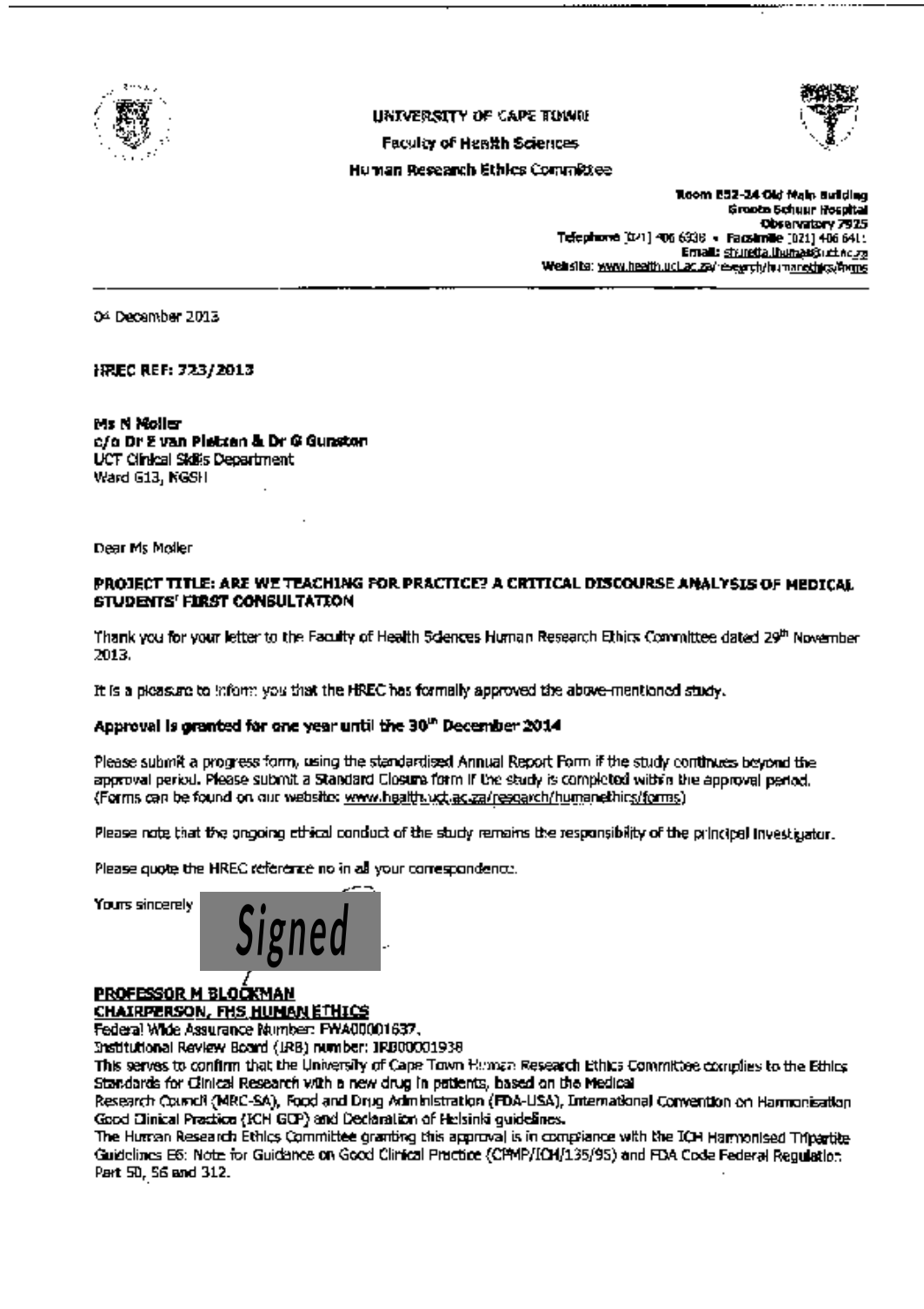
WHO, 2008. *World Health Report. Primary Health care. Now more than ever*. Available: https://www.who.int/whr/2008/08_chap3_en.pdf [2013, September 24].

WHO. 2013. *Health Topics. Primary health care*. Available: [https://www.who.int/topics/primary health care/en](https://www.who.int/topics/primary-health-care/en). [2013, September 24].

Wykurtz, G. and Kelly, D. 2002. *Developing the role of patients as teachers: literature review*. British Medical Journal. 325.:818-821.

Appendices

Appendix 1



Example of original transcript of verbal component of interview A:

1 **INTERVIEWER:** Morning Mrs Williams. So we are medical students here at the University
2 (indistinct 00:00:07) we just come in today, just asking a couple of questions about
3 (indistinct 00:00:17) just asking a couple of questions about (indistinct 00:00:23) and also to
4 just do a general exam, is that okay? And then obviously whatever we discuss today will
5 stay between us and obviously our relevant lecturer and then just to introduce ourselves,
6 my name is (indistinct 00:00:44)

7 **INTERVIEWER:** My name is (indistinct 00:00:45)

8 **INTERVIEWER:** I am Amy.

9 **INTERVIEWER:** Come and sit here Amy. So what are your (indistinct 00:00:52)

10 **INTERVIEWEE:** (indistinct 00:01:09) chest pain.

11 **INTERVIEWER:** Chest pain?

12 **INTERVIEWEE:** (indistinct 00:01:13). Ja, in Saldanha.

13 **INTERVIEWER:** And then what (indistinct 00:01:05)

14 **INTERVIEWEE:** Ja.

15 **INTERVIEWER:** Okay.

16 **INTERVIEWER:** Mevrou kan meer sê in Afrikaans as u wil en dan kan ek vertaal vir hulle.

17 **INTERVIEWEE:** (indistinct 00:01:35) vir 'n uur wakker geword en (indistinct 00:01:37) so
18 maklik (indistinct 00:01:40) swaar amper soos wat lê op my bors, so was hy.

19 **INTERVIEWER:** (indistinct 00:01:46) from the pain.

20 **INTERVIEWEE:** En hy het my laat uit pass en toe daarna (indistinct 00:01:54) en toe het ek
21 in die hospitaal wakker geskrik. En toe het die dokters vir my verduidelik wat het
22 aangegaan. Sê hy ek het 'n heart attack gekry.

23 **INTERVIEWER:** En mevrou, waar presies was die (indistinct 00:02:10)

24 **INTERVIEWEE:** Op my (indistinct 00:02:12)

25 **INTERVIEWER:** (indistinct 00:02:17) heart attack and passed out and then she woke up in
26 the hospital, getting a big fright and then doctor said to her that she had a heart attack
27 (indistinct 00:02:36)

28 **INTERVIEWER:** And how did it feel when you were having a heart attack, (indistinct
29 00:02:45) chest pain or were (interrupted)

30 **INTERVIEWEE:** Had pain in my arm.

31 **INTERVIEWER:** Had pain in your arm (interrupted)

32 **INTERVIEWEE:** Arm.

33 **INTERVIEWER:** In your left arm?

34 **INTERVIEWEE:** Ja.

35 **INTERVIEWER:** And then did you also feel (indistinct 00:02:49)

36 **INTERVIEWEE:** (indistinct 00:02:50)

37 **INTERVIEWER:** And did you also feel any sense of anxiety, or fear.

38 **INTERVIEWER:** Was u angstig toe dit gebeur het?

39 **INTERVIEWEE:** Ja.

40 **INTERVIEWER:** Het u geweet wat het gebeur?

41 **INTERVIEWEE:** (indistinct 00:03:15)

42 **INTERVIEWER:** She was (indistinct 00:03:18) she didn't know what was happening.

43 **INTERVIEWER:** And when exactly did the heart attack happen?

44 **INTERVIEWER:** Wanneer het dit gebeur?

45 **INTERVIEWEE:** Ek weet nie, die Sondag.

46 **INTERVIEWER:** Die Sondag.

47 **INTERVIEWEE:** Ja, (indistinct 00:03:35)

48 **INTERVIEWER:** And the date?

49 **INTERVIEWEE:** I don't know, I two weeks here.

50 **INTERVIEWER:** You have been here for two weeks.

51 **INTERVIEWEE:** Ja. Ja, but not here in the ICU.

52 **INTERVIEWER:** (indistinct 00:03:57)

53 **INTERVIEWEE:** Ja.

54 **INTERVIEWER:** Was it the nineteenth?

55 **INTERVIEWEE:** Ja, it was the nineteenth. Because I come here, I was on the Sunday,

56 Monday and Tuesday I come here.

57 **INTERVIEWER:** So you were in Saldanha until then.

58 **INTERVIEWEE:** Ja, I come the Sunday and Monday and Tuesday (**indistinct 00:04:25**) the
59 doctor, die dokter het my gesê ek gaan Woensdag huis toe maar ek het uitgegaan en
60 (**indistinct 00:04:30**) ek het geval. My kop het dronk geraak, en toe val ek en (**indistinct**
61 **00:04:47**) en toe het ek net uit gepass en hy het gesê hy gaan vir my oor drie weke stuur na
62 (**indistinct 00:04:55**), maar toe sê hy, hy gaan my nou stuur hy kan nie meer wag nie.

63 **INTERVIEWER:** Dit was die dokter in Saldanha?

64 **INTERVIEWEE:** Ja, ja. (**indistinct 00:05:05**) hospitaal.

65 **INTERVIEWER:** So she thought she would only be there for a few days and then when she
66 walked out she got, like dizzy almost.

67 **INTERVIEWEE:** Ja, ja.

68 **INTERVIEWER:** (**indistinct 00:05:17**)

69 **INTERVIEWEE:** En ek het geval hierso en hier by my knee geval en agterop my kop.

70 **INTERVIEWER:** So she hurt her elbow and her knee and the back of her head and then the
71 doctor said he will send her to Cape Town and then you came on the Wednesday.

72 **INTERVIEWEE:** No. Die Dinsdag.

73 **INTERVIEWER:** Dinsdag okay, she came here.

74 **INTERVIEWEE:** Ja, ek sou Woensdag huis toe gegaan het.

75 **INTERVIEWER:** Oh okay. So u het by die hospitaal geval né?

76 **INTERVIEWEE:** Ja.

77 **INTERVIEWER:** She fell at the hospital. So you had the heart attack at the hospital?

78 **INTERVIEWEE:** No.

79 **INTERVIEWER:** No at home.

80 **INTERVIEWEE:** At home.

81 **INTERVIEWER:** The she went to hospital, then she was there until Tuesday and then she
82 came here.

83 **INTERVIEWER:** And then before you had the heart attacks, did you experience any chest
84 pain?

85 **INTERVIEWEE:** No, but not so heavy. I, I can (**indistinct 00:06:08**) my (**indistinct 00:06:14**)

86 **INTERVIEWER:** Would you have done so to the previous time from the doctors?

87 **INTERVIEWEE:** Ja.

88 **INTERVIEWER:** (*indistinct 00:06:29*) Wat se tipe hart probleem het die dokter gesê u het
89 tevore?

90 **INTERVIEWEE:** Hy het gesê (*indistinct 00:06:40*) en hy gesê dat daar is 'n (*indistinct*
91 *00:06:46*) wat hulle gevind het en hulle het vir my hierna toe gestuur (*indistinct 00:06:50*)
92 Groote Schuur, maar toe het Groote Schuur eers gebel en toe het ek vir hulle – toe het hulle
93 gesê hulle het die fout gekry, Somerset (*indistinct 00:07:04*)

94 **INTERVIEWER:** So she saw the specialist in Saldanha and he told her there is a leak in her
95 heart.

96 **INTERVIEWEE:** Ja.

97 **INTERVIEWER:** And he gave her two referral letters, the one for here and the one for
98 Somerset Hospital (*indistinct 00:07:17*)

99 **INTERVIEWEE:** Ja. En hulle hou my (*indistinct 00:07:21*)

100 **INTERVIEWER:** (*indistinct 00:07:25*)

101 **INTERVIEWEE:** But every time I come here, hulle sê my bloed is baie hoog hulle sal nie
102 (*indistinct 00:07:32*) dit is baie hoog.

103 **INTERVIEWER:** So her blood pressure is very high, so they can't work. Her blood pressure is
104 very high, so they say they can't (*indistinct 00:07:45*). And then (*indistinct 00:07:47*) how
105 long.

106 **INTERVIEWEE:** (*indistinct 00:07:53*)

107 **INTERVIEWER:** (*indistinct 00:07:58*) was dit hierdie keer dat hulle gesê het of was dit
108 tevore?

109 **INTERVIEWEE:** Ja, laas jaar.

110 **INTERVIEWER:** Laas jaar.

111 **INTERVIEWEE:** Ja.

112 **INTERVIEWER:** Wanneer laas jaar?

113 **INTERVIEWEE:** Laas jaar June, maar ek het nie teruggekom nie. Ek moes teruggekom het,
114 maar ek het nie (*indistinct 00:08:15*) bang.

115 **INTERVIEWER:** (*indistinct 00:08:17*)

116 **INTERVIEWEE:** I was too scared.

117 **INTERVIEWER:** And then did you ever before in last year, before (indistinct 00:08:29)
118 shortness of breath, like, you would do something and you would feel like (indistinct
119 00:08:34)

120 **INTERVIEWEE:** Ja, ja.

121 **INTERVIEWER:** And then what sort of activity, what (indistinct 00:08:40) shortness of
122 breath sitting down doing, were you just doing normal things around the house.

123 **INTERVIEWEE:** Just normal things, like my (indistinct 00:08:51)

124 **INTERVIEWER:** So you, so you – when you were doing like normal things like hanging
125 washing you would have to stop (indistinct 00:09:09)

126 **INTERVIEWEE:** Have to stop.

127 **INTERVIEWER:** And then did you also ever experience like (indistinct 00:09:21) headaches

128 **INTERVIEWEE:** Yes.

129 **INTERVIEWER:** And then how long (indistinct 00:09:27)

130 **INTERVIEWEE:** Not long, not long.

131 **INTERVIEWER:** (indistinct 00:09:32) can you like give me a rough estimation? (indistinct
132 00:09:37) where exactly. You are saying not long distance.

133 **INTERVIEWEE:** Not long distance

134 **INTERVIEWER:** So can you just give me like a sort of estimation how long is not long
135 distance?

136 **INTERVIEWEE:** Hoe moet ek nou sê?

137 **INTERVIEWER:** Miskien 'n paar blokke of (interrupted)

138 **INTERVIEWEE:** Net 'n paar blokke.

139 **INTERVIEWER:** Honderd meter.

140 **INTERVIEWEE:** (indistinct 00:10:05)

141 **INTERVIEWER:** Sommer baie vinnig?

142 **INTERVIEWEE:** Ja.

143 **INTERVIEWER:** En die pyn was dit (indistinct 00:10:11)

144 **INTERVIEWEE:** Ja. (indistinct 00:10:12) baie (indistinct 00:10:13)

145 **INTERVIEWER:** And then once you stopped walking you would feel better?

146 **INTERVIEWEE:** Ja.

147 **INTERVIEWER:** And then in terms of, just to (indistinct 00:10:31) the heart attack that you
148 have had, in terms of severity, how (indistinct 00:10:37) register on a scale of one to ten.

149 **INTERVIEWER:** Hoe seer was die hartaanval op 'n skaal van een tot tien met een is nie seer
150 en tien is die ergste pyn wat u ooit gehad het.

151 **INTERVIEWEE:** Ja, dit was baie seer. Baie.

152 **INTERVIEWER:** Tien, nege.

153 **INTERVIEWEE:** Ja, nege, sê maar nege.

154 **INTERVIEWER:** Nege.

155 **INTERVIEWEE:** Ja.

156 **INTERVIEWER:** En wat se soort pyn was dit?

157 **INTERVIEWEE:** Dit was 'n – daardie pyn wat – dokter het – net uit gepass mos. So die keer
158 wat ek die pyn kry en, en dit was ek nie wakker nie. En ek het nie geweet wat rondom my
159 aangaan nie. Toe ek wakker skrik toe was ek by die hospitaal.

160 **INTERVIEWER:** So it was so painful that she passed out and then she woke up (indistinct
161 00:11:36) hospital.

162 **INTERVIEWEE:** Ja, don't want to go through (indistinct 00:11:42) geskrik (indistinct
163 00:11:48)

164 **INTERVIEWER:** Was this the first time you ever had a heart attack?

165 **INTERVIEWEE:** No not the first time.

166 **INTERVIEWER:** This was not the first time.

167 **INTERVIEWEE:** No.

168 **INTERVIEWER:** When, when (indistinct 00:12:00)

169 **INTERVIEWEE:** Seven years ago.

170 **INTERVIEWER:** Seven years ago.

171 **INTERVIEWEE:** But I can't talk. Ek kan nie gepraat het nie kan nie, kan nie geloop het nie.

172 **INTERVIEWER:** Na die eerste een.

173 **INTERVIEWEE:** Ja, na die eerste een.

174 **INTERVIEWER:** She couldn't talk or walk after her first heart attack.

175 **INTERVIEWEE:** Ek het therapy gekry.

176 **INTERVIEWER:** So you had physiotherapy.

177 **INTERVIEWEE:** Ja. (indistinct 00:12:21)

178 **INTERVIEWER:** Where was it at what clinic?

179 **INTERVIEWEE:** In Saldanha.

180 **INTERVIEWER:** En hoe lank het dit gevat om weer te kan stap?

181 **INTERVIEWEE:** Sommer, sommer drie maande gevat (indistinct 00:12:39) gevat en toe

182 (indistinct 00:12:43)

183 **INTERVIEWER:** Drie maande om te loop.

184 **INTERVIEWEE:** Ja.

185 **INTERVIEWER:** En hoe lank om te praat?

186 **INTERVIEWEE:** Sommer, dit was (indistinct 00:12:49) ek het nie gepraat nie, ek het so

187 gemompel so.

188 **INTERVIEWER:** (indistinct 00:12:53) it took a long time to learn to speak again. But she

189 spoke before she walked, she walked at three months.

190 **INTERVIEWER:** So wanneer het u begin om te praat en te leer om te praat?

191 **INTERVIEWEE:** Ek weet nie.

192 **INTERVIEWER:** Net voordat u geloop het.

193 **INTERVIEWER:** Just want to ask you a few questions (indistinct 00:13:41) The first thing I

194 want to ask you is, have you ever been hospitalized before?

195 **INTERVIEWEE:** (indistinct 00:13:43)

196 **INTERVIEWER:** Other than (indistinct 00:13:49) that other time and in the current

197 (indistinct 00:13:54) have you ever been hospitalized before?

198 **INTERVIEWER:** Was u ooit tevore in die hospitaal, maar nie vir die hartaanval nie?

199 **INTERVIEWEE:** Ja, ek was al tevore in die hospitaal.

200 **INTERVIEWER:** Hoekom, hoekom was u daar gewees?

201 **INTERVIEWEE:** Dit was my blindederm.

202 **INTERVIEWER:** (indistinct 00:14:15)

203 **INTERVIEWEE:** (indistinct 00:14:20)

204 **INTERVIEWER:** (indistinct 00:14:23)

205 **INTERVIEWEE:** (indistinct 00:14:25) Not here in Somerset.

206 **INTERVIEWER:** Was this before or after the heart attack?

207 **INTERVIEWEE:** (indistinct 00:14:39)

208 **INTERVIEWER:** (indistinct 00:14:40) Dit was seker naby mekaar?

209 **INTERVIEWEE:** Ja, dit was al

210 **INTERVIEWER:** Drie jaar tevore.

211 **INTERVIEWEE:** Ja, (indistinct 00:14:55) ja dit was nie lank nie toe kry ek (indistinct 00:14:59)

212 **INTERVIEWER:** Did you have any childhood illnesses such as measles, rubella?

213 **INTERVIEWER:** Wanneer 'n kind – jy – wanneer jy 'n kind was, het u enige siekte gehad?

214 **INTERVIEWEE:** Ja, ek het rumatiekkoors gehad.

215 **INTERVIEWER:** Rheumatic fever.

216 **INTERVIEWEE:** En (indistinct 00:15:25)

217 **INTERVIEWER:** (indistinct 00:15:28)

218 **INTERVIEWEE:** (indistinct 00:15:30)

219 **INTERVIEWER:** (indistinct 00:15:32)

220 **INTERVIEWEE:** Ja.

221 **INTERVIEWER:** (indistinct 00:15:45)

222 **INTERVIEWEE:** Rumatiek gehad.

223 **INTERVIEWER:** Hoe oud was u?

224 **INTERVIEWEE:** I was six.

225 **INTERVIEWER:** Sesjaar oud.

226 **INTERVIEWEE:** Ja. (indistinct 00:15:54)

227 **INTERVIEWER:** En die (indistinct 00:15:55) ook rondom daardie tyd?

228 **INTERVIEWEE:** Ja, ja.

229 **INTERVIEWER:** Dus het die rumatiekkoors die (indistinct 00:16:03) veroorsaak?

230 **INTERVIEWEE:** Ja.

231 **INTERVIEWER:** Okay so the heart problems as a result of the rheumatic fever (indistinct
232 00:16:15)

233 **INTERVIEWER:** So besides the, the (indistinct 00:16:18)

234 **INTERVIEWER:** Was daar enige ander tyd wat u in die hospitaal was?

235 **INTERVIEWEE:** (indistinct 00:16:33) Blood pressure.

236 **INTERVIEWER:** Was u bloeddruk te hoog?

237 **INTERVIEWEE:** Baie, baie. As my bloed te hoog was.

238 **INTERVIEWER:** En wanneer was dit?

239 **INTERVIEWEE:** Dit was in die laaste jaar.

240 **INTERVIEWER:** Laaste jaar.

241 **INTERVIEWEE:** Elke keer.

242 **INTERVIEWER:** Is dit baie keer wat u?

243 **INTERVIEWEE:** (indistinct 00:15:49)

244 **INTERVIEWER:** So hoeveel keer in totaal?

245 **INTERVIEWEE:** Sê maar, sê maar twee keer in een maand. Dan is ek hospitaal toe.

246 **INTERVIEWER:** En dit was net laas jaar of?

247 **INTERVIEWEE:** Net laas jaar.

248 **INTERVIEWER:** So since last year she was in hospital about twice a month when her blood
249 pressure gets very high. Is dit reg?

250 **INTERVIEWEE:** Ja.

251 **INTERVIEWER:** Suikersiekte het u?

- 252 **INTERVIEWEE:** (indistinct 00:17:23) cholesterol
- 253 **INTERVIEWER:** Hepatitis of (indistinct 00:00:17:43)
- 254 **INTERVIEWEE:** Nee.
- 255 **INTERVIEWER:** En hoe is u (indistinct 00:17:51).
- 256 **INTERVIEWEE:** Is nog 'n bietjie hoog maar (indistinct 00:18:06) dokters het nou vir my kom
- 257 sê wat gaan, wat gaan aan (indistinct 00:18:10) baie (indistinct 00:18:11)
- 258 **INTERVIEWER:** Is dit nou dat u nou (indistinct 00:18:18) is,

Appendix 2

Example of revised transcript of verbal component of interview A:

INTERVIEWER: Morning Mrs X (*Name removed to maintain anonymity*) So we are medical students here at the University of Cape Town, we just come in today, just asking a couple of questions about ..Sorry I will just close this (the student closes the curtain fully around the patient before proceeding with introduction)just asking a couple of questions about what brought you here and also to just do a general exam, it that ok? And then obviously whatever we discuss today will stay between us and obviously our relevant lecturer and then just to introduce ourselves, my name is A.. (*Name removed to maintain anonymity*)

INTERVIEWER: My name is B....(*Name removed to maintain anonymity*)

INTERVIEWER: I am C.....(*Name removed to maintain anonymity*)

INTERVIEWER: And I am D...(*Name removed to maintain anonymity*).

INTERVIEWER A: So Mrs X.how old are you?

INTERVIEWEE: *Inaudible response but students acknowledges response and writes down information*

INTERVIEWER A: So what brought you into hospital? What was the matter?

INTERVIEWEE: Can I speak Afrikaans? (*The student is evidently thrown off guard by this request and looks somewhat bemusedly at her colleagues. Student B standing next to her appears to throw his hand up which could be translated as either acknowledging her request or irritation that this interview was now a problem due to not understanding the patient*)
um...um chest pain.

INTERVIEWER: Chest pain?

INTERVIEWEE: mm but not here.. in Vredenberg Hospital.Ja, in Saldanha.

INTERVIEWER: And then what- did they refer you from Vredenberg Hospital to us?

INTERVIEWEE: Ja.

INTERVIEWER: Okay.

INTERVIEWER: Mevrou kan meer sê in Afrikaans as u wil en dan kan ek vertaal vir hulle.

INTERVIEWEE: Aah-ek het in die nag so drie uur wakker geword en die pyn het my wakker gemaak.Dit was so swaar amper soos wat lê op my bors, so was hy.

INTERVIEWER: Very heavy pain on her chest from 3 in the morning...from the pain.

INTERVIEWEE: En hy het my laat uit pass en toe daarna weet nie wat gebeur het en toe het ek in die hospitaal wakker geskrik. En toe het die dokters vir my verduidelik wat het aangegaan. Sê hy ek het 'n heart attack gekry.

INTERVIEWER: En mevrou, waar presies was die pyn

INTERVIEWEE: Op my bors

INTERVIEWER: She had a heart attack and passed out and then she woke up in the hospital, getting a big fright and then doctor said to her that she had a heart attack. Is that correct?

INTERVIEWER: And how did it feel when you were having a heart attack, did you only have the chest pain or were there... (interrupted)

INTERVIEWEE: Had pain in my arm.

INTERVIEWER: Had pain in your arm (interrupted)

INTERVIEWEE: Arm.

INTERVIEWER: In your left arm?

INTERVIEWEE: Ja.

INTERVIEWER: And then did you also feel..... sorry mam (interrupted)

INTERVIEWEE: not feeling well

INTERVIEWER: And did you also feel any sense of anxiety, or fear.

INTERVIEWER: Was u angstig toe dit gebeur het?

INTERVIEWEE: Ja.

INTERVIEWER: Het u geweet wat het gebeur?

INTERVIEWEE: Nee, nie geweet

INTERVIEWER: She was anxious and she didn't know what was happening.

INTERVIEWER: And when exactly did the heart attack happen? Wanneer het dit gebeur?

INTERVIEWEE: Ek weet nie, die Sondag.

INTERVIEWER: Die Sondag.

INTERVIEWEE: Ja, (indistinct 00:03:35)

INTERVIEWER: And the date?

INTERVIEWEE: I don't know, I two weeks here.

INTERVIEWER: You have been here for two weeks.

INTERVIEWEE: Ja. Ja, but not here in the ICU.

INTERVIEWER: Here at GSH

INTERVIEWEE: Ja.

INTERVIEWER: Was it the nineteenth?

INTERVIEWEE: Ja, it was the nineteenth. Because I come here, I was on the Sunday, Monday and Tuesday I come here.

INTERVIEWER: So you were in Saldanha until then.

INTERVIEWEE: Ja, I come the Sunday and Monday and Tuesday the doctor sent me, the doctor, *(changes to Afrikaans)* die dokter het my gesê ek gaan Woensdag huis toe maar ek het uitgegaan en dronk geraak en ek het geval. My kop het dronk geraak, en toe val ek en kan myself nie gekeur nie, en toe het ek net uit gepass en hy het gesê hy gaan vir my oor drie weke stuur na daar, maar toe sê hy, hy gaan my nou stuur hy kan nie meer wag nie.

INTERVIEWER: Dit was die dokter in Saldanha?

INTERVIEWEE: Ja, ja. Vredenberg hospitaal.

INTERVIEWER: So she thought she would only be there for a few days and then when she walked out she got, like dizzy almost.

INTERVIEWEE: Ja, ja.

INTERVIEWER: Like her head was like drunk (interrupted)

INTERVIEWEE: En ek het geval hierso en hier by my knee geval en agterop my kop.

INTERVIEWER: So she hurt her elbow and her knee and the back of her head and then the doctor said he will send her to Cape Town and then you came on the Wednesday.

INTERVIEWEE: No. Die Dinsdag.

INTERVIEWER: Dinsdag okay, Tuesday she came here.

INTERVIEWEE: Ja, ek sou Woensdag huis toe gegaan het.

INTERVIEWER: Oh okay. So u het by die hospitaal geval né?

INTERVIEWEE: Ja.

INTERVIEWER: She fell at the hospital.

INTERVIEWER: So you had the heart attack at the hospital?

INTERVIEWEE: No.

INTERVIEWER: No at home.

INTERVIEWEE: At home.

INTERVIEWER: The she went to hospital, then she was there until Tuesday and then she came here.

INTERVIEWER: And then before you had the heart attacks, did you experience any chest pain?

INTERVIEWEE: No, but not so heavy. I, I can (*change to Afrikaans*) ek kan pille onder my tong sit en dan help dit 'n bietjie maar nou kan ek nie pille onder my tong sit, dit sal nie help, die pyn is te swaar.

INTERVIEWER: Were you diagnosed with a previous heart problem by doctors?

INTERVIEWEE: Ja.

INTERVIEWER: What exactly was your diagnosis? (*The patient does not appear to understand the question as the student looks to student C to ask the question in Afrikaans*)

INTERVIEWER: Wat se tipe hart probleem het die dokter gesê u het tevore?

INTERVIEWEE: Hy het gesê iets was nie lekker nie en hy gesê dat daar is 'n lek daar wat hulle gevind het en hulle het vir my hierna toe gestuur en twee briewe gegee, een vir Somerset en een vir Grootte Schuur, maar toe het Grootte Schuur eers gebel en toe het ek vir hulle – toe het hulle gesê hulle het die fout gekry, Somerset se brief opgeskeur.

INTERVIEWER: So she saw the specialist in Saldanha and he told her there is a leak in her heart.

INTERVIEWEE: Ja.

INTERVIEWER: And he gave her two referral letters, the one for here and the one for Somerset Hospital. She phoned first and came here.

INTERVIEWEE: Ja. En hulle hou my hier

INTERVIEWER: They kept her here since

INTERVIEWEE: But every time I come here (*Change to Afrikaans*) hulle sê my bloed is baie hoog hulle sal nie werk nie want dit is baie hoog.

INTERVIEWER: So her blood pressure is very high, so they can't work on her. Her blood pressure is very high, so they say they can't work because of the high blood pressure

INTERVIEWER: . And then when did they diagnose you with that heart problem? How long ago? Do you remember?

INTERVIEWEE: When was it? (*Patient not understanding question*)

INTERVIEWER: Was dit hierdie keer dat hulle gesê het of was dit tevore?

INTERVIEWEE: Ja, hele tyd, laas jaar.

INTERVIEWER: Laas jaar.

INTERVIEWEE: Ja.

INTERVIEWER: Wanneer laas jaar?

INTERVIEWEE: Laas jaar June, maar ek het nie teruggekom nie. Ek moes teruggekom het, maar ek het nie. Ek was te bang dokter

INTERVIEWER: June last year she was diagnosed

INTERVIEWEE: I was too scared. (*Patient speaks softly almost in an aside*)

INTERVIEWER: And then did you ever before in last year, before you were diagnosed did you ever experience shortness of breath, like, you would do something and you would feel like you were short of breath

INTERVIEWEE: Ja, ja.

INTERVIEWER: And then what sort of activity, when did you experience shortness of breath sitting down doing, were you just doing normal things around the house.

INTERVIEWEE: Just normal things, like my bed, washing dishes, doing my washing. I was feeling tired.

INTERVIEWER: So you, so you – when you were doing like normal things like hanging washing you would have to stop. Is that right?

INTERVIEWEE: Have to stop.

INTERVIEWER: And then did you also ever experience like pain in your legs when you walk

INTERVIEWEE: Yes.

INTERVIEWER: And then how long a distance could you walk before the pain started

INTERVIEWEE: Not long, not long distance

INTERVIEWER: Can you like give me a rough estimation? Maybe to where exactly. You are saying not long distance.

INTERVIEWEE: Not long distance

INTERVIEWER: So can you just give me like a sort of estimation of how long is not long distance?

INTERVIEWEE: Hoe moet ek nou sê?

INTERVIEWER: Miskien 'n paar blokke of (interrupted)

INTERVIEWEE: Net 'n paar blokke.

INTERVIEWER: Honderd meter.

INTERVIEWEE: Twee meters

INTERVIEWER: Sommer baie vinnig?

INTERVIEWEE: Ja.

INTERVIEWER: En die pyn was dit hier of baie bo?

INTERVIEWEE: Ja. Dis bo. Baie hier bo

INTERVIEWER: And then once you stopped walking you would feel better?

INTERVIEWEE: Ja.

INTERVIEWER: And then in terms of, just to go back to the heart attack that you have had, in terms of severity, how painful would you say the experience was if you rate it on a scale of one to ten.

INTERVIEWER: Hoe seer was die hartaanval op 'n skaal van een tot tien met een is nie seer en tien is die ergste pyn wat u ooit gehad het.

INTERVIEWEE: Ja, dit was baie seer. Baie.

INTERVIEWER: Tien, nege.

INTERVIEWEE: Ja, nege, sê maar nege.

INTERVIEWER: Nege.

INTERVIEWEE: Ja.

INTERVIEWER: En wat se soort pyn was dit?

INTERVIEWEE: Dit was 'n – daardie pyn wat – dokter het – net uit gepass mos. So die keer wat ek die pyn kry en, en dit was ek nie wakker nie. En ek het nie geweet wat rondom my aangaan nie. Toe ek wakker skrik toe was ek by die hospitaal.

INTERVIEWER: So it was so painful that she passed out and then she woke up and got a big fright and woke up in hospital.

INTERVIEWEE: Ja, don't want to go through the hospital. Ek het daar wakker geskrik

INTERVIEWER: Was this the first time you ever had a heart attack?

INTERVIEWEE: No not the first time.

INTERVIEWER: This was not the first time.

INTERVIEWEE: No.

INTERVIEWER: When, when last did you have one

INTERVIEWEE: Seven years ago.

INTERVIEWER: Seven years ago.

INTERVIEWEE: But I can't talk. Ek kan nie gepraat het nie kan nie, kan nie geloop het nie.

INTERVIEWER: Na die eerste een.

INTERVIEWEE: Ja, na die eerste een.

INTERVIEWER: She couldn't talk or walk after her first heart attack.

INTERVIEWEE: Ek het therapy gekry.

INTERVIEWER: So you had physiotherapy.

INTERVIEWEE: Ja. By die clinic

INTERVIEWER: Where was it? At what clinic?

INTERVIEWEE: In Saldanha.

INTERVIEWER: En hoe lank het dit gevat om weer te kan stap?

INTERVIEWEE: Sommer, sommer drie maande gevat, sê maar drie maande gevat en toe dab bietjie, bietjie

INTERVIEWER: Drie maande om te loop.

INTERVIEWEE: Ja.

INTERVIEWER: En hoe lank om te praat?

INTERVIEWEE: Sommer, dit was, ek het nie gepraat nie, ek het so gemompel so.

INTERVIEWER: She said at the beginning she was just mumbling, it took a long time to learn to speak again. But she spoke before she walked, she walked at three months.

INTERVIEWER: So wanneer het u begin om te praat om weer te leer om te praat?

INTERVIEWEE: Ek weet nie.

INTERVIEWER: Net voordat u geloop het.

INTERVIEWER: Just want to ask you a few questions about your medical history. The first thing I want to ask you is, have you ever been hospitalized before?

INTERVIEWEE: (indistinct 00:13:43)

INTERVIEWER: Other than the heart attack that other time and for the current heart attack have you ever been hospitalized before?

INTERVIEWER: Was u ooit tevore in die hospitaal, maar nie vir die hartaanval nie?

INTERVIEWEE: Ja, ek was al tevore in die hospitaal.

INTERVIEWER: Hoekom, hoekom was u daar gewees?

INTERVIEWEE: Dit was my blindederm.

INTERVIEWER: So her appendix was taken out as well

INTERVIEWER: When was this

INTERVIEWEE: 3 years ago. Not here in Somerset.

INTERVIEWER: Was this before or after the heart attack?

INTERVIEWEE: Ja before

INTERVIEWER: Dit was seker naby mekaar?

INTERVIEWEE: Ja, dit was al

INTERVIEWER: Drie jaar tevore.

INTERVIEWEE: Ja, (indistinct 00:14:55) ja dit was nie lank nie toe kry ek die heart attack

INTERVIEWER: Did you have any childhood illnesses such as measles, rubella?

INTERVIEWER: Wanneer 'n kind – jy – wanneer jy 'n kind was, het u enige siekte gehad?

INTERVIEWEE: Ja, ek het rumatiekkoors gehad.

INTERVIEWER: Rheumatic fever.

INTERVIEWEE: En 'n gaatjie

INTERVIEWER: 'n gaatjie in die hart?

INTERVIEWEE: Nie 'n gaatjie nie, ek sal sê 'n lek hart

INTERVIEWER: 'n lek hart?

INTERVIEWEE: Ja.

INTERVIEWER: 'n lek hart. That will be a leaking heart.

INTERVIEWEE: Rumatiek gehad.

INTERVIEWER: Hoe oud was u?

INTERVIEWEE: I was six.

INTERVIEWER: Sesjaar oud.

INTERVIEWEE: Ja. (indistinct 00:15:54)

INTERVIEWER: En die lek hartook rondom daardie tyd?

INTERVIEWEE: Ja, ja.

INTERVIEWER: Dus het die rumatiekkoors die lek hart veroorsaak?

INTERVIEWEE: Ja.

INTERVIEWER: Okay so the heart problems as a result of the rheumatic fever (indistinct 00:16:15)

INTERVIEWER: So besides the, the hospitalization for the heart attack and appendix was there no other hospitalizations?

INTERVIEWER: Was daar enige ander tyd wat u in die hospitaal was?

INTERVIEWEE: Only for Blood pressure.

INTERVIEWER: Was u bloeddruk te hoog?

INTERVIEWEE: Baie, baie. As my bloed te hoog was.

INTERVIEWER: En wanneer was dit?

INTERVIEWEE: Dit was in die laaste jaar.

INTERVIEWER: Laaste jaar.

INTERVIEWEE: Elke keer.

INTERVIEWER: Is dit baie keer wat u?

INTERVIEWEE: All the time

INTERVIEWER: So hoeveel keer in totaal?

INTERVIEWEE: Sê maar, sê maar twee keer in een maand. Dan is ek hospitaal toe.

INTERVIEWER: En dit was net laas jaar of?

INTERVIEWEE: Net laas jaar.

INTERVIEWER: So since last year she was in hospital about twice a month when her blood pressure gets very high. Is dit reg?

INTERVIEWEE: Ja.

INTERVIEWER: Have you ever - have you been diagnosed with diabetes

INTERVIEWER: Suikersiekte het u?

INTERVIEWEE: Nee, net I have cholesterol in my body

INTERVIEWER: So she has cholesterol as well

INTERVIEWER: Hepatitis or asthma

INTERVIEWER: Hepatitis of asthma (*Repeat in Afrikaans*)

INTERVIEWEE: Nee.

INTERVIEWER: So you were just diagnosed with hypertension (*Student A interrupts further questioning to ask...*)

INTERVIEWER: En hoe is u bloed nou

INTERVIEWEE: Is nog 'n bietjie hoog maar ek raak 'n bietjie nouskierig, die dokters het nou vir my kom sê wat gaan, wat gaan aan . Ek is baie nouskierig daaroor

INTERVIEWER: Is dit nou dat u nou in die hospital is?

Appendix 3:

HDV: 0005: Date of Interview: 3 th February 2014									
	Line from Transcript	Type of question (Open or closed)	Reasoning behind question (Probing for new or additional information or clarification) Multiple Questions (#)	Clarification for students understanding	Display of student insecure questioning technique (repetition or rephrasing question)	Clarification for patient's understanding	Acknowledgment of hearing patient's statement (use of OK or directly to statements by patient) ^ Not picking up on patient's concerns/statements	Related to which part of interview	Interruption by
1	9	O	Probing (N)		*(Reph)			PPP	
2	11	C	Clarification	*			Patient requests to speak Afrikaans – students continue	PPP	
3	13	C	Clarification	*				PPP	
4	15						*(OK)	PPP	
5	16 (Afrik)						* Student 2 acknowledges language choice and says will translate for colleagues	PPP	
6	19		Clarification	* Translation				PPP	
7	23 (Afrik)	C	Probing (A)					PPP	
8	25		Clarification	* Translation				PPP	
9	28	O	Probing (A)		*(Reph)			PPP	Patient
10	31	C	Clarification	*				PPP	Patient
11	33	C	Probing (A)					PPP	
12	35	O	Probing (A)					PPP	Patient
13	37	C	Probing (A)					PPP	
14	38 (Afrik)	C	Clarification			*Translation		PPP	

15	40 (Afrik)	C	Probing (A)					PPP	
16	42			* Translation				PPP	
	Line from Transcript	Type of question (Open or closed)	Reasoning behind question (Probing for new or additional information or clarification) Multiple Questions (#)	Clarification for students understanding	Display of student insecure questioning technique (repetition or rephrasing question)	Clarification for patient's understanding	Acknowledgment of hearing patient's statement (use of OK or directly to statements by patient) ^ Not picking up on patient's concerns/statements	Related to which part of interview	Interruption by
17	43	O	Probing (A)					PPP	
18	44 (Afrik)	O	Repeat			*		PPP	
19	46	C	Clarification	*				PPP	
20	48	C	Clarification	*				PPP	
21	50	C	Clarification	*				PPP	
22	52	C	Clarification	*				PPP	
23	54	C	Clarification	*				PPP	
24	57	C	Clarification	*				PPP	
25	63 (Afrik)	C	Clarification	*				PPP	
26	65			* Translation				PPP	
27	68			* Translation				PPP	
28	70			* Translation				PPP	Corrected by patient
29	73			* Translation				PPP	
30	75 (Afrik)	C	Clarification				*(OK)	PPP	
31	77	C	Clarification	* Translation				PPP	Corrected by patient
32	79			* Translation				PPP	
33	81			* Translation				PPP	
34	83	O	Probing (A)					PPP	
35	86	C	Probing (A)					PPP	

36	88	O	Probing (A)					PPP	
37	88 (Afrik)		Repeat					PPP	
	Line from Transcript	Type of question (Open or closed)	Reasoning behind question (Probing for new or additional information or clarification) Multiple Questions (#)	Clarification for students understanding	Display of student insecure questioning technique (repetition or rephrasing question)	Clarification for patient's understanding	Acknowledgment of hearing patient's statement (use of OK or directly to statements by patient) ^ Not picking up on patient's concerns/statements	Related to which part of interview	Interruption by
38	94			* Translation				PPP	
39	97			* Translation				PPP	
40	100			* Translation				PPP	
41	103			* Translation				PPP	
42	104	C	Clarification	*	*(Reph)			PPP	
43	106 (Afrik)	C	Clarification	*				PPP	
44	108	C	Clarification	*				PPP	
45	110	O	Probing (A)					PPP	
46	113			* Translation			^ Patient's concern completely ignored in translation	PPP	
47	115	C	Probing (N)		*(Reph)			PPP	
48	118	O	Probing (A)		*(Reph)			PPP	
49	121	C	Clarification	*	*(Reph)			PPP	
50	124	C	Probing (A)					PPP	
51	126	O	Probing (A)					PPP	
52	128	C	Probing (A)					PPP	
53	131	O	Probing (A)					PPP	
54	134 (Afrik)	C	Repeat			*		PPP	Patient
55	136 (Afrik)	C	Probing (A)					PPP	
56	138 (Afrik)	C	Clarification	*				PPP	

57	140 (Afrik)	C	Probing (A)					PPP	
58	142	C	Probing (A)					PPP	
	Line from Transcript	Type of question (Open or closed)	Reasoning behind question (Probing for new or additional information or clarification) Multiple Questions (#)	Clarification for students understanding	Display of student insecure questioning technique (repetition or rephrasing question)	Clarification for patient's understanding	Acknowledgment of hearing patient's statement (use of OK or directly to statements by patient) ^ Not picking up on patient's concerns/statements	Related to which part of interview	Interruption by
59	144	O	Probing (A)		*(Reph)			PPP	
60	146			* Translation				PPP	
61	149 (Afrik)	C	Clarification			*		PPP	
62	151(Afrik)	C	Clarification	*				PPP	
63	153 (Afrik)	O	Probing (A)					PPP	
64	157			* Translation				PPP	
65	160	C	Probing (A)					PPP	
66	162	C	Clarification	*				PPP	
67	164	C	Probing (A)		*(Rep)			PPP	
68	166	C	Clarification	*				PPP	
69	168	C	Clarification	*				PPP	
70	170			* Translation				PPP	
71	172	C	Clarification	*				PPP	
72	174	C	Probing (A)		*(Reph)			PPP	
73	176 (Afrik)	O	Probing (A)					PPP	
74	179 (Afrik)	C	Clarification	*				PPP	
75	181(Afrik)	C	Probing (A)					PPP	
76	184			*Translation				PPP	
77	186 (Afrik)	O	Probing (A)					PPP	
78	188 (Afrik)	C	Probing (A)					PPP	

1	189	O	Probing (N)		*(Reph)			PMH	
2	192	O	Repeat			*		PMH	
	Line from Transcript	Type of question (Open or closed)	Reasoning behind question (Probing for new or additional information or clarification) Multiple Questions (#)	Clarification for students understanding	Display of student insecure questioning technique (repetition or rephrasing question)	Clarification for patient's understanding	Acknowledgment of hearing patient's statement (use of OK or directly to statements by patient) ^ Not picking up on patient's concerns/statements	Related to which part of interview	Interruption by
3	194 (Afrik)		Repeat			*		PMH	
4	196(Afrk)	O	Probing (A)		*(Rep)			PMH	
5	198			*Translation				PMH	
6	199	C	Probing (A)					PMH	
7	202	C	Probing (A)					PMH	
8	204 (Afrik)	C	Probing (A)					PMH	Student
9	206 (Afrik)	C	Clarification	*				PMH	
10	208	C	Probing (N)(#) Medical terms					PMH	
11	209 (Afrik)				*(Reph)	*		PMH	
12	211	C	Clarification	*				PMH	
13	213	C	Clarification	*				PMH	
14	215	C	Clarification	*				PMH	
15	217			*Translation				PMH	
16	219	C	Probing (A)					PMH	
17	221	C	Clarification	*				PMH	
18	223(Afrik)	C	Probing (A)					PMH	
19	227			*Translation				PMH	
20	229	O	Probing (A)					PMH	
21	230(Afrik)		Repeat			*		PMH	
22	232(Afrik)	C	Probing(A)					PMH	

23	234(Afrik)	C	Probing(A)					PMH	
24	236	C	Clarification	*				PMH	
	Line from Transcript	Type of question (Open or closed)	Reasoning behind question (Probing for new or additional information or clarification) Multiple Questions (#)	Clarification for students understanding	Display of student insecure questioning technique (repetition or rephrasing question)	Clarification for patient's understanding	Acknowledgment of hearing patient's statement (use of OK or directly to statements by patient) ^ Not picking up on patient's concerns/statements	Related to which part of interview	Interruption by
25	238(Afrik)	C	Probing (A)					PMH	
26	240(Afrik)	O	Probing (A)					PMH	
27	242	C	Probing					PMH	
28	244			*Translation				PMH	
29	245	C	Clarification	*				PMH	
30	247	C	Probing (N)					PMH	
31	247(Afrik)		Repeat			*		PMH	
32	249	C	Probing (A)(#)					PMH	
33	249(Afrik)		Repeat					PMH	
34	251	C	Clarification	*				PMH	
35	251 (Afrik)	O	Probing (A)					PMH	
36	254(Afrik)	C	Clarification	*				PMH	