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Assessing Patient-Centered Communication In Medical Education: A Crystallized Approach To Understanding The Quality, Nature, And Form Of Feedback By Standardized Patients

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**ASSESSING PATIENT-CENTERED COMMUNICATION IN MEDICAL EDUCATION:
A CRYSTALLIZED APPROACH TO UNDERSTANDING THE QUALITY, NATURE,
AND FORM OF FEEDBACK BY STANDARDIZED PATIENTS**

by

SIMONE KATHE BRENNAN

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

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Approved By:

Advisor

Date

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DEDICATION

I dedicate this dissertation to my family, who are no longer on this earth...

Oiva and Taimi Hyvonen-Halonen

Ree Ann Halonen, Chuck Hanke, and Samantha Webb-Sterkel

Robert and Irene Mills-Norton

Theodore Mills Norton

Bette Reuter Brennan and Timothy Brennan

Margaret Stark Munro

The strength and beauty of your lives guided me through this journey.

I love you all so very much.

Thank you for being with me, every step of the way.

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of a life well-lived, reminding me (especially you, John, Violette, and Ashton) what it means to giggle and laugh and most of all, despite all odds, to hang on to hope, and to each other.

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To my sister, Emily Norton, you are a genius. A poetic, beautiful genius. You are also a fighter, consummately resilient, and truly one of the most non-judgmental people I know. You have been my security blanket and advisor, having the unique ability to connect with me in our sister-speak shortcuts, allowing me the space to be afraid and overwhelmed, proud and reflective.

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To my kids, Sam and Chris, you are two of the most remarkable young men I have ever had the fortune to know – you bring me so much hope and joy. Sam, in addition to you being unbelievably bright, your commitment to being an exemplary worker, to living a life driven by your values, and to building a strong relationship with someone as extraordinary as Lauren, is nothing short of remarkable. You tackle these many challenging and sometimes competing priorities with tremendous poise and confidence - you are a true inspiration to me. Chris, you are one of the most intelligent-pragmatic-compassionate people I have ever met. The comfortable manner with which you navigate all sorts of challenging people and new situations is remarkable. Your courage for trying new things, pushing your own comfort zone is awesome – and contagious. You remind me to be unafraid, too and I am so thankful for this, and for you.

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PREFACE

*All these great barns out here in the outskirts,
black creosote boards knee-deep in the bluegrass.
They look so beautifully abandoned, even in use.
You say they look like arks after the sea's
dried up, I say they look like pirate ships,
and I think of that walk in the valley where
J said, You don't believe in God? And I said,
No. I believe in this connection we all have
to nature, to each other, to the universe.
And she said, Yeah, God. And how we stood there,
low beasts among the white oaks, Spanish moss,
and spider webs, obsidian shards stuck in our pockets,
woodpecker flurry, and I refused to call it so.
So instead, we looked up at the unruly sky,
its clouds in simple animal shapes we could name
though we knew they were really just clouds—
disorderly, and marvelous, and ours.*

In her poem, “What It Looks Like To Us and the Words We Use”, Ada Limon paints a vivid picture of two friends with different perspectives on old barns, God, and clouds, exploring contradictions and connections between their different worldviews, enriching their own and each other’s perspectives through different ways of knowing. Similarly, Ellingson (2009) advances crystallization as a way of looking at phenomena through multiple facets. Rooted in the

traditions of social constructivism and feminism, crystallization provides a framework for scholars to consider a wide range of genres, methods, and practices. Crystallization, originally conceptualized by Richardson (2000), is not a new methodology, but advances a novel framework for inquiry, linking methodological approaches across the qualitative continuum. As a meta-method, crystallization, fits within a social constructionist paradigm, wherein meaning is constituted and continually renegotiated in language between people. Taking a crystallized approach serves to deepen qualitative researchers' collective potential for not just one way of knowing, but for multiple ways of knowing, about a given phenomenon.

Ellingson (2009) frames crystallization not through rigid criteria, but through five guiding principles. First, crystallization is fundamentally qualitative; as such it is committed to promoting in-depth understanding and “thick description” of phenomena (Ellingson, 2009 quoting Geertz, 1973, p. 10). Crystallization creates room for seeking out deep understanding in the traditional sense, by gathering many details, but also by tapping into multiple forms of inquiry and ways of representing and exploring phenomena. In doing so, scholars can bring together a depth of understanding unachievable by using only one methodological approach. Second, crystallization promotes accessing methodologies across the paradigmatic continuum of qualitative approaches, including analytic, performative, interpretive, postpositive, and artistic. Ellingson's advancement of incorporating different genres of methodology stops short of post-positive / quantitative research.

The third principle promotes engaging with more than one genre of writing. This not only opens up opportunities previously unexplored in terms of articulating scholarship, but also advances writing as inquiry, (see also Richardson & St. Pierre, 2005), whereby the very act of writing and analyzing work together to advance newer epistemologies. The fourth principle is

reflexivity, allowing the author to gain deeper insights into self through the process of inquiry. This principle promotes researchers making visible their subjectivities, thus fostering researcher integrity, transforming subjectivity “from a problem into an opportunity” (Ellingson, 2009, p. 13), and serving to enhance a form of reflexive validity. The fifth and final principle addresses the fact that crystallization embraces the contingent, partial, multiple and situated facets of knowledge. In doing so, it forges a clear path away from claims of a singular, objective truth.

As an interpretive-critical health communication scholar I am drawn to crystallization in my dissertation research for its potential in conducting dynamic and meaningful research that can be disseminated and discussed among diverse groups of scholars. Thus, I embrace crystallization for providing opportunities to explore multiple qualitative methods, and include both thematic iterative analysis (Tracy, 2013) and narrative analysis (Charon, 2006) in this dissertation research. As an academic professional working in medical education, a field dominated by outcomes-based post-positivistic scholarship, I am aware that here, qualitative approaches have a limited and (sometimes) resistant audience, with fewer opportunities for funding and publishing. As such, I concurrently push the boundaries of crystallization towards exploring post-positivistic inquiry as yet another ‘way of knowing’, by also studying my dissertation phenomenon deductively through the use of content analysis.

Methodologically, crystallization advances two distinct means for creating and publishing research. The first, which is largely reflective of my dissertation research, is the *dendritic* approach. Dendritic crystallization advances the creation of multiple texts, utilizing various analytical approaches and writing genres, each illuminating a facet of the central phenomena through a unique theoretical and/or methodological perspective. One of the key benefits of dendritic crystallization is that it sharpens “sense-making processes”, by stimulating formation of

connections, highlighting relationships, and defining emerging patterns within and between the various methods and writing styles (Ellingson, p. 128). Additionally, taking a dendritic approach provides a pathway for dispersing scholarship among different audiences through a wider range of journals and conference opportunities. Reflecting on the three distinct methodological approaches used in this dissertation, I am excited about the possibilities for presenting findings to my colleagues in both the qualitative and post-positive camps spanning across health communication and medical education realms.

Alternatively, *integrated crystallization* allows for multiple approaches to be synthesized into one document, either *woven* (deliberately mixing / weaving different genres into a single text) or *patched* (blocking different approaches side-by-side, while still speaking as one).¹ While not adhering to either integrated approach exactly as articulated by Ellingson, in the final chapter of this dissertation research, I attempt to integrate findings from the three research studies by widening the lens, focusing on the ways in which findings from each of the studies speak to one another, potentially forging new understandings of honoring voices from lay communities and serving to advance communication skills assessment strategies.

With regard to representation, I also naturally incorporate the call of crystallization to engage with multiple writing styles. The deductive study, (content analysis), is written to represent the scientific, research-report style of writing associated with post-positivism. The two inductive studies (iterative-thematic and narrative analyses) are written representative of the singular, reflexive approaches associated with qualitative scholarship. Lastly, as with the poetic introduction to this preface, in the final chapter of this dissertation, I preface the various sections

¹ For an example of *woven integration*, see “Critical Communication Pedagogy” (Fassett and Warren, 2007). For an example of *patched integration*, see “Life After Leaving: The Remains of Spousal Abuse” Tamas (2011).

of the chapter with an artistic element (i.e., personal reflections, quotes, or philosophical musings from other scholars), to frame my integrated conclusions and final thoughts. In doing so, I hope to honor through a stylistic aesthetic, the beauty of multiplicity.

I mindfully chose crystallization to frame my dissertation research for its resonance with my multiple standpoints as an interpretive/critical scholar, working in a post-positive world. In adopting this complex and dynamic approach to scholarship, the past two years have put me squarely in the front seat of an emotional rollercoaster, as I endeavored to understand my chosen phenomenon through the multiple facets. At times, the qualitative and quantitative approaches of inquiry collided in my brain, undermining my ability to focus, depleting my energies. Other times, as hopefully is evidenced throughout this dissertation manuscript, they coalesced, achieving that which crystallization is intended to do – forging out unexpected and original ways of knowing. On a personal note, the most profound result of engaging with crystallization is that it has required of me – at all times - to be honest and true to the rigor associated with each of the methods included in this body of research. There are no ‘easy outs’ in crystallization, no shortcuts to establishing crystallized knowledge claims. Consequently, while crystallization has provided me a pathway to conducting meaningful research, it forced upon me an ethicality for which I was initially unprepared, fortifying my ability to emerge a wholly responsible scholar, both to my dual fields of health communication and medical education, but perhaps most importantly, to myself.

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Chapter 1: Introduction

Strong communication skills are integral to good clinical practice and a mainstay of the present curriculum at all accredited medical schools and residency training programs in the U.S. The emphasis on communication skills training is due in large part to standards set by governing and accreditation entities (Accreditation Council for Graduate Medical Programs Common Program Requirements, 2013; Liaison Committee on Medical Education, 2012; Lurie, 2003). These standards were implemented due to the breadth of research demonstrating the positive implications of effective patient-provider communication. Namely, that improved communication correlates to better clinical decisions and health outcomes, greater patient compliance, increased patient safety, a reduction in malpractice suits, and satisfaction for patients and physicians alike (Barrier, Li, & Jensen, 2003; Makoul & Curry, 2007).

Over the past 30 years, communication training in medical education shifted from a purely apprentice-based approach, wherein residents would routinely acquire communication behaviors through observation of senior physicians, toward a more formalized component of the clinical training curriculum (Razack et al., 2007). Additionally, the emphasis on what constitutes effective communication has undergone a transformation, moving away from the biomedically informed model of doctor-centered communication, toward a focus on *patient-centered communication*, (Epstein & Street, 2007; Stewart et al., 2003), reflective of the biopsychosocial model (Duggan, Geller, Cooper, & Beach, 2006; Engel, 1977).

Although there is no universal model for teaching and assessing patient-centered communication, one common approach is the use of Standardized Patients (SPs). SPs are healthy lay-people hired and trained to portray a scripted patient role in a clinical scenario (simulated encounter) for the purposes of teaching and/or assessing communication skills (Hodges, 2003;

Rubin & Philip, 1998). Following each simulated encounter, SPs are often asked to provide verbal feedback to the student or resident about how he or she related and communicated with the patient during the encounter (Egener & Cole-Kelly, 2004; Hassell 2012). Medical educators and residents have reported favorably on SP feedback, (Bokken, Linssen, Scherpbier, van der Vleuten & Rethans, 2009; Lane & Rollnick, 2007) but little is understood about the exact content or form of the feedback, particularly the degree to which SP feedback provides learners with a deeper or more robust understanding of patient-centered communication. Additionally, little is known about why SP feedback is received so favorably.

SPs are trained to provide written assessment and oral feedback using one of the many available communication assessment instruments. One such instrument is the adapted version of the Kalamazoo Essential Elements Communication Checklist (KEECC-A), an expert-developed rubric used to assess residents' communication and relational skills (Joyce, Steenbergh & Scher, 2010; Makoul, 2001). The original Kalamazoo assessment model was developed in 1999 by an invited consortium of communication experts at the Bayer-Fetzer Institute in Kalamazoo, MI. The Kalamazoo model is widely referenced in the development of patient-centered communication training programs and the KEECC-A is specifically advanced for use in the Accreditation Council for Graduate Medical Education (ACGME) toolbox for assessment of communication skills (Baribeau, Mukovozov, Sabljic, Eva & Delottinville, 2012; Berger, Blatt, McGrath, Greenberg, & Berrigan, 2010; Calhoun, Rider, Meyer, Lamiani, & Truog, 2009). To date, little has been published on the utility of the KEECC-A as an assessment tool for patient-centeredness in residency learning-environments. Furthermore, Goyal et al. (2008) expressed concerns that instruments such as the KEECC-A, which are developed entirely by clinical and medical educators, are reductionist and, as such, do not accurately reflect the nuances and scope

of effective patient-centered communication. While some have called for development of communication assessment tools and curricula that are informed by and sensitized to patient's perspective (Epstein, 2006; Ishikawa, Hashimoto & Kiuchi, 2013; Rose and Wilkerson, 2001) it appears that to date, little has been done in this regard.

SPs offer exciting possibilities for gaining deeper understanding of patient-centered communication. Although SPs do not directly represent patient populations, they do reflect what Mishler (1984) would refer to as representatives of the "lifeworld". The vast majority of SPs throughout the country are actors, retirees, or other lay-people interested in working within a medical-educational environment. By design, SPs do not have formal / prior clinical or medical-educational training, as they are recruited to serve as bona fide representatives of the lay community. Thus, SPs straddle multiple realities; that of real-world patients and consumers of medicine; pseudo-insider to the practices of medical education; community members with a lived history and cultural uniqueness; and as an engaged, educational participant, with a desire to improve communication between physicians and patients. Consequently, SPs have the potential to provide valuable insights into gaining understandings of the lifeworld perspective in patient-centered communication. Despite the fact that SPs are a mainstay of most educational training programs, there has been little to no research done focusing on the SP perspective with regards to this phenomenon.

Purpose of Research

The purpose of this dissertation research is to examine and explore the quality, nature and form of patient-centered feedback delivered to medical residents by SPs. Specifically, I will employ multiple methods, applying Ellingson's (2009) articulation of *crystallization*, which advances exploring a phenomenon through different genres. With crystallization, Ellingson urges

researchers to avoid seeing research methods as dichotomous, but rather work toward embracing different methodologies along a continuum of approaches, providing opportunities to forge insights into different ways of knowing and understanding a phenomenon. The three methods used in this body of research, combining deductive and inductive explorations, are (a) content analysis, (b) thematic analysis and (c) narrative analysis. Implications of this research are to extend understandings of how residency programs can best teach and assess patient-centered communication by focusing on the voices of SPs, who serve as representatives of the lifeworld. Additionally, this research serves to extend the possibilities for crystallization methodologically, as this is the first known study to include a post-positive method (i.e., content analysis) as part of a crystallized inquiry. Furthermore, it is hoped that this research will encourage further studies into exploring the perspectives of SPs, as an integral part of the medical educational landscape.

Dissertation Outline

Chapter 2 provides a literature review of the historical and theoretical foundations relative to this dissertation research. It also explores different models of clinical communication, with specific emphasis on patient-centered communication, as well the Kalamazoo Consensus Statement as a framework for delivering patient-centered communication. With specific regard to medical education, this review also explicates Standardized Patient methodology and Objective Structured Clinical Exams. Lastly, it provides an introduction to the three separate studies conducted under the meta-method of crystallization (Ellingson, 2009).

The next three chapters cover the three individual studies performed as part of this dendritic approach to crystallization, each investigating KEECC-A informed SP feedback through a unique facet of the crystal. Chapter 3 describes the content analysis study, Chapter 4

the thematic analysis, and Chapter 5 the narrative inquiry. The final chapter (Chapter 6) widens the lens, providing a discussion of the integrated findings from the three research studies.

Chapter 2: Literature Review

To better understand the current emphasis on patient-centered communication, it is necessary to reflect back on historical antecedents and corresponding theoretical foundations that led to our current understanding of best practices in doctor-patient communication. Exploring these historical and theoretical pathways, situates the relevance of the current research as well as future directions for improving communicative relationships in medicine.

Historical and Theoretical Foundations: Biomedical vs. Biopsychosocial Models

Two models of health care have dominated the practice and delivery of Western medicine for over the past century; the *biomedical model* of healthcare being the predominant model for most of the 20th century, while more recently, the *biopsychosocial model*, first articulated by Engel in 1977, has greatly influenced the practice and education of medicine in recent years. Ontologically and epistemologically, these two models have been informed from vastly different theoretical understandings (functional vs. social constructionism), promulgating unique approaches to the manner by which student doctors are educated and evaluated in delivery of patient care and patient communication. Despite their fundamental differences, as I will later discuss, these two models continue to co-exist in present-day deliveries of medical educational programs, often causing internal tensions over structure and priorities in the field.

The biomedical model. In the 17th century Rene Descartes introduced the idea of mind/body dualism, asserting the mind as an intangible, non-measurable entity, distinct and separate from the functioning of the body (Greer, 2003). Traditional Western medical practices are built upon Cartesian dualism, with physicians approaching the patient's body from a foundational scientific perspective as an object of study, referred to as the biomedical model (Gray, 2011; Sharf & Vanderford, 2003). The biomedical model privileges objectivity,

empiricism, and outcomes, measurable or verifiable by scientific method (Sharf & Vanderford, 2003).

Specific to North America, philosophical tenets of Cartesian dualism and the biomedical model were operationalized and institutionalized in the training of physicians via the publication of a report by Abraham Flexner, an early 20th century educator (Bonner, 1989; Ehrenreich & English, 2010). The Flexner Report, published in 1910, was motivated by recent breakthroughs in germ theory as well as a highly structured, scientific training model being utilized in Germany (Barzansky, 2010; Riggs, 2010; Salmon & Berliner, 1980). Hiatt and Stockton (2003) assert the Flexner Report continues to be highly regarded by many in the medical community for the systematic rigor with which it was developed and for establishing a doctrine of best practices in the accreditation of medical schools and overall education provided to medical students, forming a single (acceptable) approach to medical education (Magnus & Mick, 2000). In addition, Flexner sought to develop physicians as independent scientists, focusing on scientific method “in which the physician is “concerned chiefly with his acquisition of the proper knowledge, attitude, and technique”” (Doukas, McCullough, & Wear, 2010, p. 319). Consequently, the recommendations of the Flexner report were far-reaching, resulting in well-defined entrance requirements to medical school, standardized training approaches, and most importantly, greater focus on basic science and the biomedical model within a university setting (Barzansky, 2010; Hewa, 2002; Hiatt & Stockton, 2003; Magnus & Mick, 2000). Understandably, the Flexner report is highly regarded among many educators for improving the quality of medical training, raising the standards for patient safety and care (Barzansky, 2010). However, others point to significant flaws in the report, most notably for its narrow emphasis on scientific method, and complete rejection of alternative or holistic clinical approaches. Critics argue that wholesale

adoption of the biomedical approach essentially reduces patients to the presence or absence of pathologies, while rejecting compelling psychosocial and cultural considerations of illness and health (Ehrenreich & English, 2010; Salmon & Berliner, 1980).

Ironically, a significant and largely unrecognized portion of Flexner's report focused on the need for physicians to be well-rounded and highly educated in the humanities as a prerequisite to medical education. Furthermore, while Flexner may have done so from a paternalistic paradigm, (see Magnus & Mick, 2000) his report advocated for physicians to work for the social good, committed to the delivery of medical care to the poor and underserved (Doukas et al., 2010; Magnus & Mick, 2000). The social climate of the day however was focused on the creation of a scientific and intellectual elite, trending away from holistic, communal approaches (Ehrenreich & English, 2010). Forces within this societal climate placed greater value on scientific method, thus eschewing any commentary Flexner may have had on the humanistic and altruistic aspects of training future physicians. Some assert that this lack of attention to the humanistic aspects of the Flexner report continues through today (Riggs, 2010).

Theoretically, as suggested by Sharf & Vanderford (2003), the biomedical model reflects traditions aligned with medical functionalist theory. Turning to its roots in sociology, functionalism, as a meta-theory presumes that societies and cultures are homeostatic rather than conflictual, and that the social world is objectively real (Bissell, Morgal-Traulsen & Stig-Haugbolle, 2002; McClelland, 2000). Specific to medical sociology, functionalism is mirrored in the Western biomedical model, which strives for scientific detachment from the subjectivity of patients' experiences (Bissell, et al, 2002; Sharf & Vanderford, 2003). Medical functionalists contend there are clearly defined roles for both patients and doctors (Ishikawa et al., 2013),

whereby "doctors are principled and benign, and patients adopt a sick role, wanting to recover and to comply with treatment" (Alderson, 1998, p. 1008).

The biopsychosocial model. In 1977 George Engel, reacting to the reductionist paradigm of the biomedical health model proposed a new paradigm for physician training and delivery of clinical care. He coined this new paradigm the biopsychosocial model, advocating for a return to holistic approaches in clinical practice, through the inclusion of the patient's biomedical (illness) presentation, as well as elements of their psychological, environmental and cultural lives (Engel, 1977; Gray, 2011). Engel, a psychiatrist, saw many opportunities for the biopsychosocial model within his own field, yet he advocated for the advancement of this new model across the continuum of medical disciplines, as he viewed the biomedically-oriented reductionist approach to medicine as ultimately detrimental to ensuring effective delivery and positive outcomes of patient care. Furthermore, Engel challenged the medical community to consider the fact that the biomedical model was, as are all other forms of models, "...nothing more than a belief system, utilized to explain natural phenomena, to make sense out of what is puzzling or disturbing" (p. 130). According to Engel, the biomedical model had moved beyond being one way of understanding the world, it had become a dogma. Using a framework of systems theory, Engel suggested that just as there exists an understanding among biologists of a hierarchical interconnectedness of atoms, molecules, cells, organisms, organs, and people, so too was there a similar, linear interconnectedness between the biomedical, the psychological and the societal elements of a patient's life. Herein, he saw a framework for bridging the reductionist and holistic divide, allowing stakeholders (i.e., clinical, social, and psychological supports) from all aspects of the patient's life, the opportunity to work together in the best interest of the patient.

Engel's articulation of the biopsychosocial model is viewed by many as the pivotal turning point in the development of subsequent models that enlist and engage the patient as an empowered partner in the clinical dyad (Dwamena, Mavis, Homes-Rovner, Walsh & Loyson, 2009; Goyal et al., 2008). Borrell-Carrio, Suchman, and Epstein (2004) defend the premise of Engel's articulation of his model, but suggest several arenas to clarify and extend it, to provide more pragmatic utility in clinical practice. Among their suggestions, they advance an enhanced biopsychosocial model that specifically articulates constructs such as self-awareness, empathic curiosity, and a focus on the dialogic. Ultimately, they argue that gaining a full understanding of the health of a patient is going to be best served by working in partnership with the patient, forming shared understandings realized through the process of delivering medical care and not based entirely on a priori assumptions. In many ways, without explicitly stating as much, Borrell-Carrio et al. (2004) advance a theoretical framework of social constructionism as a more effective means for practical implementation of the biopsychosocial model.

Social constructionism. Social constructionism, is a theoretical orientation challenging taken-for-granted assumptions of knowledge and 'truth' as fixed entities, instead asserting that knowledge is socially, culturally, and historically mediated. Furthermore, it asserts that knowledge is gained not through the accepted paradigm of the individual learner, but through relationships and communication with others (Shotter & Gergen, 1999). To this end, social constructionism argues that many of the taken-for-granted tenets by which we structure and enact our lives are also socially constructed, and not inherently representative of a singular truth. This theory is particularly helpful for contextualizing and addressing some of the challenges faced by educational practices of Western medicine, which, as Engel himself alluded to, is itself, a social construct (see also Ehrenreich & English, 2010; Salmon & Berliner, 1980).

In the 30+ years since the biopsychosocial model was first introduced, it has received mixed reviews among clinical educators and medical learners (e.g., residents, students) with some suggesting it is simply too cumbersome, and lacking of focus to incorporate in medical curricula, while others disregard it based on its lack of developmental rigor (Astin, Sierpina, Forsys, & Clarridge, 2008; Kontos, 2011). Furthermore, the biopsychosocial model has also realized varying degrees of adoption in medical education. Most medical schools and residency programs advance biopsychosocial approaches in their formal curricula, teaching the basic clinical sciences and biomedical understandings of disease along with learner opportunities to gain understandings into psychosocial and cultural implications of health (Accreditation Council for Graduate Medical Programs Common Program Requirements, 2013; Liaison Committee on Medical Education, 2012). Despite the fact that medical education programs assert they are incorporating biopsychosocial-like criteria in their curricula, there is some evidence that, in actual practice, medical students and residents alike are not getting much exposure to education beyond the biomedical paradigm (Astin et al., 2008). Some have suggested that the much discussed *hidden curriculum* in medicine, that is, the informal conversations between senior faculty and residents or preceptors and students, continues to privilege and reinforce the dominance of the biomedical model in the practice of medicine (Makoul, 2006; Taylor, 2003). Others have suggested that the educational trend toward measurement and outcomes leaves no room for students and residents to fully engage in the lifeworld of the patient (Mishler, 1984; Wear & Varley, 2007). While the educational and practical world of medicine continues to struggle with a full acceptance of the biopsychosocial model, per se, what is clear is that Engel's model paved the way for some manifestations therein to find their niche within the community. This is particularly evident in the realm of doctor-patient communication.

Models of Clinical Care and Clinical Communication

Clearly the biomedical model and the biopsychosocial model have served to inform unique pathways for the delivery of clinical practice, the former focused on the functional and mechanical aspects of the human body; the latter dedicated to constructing a multifaceted picture of health from the biological, the psychological, and the social components of a patient's life. Consequently, each of these models also informs different expectations of the manner with which physicians and patients communicate with one another. I now turn to a brief discussion of the variety of models of doctor-patient communication and how they are situated in clinical care and medical education.

The biomedical model and doctor-centered communication. As previously discussed, the biomedical model is reflective of Functional Theory, which asserts itself as "objectively real", striving for scientific detachment from the subjectivity of patients' experiences (Sharf & Vanderford, 2003). Sharf and Vanderford (2003) present an argument that underscores the functional approach in medicine, asserting that Western physicians have historically utilized a biomedical, clinical approach in their communication with patients. They argue that physicians communicate utilizing "objective language to present traditional, biomedical information about organic, verifiable, measurable signs of disease...evidenced by clinical signs, laboratory tests, imaging and other technology" (p. 11). Ultimately, the biomedical model privileges what Stewart et al. (2003) refer to as doctor-centered communication, wherein doctors do most of the talking, control the discussion through the use of standardized history-taking protocols (see Zoppi & Epstein, 2002), choose which topics will be discussed, and ultimately have the choice of when to start and end conversations with patients (du Pre, 2010).

For much of the last century doctor-centered communication was considered best-practice in clinical care. This was based on several reasons, including (a) not wanting to ‘confuse’ the patient; (b) as a means for time-management; (c) not wanting to be distracted by patient concerns that did not pertain to the presenting (clinical) problem; (d) simply put, ‘doctor knows best’ (see du Pre, 2010; Taylor, 2003). As recently as the early 1990s there was no formal curriculum for teaching communication, per se. Instead, communication was passed on via an apprenticeship model whereby learners would learn about bedside manner on clinical rounds and through observing senior clinicians. The only structured portion of what could be considered a communication component of traditional medical curricula, was teaching students and residents how to elicit a patient history which was, and in many ways remains to be, entirely doctor-controlled. (Zoppi & Epstein, 2002).

The biopsychosocial model and related models of communication. Whereas doctor-centered communication is the single communicative style associated with the biomedical model, there are various models of health communication associated with the biopsychosocial model, including (a) shared decisions making, (b) relationship-centered communication, and (c) patient-centered communication.

The first of these three models, *shared decision-making* was first advanced by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in its 1982 report *Making Health Care Decisions*, focused on informed consent (Makoul & Clayman, 2006). Shared decision-making was developed as a reaction to paternalism in the medical encounter, specifically with regard to the physician as sole decision maker concerning choices for treatment modalities (Charles, Gafni, & Whelen, 1997). Thus, whereas other biopsychosocial-informed communication models seek to engage and empower

patients in multiple aspects of their health care, shared decision-making has a narrow and exclusive focus solely on treatment decisions (Charles et al., 1997; Goyal et al., 2008). Goyal et al. (2008) suggest shared decision-making is entirely focused on information exchange, generally oversimplifying the complexities that can arise in a clinical encounter. For example, in the case of the patient given a diagnosis of cancer, shared decision-making would advocate for the doctor and the patient to share (discuss) whatever information they know regarding the subject, (i.e., the doctor providing the technical information, the patient discussing their understanding of the diagnosis and treatment options). Based on this exchange, the patient would be instantaneously equipped and empowered with the necessary information, able to make a well-informed decision regarding their treatment plan. Goyal et al. (2008) contend that shared decision-making's formula for ensuring patient empowerment could present an untenable choice for the patient, who perhaps is still reeling from a diagnosis of cancer, yet now being told they are empowered to make a decision over treatment options that may never have entered their consciousness prior to the clinical visit (e.g., making a decision between surgery and radiation / chemo treatments).

In the 1990's, scholars grounded in the biopsychosocial model moved beyond shared decision-making towards the concept of patient-centeredness, patient-centered care and patient-centered communication (see Beach, Inui & Relationship Centered Care Research Network 2006; Duggan et al., 2006; Stewart et al., 2003). Epstein et al., (2005) suggest that while these three terms are often used interchangeably, there are in fact distinct differences between the three. They suggest that *patient-centeredness* refers to moral² and philosophical assumptions, wherein physicians ensure that patients' needs, wants, and perspectives are prioritized, patients are routinely provided an opportunity to have input into their care, and physicians work

² See Duggan, Geller, Cooper & Beach (2006) for a further discussion of the moral nature of patient-centeredness

diligently to enhance building equal partnerships with patients. *Patient-centered care* refers to the enactment or delivery of a range of individual behaviors or actions that ensure patient-centeredness. *Patient-centered communication* focuses specifically on the communicative interactions among clinicians, patients, and family members that promote the underlying philosophical assumptions patient-centeredness. Thus, patient-centered communication shifts from clinical communication being directed and controlled entirely by the physician, to a more dialogic and shared process that empowers the patient, who is seen as the central figure in the dyad. Patient-centered communication extends communicative assumptions inherent in both the biopsychosocial model and shared decision-making by embracing patient's lived realities, including a deeper understanding of social and cultural contexts. Additionally, patient-centered communication has broadened the scope of the patient encounter from the narrow and exclusive focus on treatment options articulated by shared decision-making, to a fuller conceptualization of clinical care, including (a) understanding the patient's perspective; (b) exploring the disease and illness experience as understood by the patient as well as addressing the patient's needs, ideas, and functioning; (c) finding common ground by reaching a shared understanding of both the problem and the treatment that is aligned with the patient's values; and (d) sharing both the responsibility and the power of decision-making with the patient to their level of comfort with the process (Epstein et al., 2005; Stewart et al., 2003). Additional nuanced articulations of patient-centered communication can be found in cancer communication (Epstein & Street, 2007; McCormack et al., 2011), patient interviewing (Smith, 2002), and in multitude other specialties and contexts (see Goyal et al., 2008 and McCormack et al., 2011).

The movement toward patient-centered communication started in the early 1990s, attributed in part to the growing shift toward a consumer-driven society, with patients situated

more as customers, and less as passive receptors of clinical care (Ishikawa et al., 2013). Additionally, the burgeoning of health information readily available to patients via the Internet provided patients with access to knowledge that, as recently as a couple of decades ago, were solidly and exclusively anchored in the clinician's domain (Koch-Weser, Bradshaw, Gualtieri, & Gallagher, 2010). Over the past decade, various reports have been published, and educational standards have been modified to accommodate patient-centeredness in part due to the breadth of empirical research conducted, supporting the positive impact of both adopting a patient-centered philosophy and engaging in patient-centered communication (Cohen, Black, Holyst, & Krackov, 2000; Carvahlo et al., 2011; du Pre, 2001; Peck, 2011; Smith et al., 2000; Sparks, Villagran, Parker-Raley, & Cunningham, 2007).

Relationship-centered communication is in many ways integrated within, but in other ways an extension of, patient-centered communication. Relationship-centered care expands the focus on the dyadic connection between physician and patient, suggesting that quality patient care is achieved through open lines of communication with not just the patient, and perhaps their immediate family, but with others who are intrinsically connected to the patient's illness. These 'others' can include immediate and extended family and friends of the patient, other specialists affiliated with the patient's care, ancillary members of the medical team (e.g., nurses, specialists, technicians, etc.), and with organizations and care agencies the patient may be connected to outside of the immediate hospital setting (Beach, Inui, et al., 2006; Duggan et al., 2006; Suchman, 2005; Tresolini & Pew Fetzter Task Force, 1994; Williams, Frankel, Campbell, & Deci, 2007). Relationship-centered care is also advanced as forging a strong relationship with oneself, particularly for the physician, by engaging in self-reflective practices after patient encounters, evaluating one's own strengths and challenges in the delivery of care (Beach, Inui, et

al., 2006). Additionally, some assert relationship-centered care as the opportunity to build a relationship with a patient over time, which can be challenging to physicians who do not have continuous care with patients (e.g. Emergency Room physicians, surgeons, hospitalists, and a multitude other specialties and sub-specialties), as well as those who practice under strict guidelines with managed care (Meyer, 2009).

Throughout the language of accreditation agencies, as well as within the curricula of many medical education programs, there are references to elements of relationship-centered care (e.g., keeping lines of communication open with patients' families as well as inter- and intra-professionally) (Beach, Inui, et al., 2006). However, due in large part to privacy laws on both the state and federal level,³ the prevailing approach to patient communication is almost exclusively articulated as patient-centered communication, giving primary agency to the patient, themselves. Thus, among all the communication-specific models that developed from a biopsychosocial foundation, patient-centered communication is considered the gold standard (see Eggly et al., 2009) for both practitioners and medical educators.

Patient-Centered Communication in Medical Education

A primary location for integrating patient-centered communication into medical practice is in medical education. Accreditation entities for both undergraduate and graduate medical education have advanced patient-centered communication as a core competency of clinical practice (Joyce et al., 2010; Liaison Committee on Medical Education, 2012). Additionally, physician licensure is now hinged on successful completion of communication and interpersonal

³ American Health Information Management Association; see http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_016464.hcsp?dDocName=bok1_016464

skills exam⁴ required of all medical students prior to admission in a residency program. Consequently a number of checklists and training approaches have been developed for teaching and assessing patient-centered communication skills within a medical context (see Kalet et al., 2004; Keller & Carroll, 1994; Makoul, 2001; Makoul & Schofield, 1999; Windish, Price, Clever, Magaziner, & Thomas, 2005).

In this section, I will discuss one widely utilized model for teaching and assessing patient-centered communication skills in residents, the Kalamazoo framework. I will also discuss a primary means through which patient-centered communication is implemented in educational curricula, namely through the use of Standardized Patients (SPs) and Objective Structured Clinical Exams (OSCEs).

The Kalamazoo consensus statement. A new model for assessing patient-centered communication and interpersonal skills was first envisioned at a meeting held at the Bayer-Fetzer Institute in 1999. Here, leaders in communication from prominent medical universities as well as a variety of professional health care organizations evaluated five popular models of research based on doctor-patient communication. The five models evaluated were: (a) Bayer Institute for Health Care Communication E4 Model, (b) Three-Function Model/Brown Interview Checklist, (c) The Calgary-Cambridge Observation Guide, (d) Patient-centered clinical method, (e) SEGUE Framework for teaching and assessing communication skills (Makoul, 2001).

The purpose of the conference was to identify essential elements, common to all five of the presented models, which could be advanced as a common framework for communication curricula in both graduate and undergraduate medical environments. Known as the Kalamazoo Consensus Statement (KCS), the authors articulated a total of seven essential communication

⁴ United States Medical Licensing Examination - Step 2 CS; see <http://www.usmle.org/step-2-cs/>

tasks representing tangible examples of communication skill competencies: (1) build the doctor–patient relationship, (2) open the discussion, (3) gather information, (4) understand the patient’s perspective, (5) share information, (6) reach an agreement on problems and plans, and (7) provide closure (Duffy et al., 2004; Goske, Reid, Yaldoo-Poltorak, & Hewson, 2005; Makoul, 2001)

The generation of the KCS (later termed Kalamazoo I) was extremely influential in the development and implementation of patient-centered communication-training and assessment initiatives throughout U.S. medical education programs. Kalamazoo I served as a framework for informing both residency and undergraduate communication training environments (Goske et al., 2005; Joyce et al., 2010; Schirmer et al., 2005; Shue, 2010). Since the generation of the Kalamazoo I report, the model was formalized into a communication assessment tool, originally with 23 items, assessing sub-competencies with three discrete scoring options (not done, needs improvement, done well), which were unwieldy and time-consuming for practical use (Rider, Hinrichs, & Lown, 2006). Rider et al. (2006) adapted the Kalamazoo Essential Elements Checklist by replacing the original response options with a 5-point Likert scale that allowed raters to evaluate each communication skill on a continuum from poor to excellent, essentially shifting to global ratings of the seven, communication competencies, each explicated by a series of defined sub-competencies. This adapted version known as the KEECC-A has continued to both influence and be directly used in a number of patient-centered communication training and testing environments (Baribeau, et al., 2012; Berger, et al., 2010; Calhoun, et al., 2009). (see Appendix A for the KEECC-A instrument and sub-competencies as defined by Rider, et al., 2006)

Models such as the Kalamazoo are designed to inform, teach and assess patient-centered

communication, eliciting a deeper and more nuanced understanding of a patient's views and beliefs of their health and illness. Patient-centered communication models share a common desire to move away from the scientific detachment found in the biomedical approach, toward an emphasis reflected by the biopsychosocial model, acknowledging the patient's perspective and culture, and empowering the patient to make decisions about their health and treatment options (Goyal et al., 2008). However, tools such as the KEECC-A and others designed to teach and assess patient-centered communication are not without criticism. Two primary criticisms are (a) the fact that they have been solely developed by clinicians, absent the inclusion of patients' voices or significant participation in their creation, and (b) for their emphasis on communication skills building and isolated communicative behaviors (Dwamena et al., 2009; Goyal et al., 2008).

With regard to the first criticism, despite the fact that patient-centeredness and other iterations of the biopsychosocial model were first introduced into the curriculum over 20 years ago, there are many who suggest the biomedical model perseveres (Alonso, 2004; Barrier et al., 2003; David & Holloway, 2005; Greer, 2003). As such, physicians continue to be viewed, by themselves and others, as the experts in not just medical practice but also in the development of medical educational tools and assessments. Furthermore, the influence of the hidden curriculum is profound, as some assert it continues to reinforce vestiges of sometimes outdated or contraindicated approaches in clinical behavior and doctor-patient communication (Salmon & Young, 2005; Rosenbaum & Axelson, 2013; Silverman, 2009; Taylor, 2003). Thus, curricula and assessment tools which are intended to better understand and solicit the layperson's voice in patient-centered communication have been exclusively developed by physicians and medical educators (Dwamena et al., 2009), promulgating the biomedical health model via the development of reductionist scales of measurement of patient-centered communication.

As for the second criticism, patient-centered communication training and assessment is routinely focused on specific operationalized skills. Consequently, learners are assessed and receive feedback on discrete communication behaviors, such as eye contact and body language, use of open-ended vs. close-ended questions, etc. Goyal et al. (2008) argued that this produces nothing more than a reductionist checklist, resulting in “an inventory of manneristic stage directions...better suited to the dugout coach giving signs to a runner on second or to one of Beckett’s tramps expressing his disembodied comfort” (p. 735), suggesting that current patient-centered communication tools such as the KEECC-A are more reflective of the biomedical model than a truly patient-centered approach. Furthermore, the reductive nature of the instruments used in these assessments is incapable of capturing what Goyal et al. (2008) referred to as the “interpretive or iterative” (p. 735) nature of the dialogue, thus obscuring the learner from being able to appreciate the complexities that inevitably arise within a patient encounter. Because of the predetermined reductionist nature of these teaching and assessment instruments, there are limited opportunities to capture the twists and turns patient-physician communicative encounters take as they co-create the narrative of health, illness, and disease.

Standardized patients and OSCEs. One primary application for training and assessing patient-centered communication skills among residents using the KEECC-A, and similar assessment tools, is through the use of SPs and OSCEs (Joyce et al., 2010). Standardized Patients (SPs) are lay people trained to work with learners across the continuum of medical education. SPs are an essential component of medical education and are used in most U.S. medical education programs, both at the undergraduate and graduate levels (Wallach et al., 2001). SPs play an important role across the continuum of teaching and assessing learners’ clinical skills, including physical exam maneuvers, medical-history taking, and communication and

interpersonal skills. SPs are used in a variety of teaching and testing environments to portray a patient role, rate the performance of the learners, and often are used for providing patient-centered feedback to learners, wherein they orally share their reflections with learners regarding their communication and interpersonal skills. SPs are trained to provide this oral feedback utilizing instruments and rubrics of patient-centered communication skills, developed by clinical educators, such as the KEECC-A. As previously discussed, SPs play a unique role in the development of patient-centered communication skills in learners; they serve a dual role as an insider to the educational process, but also as members of the lay patient community and thus serve as informal ambassadors, or liaisons to, the general patient community, providing an opportunity to gain insights into the patient perspective for studying patient-centered communication. SPs represent what Mishler (1984) referred to as voices from the “lifeworld”.

Due to demands of accreditation and institutional entities, the Objective Structured Clinical Exam (OSCE) is increasingly used in graduate medical educational environments for the observation and assessment of measures of clinical competence in a standardized and reliable manner (Accreditation Council for Graduate Medical Education, 2013; Rau, 2011). OSCEs consist of multiple ‘stations’ of SPs, each offering a unique patient presentation designed to challenge the resident to apply patient-centered communication skills commonly used in actual clinical environments. Examples of OSCE stations range from straightforward, everyday encounters (e.g., a patient receiving informed consent or discussing medication changes with a resident) to more intense patient scenarios where the resident has to manage an angry patient, share bad news with a terminal patient, or admit to a medical error. OSCE stations are based on actual clinical encounters and are designed to assess some of the required clinical competencies, primarily communication and interpersonal skills, professionalism, or cultural competence, each

of which present a challenge to, or an opportunity for, affecting the quality of patient care. The strength of the OSCE from an educator / evidence-based perspective is that it allows learners to apply their clinical knowledge in a structured setting, with SPs rating their performance using validated and reliable instruments (Boulet, De Champlain, & McKinley, 2003; Whelan et al., 2005). Residents often receive immediate spoken feedback from the SPs as well as objective observers (e.g., clinical faculty) and may have the opportunity to view videotapes of the exam, making it a powerful tool for both assessment and feedback (Bokken, Linszen, Scherpbier, van der Vleuten & Rethans, 2009; Branch & Paranjape, 2002). SPs have been found to be highly reliable for both teaching and assessing communication competence (Barry et al., 2010; Klamen & Yudowsky, 2002; van Zanten, Boulet, & McKinley 2007) and are valued by medical educators for their uniformity in providing standardized clinical skills feedback (Bokken, Rethans, et al., 2009).

The Present Research

As described earlier, the Kalamazoo Model has been influential on the development and execution of patient-centered communication skills curricula in residency training programs across the U.S. (Goske, et al., 2005; Gross-Cohn, Jia, Chapman-Smith, Erwin & Larson, 2011; Razack et al, 2007; Schirmer et al., 2005) Despite this, there are only five known published studies that address the utility of the KEECC-A as an assessment tool (see Calhoun et al., 2009; Joyce et al., 2010; Porcerelli, Brennan, Carty, Ziadni, & Markova, 2015; Rider et al., 2006; Schirmer et al., 2005;). All of these studies focus primarily on psychometric qualities of the KEECC-A and earlier iterations of the Kalamazoo model, but none assess the degree to which the content, quality and /or form of KEECC-A resonates with SPs as a true measure of patient-centered communication. Ishikawa et al. (2013) suggest that lay perspectives have been largely

overlooked in clinical communication scholarship and make recommendations to include the patient perspective towards understanding of patient-centered communication. Over ten years ago, Rose and Wilkerson (2001) advocated for broadening the scope and usage of SP methodology, including greater use of SP narratives when evaluating clinical skills, (e.g., communication skills), as SPs provide invaluable lifeworld perspectives. To date, there are no known published studies that include or reflect on SP voice towards informing greater understanding of patient-centered communication. Thus, one of the primary goals of the present dissertation research is to examine the KEECC-A as a framework for patient-centeredness, and the extent to which it is reflective in both content and form to what is most salient to SPs as ambassadors of the larger lifeworld community with regard to patient-centered communication.

A primary intersection for addressing SP perspectives and attitudes toward patient-centered communication is in the delivery of patient-centered feedback. I work in a clinical skills center at the Wayne State University School of Medicine (WSU-SOM). During OSCEs conducted at our center, SPs regularly provide verbal feedback residents from the subjective role of the patient. SPs have no prior clinical experience. Their role is to serve as a proxy-patient in medical education curricula, allowing learners an opportunity to engage with a member of the lay community. While SPs provide a lifeworld perspective, there is an inherent tension in this process, as they are also trained and expected to use the objectivist tool (The KEECC-A) provided to them by the medical educators, which may result in a dialectical push and pull of the enacted, subjective experience of providing feedback filtered through objective criteria as imagined / developed by the educators. At the WSU-SOM, SPs have anecdotally commented during post-OSCE debriefing sessions on a disconnect they experience between the rubric they are required to use when providing feedback (i.e., the KEECC-A), and what they would actually

prefer to share, with regard to residents' communication skills. Eggly, Brennan & Wiese-Rometsch (2005) identified a similar challenge with professionalism expectations of medical residents, noting that educator-informed expectations of professionalism (another of the ACGME core competencies) were often at odds with the lived experience of what interns and residents experienced and observed in their lived clinical practice.

Research Questions

My overall research question is:

What is the nature of SP feedback provided to residents regarding communication?

The three specific research questions are:

RQ1: What is the content and valence (negative vs. positive) of Standardized Patient feedback in discussing constructs of patient-centeredness as articulated in the adapted version of the Kalamazoo Essential Elements of Communication Checklist

RQ2: What feedback, if any, provided is not covered by the KEECC-A and SP training?

RQ3: What is the form of feedback provided not covered by the KEECC-A?

Methods

In 2013 the WSU-SOM Graduate Medical Education (GME) program offered a multi-station OSCE for all sole-sponsored programs (both medical and surgical specialties) to assess communication and interpersonal skills of their residents. The content of the OSCE patient encounters included four areas of clinical practice: informed consent, error disclosure, delivering

bad news, and health disparities⁵. All of the cases are fictionalized composites of actual clinical encounters (see Appendix B for a description of the OSCE cases).

The adapted version of the Kalamazoo Essential Elements of Communication Checklist (KEECC-A) was selected for use in this OSCE for its flexibility to provide quantitative assessment, serve as a mechanism for resident self-reflection, and provide a rubric as an SP feedback tool (see Appendix A for the rating instrument and sub-competencies as defined by Rider, et al., 2006). The design of the OSCE allowed for multiple opportunities for the KEECC-A to be utilized; first SPs were trained to use it to rate residents' patient-centered communication skills, providing a score on each of the seven rating items; second, residents were asked to self-reflect on their patient-centered communication skills and rate themselves using the KEECC-A immediately following each patient encounter; third, residents returned to each patient room after completing their self-reflection so they could receive verbal patient-centered feedback from the SP, regarding their patient-centered communication skills. The patient-centered feedback sessions were limited to four minutes, wherein the SPs were trained to discuss with a resident one or two particularly salient items included in the KEECC-A. SPs received 4-6 hours of training in using the KEECC-A as both a rating instrument and as a tool for providing patient-centered communication; residents had no formal training in using it as a self-reflection tool (see Appendix C for a complete overview of the OSCE).

In this research, I will apply crystallization (informed by Ellingson, 2009) as a meta-method, addressing a series of distinct research questions through a combination of methodologies, namely content and thematic analysis as well as narrative analysis.

⁵ All residents, regardless of specialty, participated in all patient encounters. The only difference between the two OSCEs was the Health Disparities case; here, unique cases were offered to the surgical vs. the medical specialists.

Crystallization is well suited for this type of research as it is grounded in social constructionism, wherein meaning is constituted and continually renegotiated in language between people, and is socially and culturally situated. Additionally, like social constructionism, crystallization asserts that truth is not singular, nor is it neatly positioned in one fixed location. As such, a rich understanding of any phenomena requires incorporating different methodologies, various theories, and different ways of knowing. Tracy (2010) advances the use of crystallization as an indicator of “excellent quality” (p. 16) in qualitative research methods, as it extends understanding of phenomena in more complex and in-depth ways. Furthermore, crystallization provides a platform to explore multiple voices, including those that are often marginalized. As there are no known quantitative or qualitative explorations into feedback conversations between SPs and residents, taking a crystallized approach is a salient choice for this line of inquiry. Specific to patient-centered communication, the voices that have been most lacking, and yet hold tremendous possibility for understanding the complexities of this phenomenon, are those of the SPs themselves. To have the opportunity to capture those voices as they engage dialogically with learners, as well as to provide an opportunity to explore their notions of the nature patient-centered communication, as well as which elements of educator-articulated patient-centered communication does or does not resonate with them, may provide insights that can help extend the current iterations of truly patient-centered communication.

Implications

This dissertation research takes a crystallized approach towards forging new understandings of the phenomena of patient-centered communication, as informed through the voices of SPs. Here, I take initial steps toward gaining better understandings of the elements of patient-centered communication that are most salient to SPs, as members of the community,

representing the “voice of the lifeworld” (Mishler, 1984). Through engaging with multiple methods of inquiry (content analysis, thematic iterative analyses), exploring the content of SP feedback framed by the KEECC-A both deductively and inductively, I hope to gain deeper understandings of which elements of the KEECC-A resonate and reflect the desires of the lifeworld voices of SPs, potentially strengthening its utility as a measure of patient-centered communication. Through narrative analysis, I seek to identify insights into the form of SP feedback, by which the community of health communication and medical education scholars can extend our understandings of what constitutes patient-centered communication, and the degree to which current measures of patient-centered communication fully capture those elements most desired by SPs as representative of lifeworld voices.

Chapter 3: A Content Analysis of Standardized Patient Feedback

Over the past 30 years there has been a growing emphasis on patient-centered communication skills training in medical education, due in large part to standards set by governing and accreditation entities (Lurie, 2003). These standards evolved as a response to the breadth of research demonstrating the positive implications of patient-centered communication, placing the patient as an equal partner in the medical encounter, an ‘expert’ in their own values, needs, and preferences for treatment and care (Epstein, et al., 2005). This body of research establishes that a patient-centered approach to communication fosters improved clinical decisions and health outcomes, greater patient compliance, increased patient safety, a reduction in malpractice suits, and improved satisfaction for patients and physicians alike (Barrier, et al., 2003; Makoul & Curry, 2007). Consequently, patient-centered communication skills training and assessment is now an integral component of curricula at all accredited medical schools and residency training programs in the U.S.

One highly regarded tool for assessing and teaching patient-centered communication is the adapted version of the Kalamazoo Essential Elements Communication Checklist (KEECC-A). The origins of the KEECC-A are rooted in a meeting held in 1999 at the Bayer-Fetzer Institute in Kalamazoo, MI, where leading clinical and communication educators convened to articulate a shared understanding of best practices in patient-centered communication skills training. Here, they evaluated five common models of patient-centered communication assessment, identifying through iterative reflection and dialogue, seven essential elements common to each of the models: (1) build the doctor–patient relationship, (2) open the discussion, (3) gather information, (4) understand the patient’s perspective, (5) share information, (6) reach agreement, and (7) provide closure (Duffy et al., 2004; Goske, et al., 2005; Makoul, 2001).

The initial checklist that emerged from this consortium had little utility, consisting of 23 items, assessing a variety of sub-competencies, with three discrete scoring options (not done, needs improvement, done well) (Rider, et al., 2006). Rider et al. (2006) adapted the original checklist by replacing the response options with a 5-point Likert scale, evaluating each element on a continuum from poor to excellent, essentially shifting to global ratings for each of the 7 identified essential elements (see Appendix A). The current iteration of the Kalamazoo Essential Elements Checklist – Adapted version (KEECC-A) serves as a gold standard of patient-centered communication assessment, established as well validated, reliable, and flexible for multi-rater use (Calhoun et al., 2009; Joyce et al., 2010; Porcerelli et al., 2015). As such, the KEECC-A continues to be referenced directly and indirectly in a range of patient-centered communication training and testing environments (Baribeau, et al., 2012; Berger, et al., 2010; Calhoun, et al., 2009).

The movement toward inclusion of patient-centered communication is routinely accepted and integrated into medical curricula. However, some scholars suggest that, despite efforts to emphasize a patient-centered approach in medical training and assessment, the biomedical model, which privileges the doctor as the sole expert, perseveres (Alonso, 2004; Barrier et al., 2003; David & Holloway, 2005; Greer, 2003). One indicator of this is found in the very formation of patient-centered communication assessment tools, such as the KEECC-A. Construction of these measures espouse to be reflective of a patient-centered approach, yet are primarily informed by medical educational experts (Makoul, 2001), scholarly observations of patient encounters (Epstein et al, 2005), or reviewing a priori research data (Keller & Carroll, 1994). The development of the KEECC-A appears to have adopted a similar approach, having been primarily informed by a review of health communication literature, theoretical concepts,

and scholarly expert consensus. In short, educational experts have largely engineered assessment measures of patient-centered communication devoid of the layperson's perspective. The failure to inform assessment models via patient engagement, results in instruments that lack the most salient forms of expert and content validity – the ground level inclusion of 'lifeworld voice' (Mishler, 1984).

Patient-Centered Communication Assessment: OSCEs and SPs

Assessment of communication skills is a top priority for Graduate Medical Education (GME) Programs. Effective patient communication is one of the core competencies established and monitored by the Accreditation Council for Graduate Medical Education (ACGME). One widely used mechanism for assessing resident communication competency is the Objective Structured Clinical Exam (OSCE). OSCEs consist of multiple, timed, patient encounters designed to assess clinical competencies, (e.g., communication and interpersonal skills, professionalism, cultural competence, etc.). Here, patient roles are designed to present a challenge to or opportunity for the learner to demonstrate patient-centered communication in a variety of situations. Educators value OSCEs as they allow a standardized observation of learners in a structured setting, using psychometrically validated instruments such as the KEECC-A (Boulet, et al., 2003; Whelan et al., 2005; Zayyan, 2011).

To increase the fidelity of OSCE encounters, medical educators use Standardized Patients (SPs) to portray the role of the patient. SPs are healthy lay-people trained to portray the scripted patient roles included in the OSCE environment (Hodges, 2003; Rubin & Philp, 1998). SPs have no prior clinical or medical educational experience. Previous research indicates congruence between learner communication with SPs and communication with actual patients, noting that SPs provide an equivalent communicative experience to that of actual clinical encounters

(Schwartz, Rothpletz-Puglia, Denmark & Byham-Gray, 2014). SP's unique role, then, is to serve as a proxy-patient in medical education curricula, allowing residents an opportunity to engage with a member of the lay community, gaining a 'lifeworld' (Mishler, 1984) perspective. Following each simulated encounter, SPs are trained to rate residents' communication and interpersonal skills using educator-developed assessment tools (e.g., the KEECC-A). In some formative OSCE settings, SPs are also trained to provide oral patient-centered feedback to the resident. SP Feedback is generally framed by the criteria of the assessment instrument, focusing on strengths and weaknesses in the resident's communication and interpersonal skills, with the SP providing suggestions for improvement from the perspective of the patient (Egener & Cole-Kelly, 2004; Hassell 2012).

Empirically, SPs have been shown to provide a reliable resource for teaching and assessing patient-centered communication (Barry et al., 2010; Klamen & Yudowsky, 2002; van Zanten, et al., 2007). Additionally, SPs are highly valued by medical educators for their uniformity in providing standardized oral feedback (Bokken, Rethans, et al., 2009). Medical educators and residents report favorably on the feedback provided by SPs, (Bokken, Linssen, et al., 2009; Lane & Rollnick, 2007). To date, there have been no studies exploring the nature (i.e., content and valance) of oral SP feedback provided.

The Present Research

In 2013 a team of educators from the Wayne State University School of Medicine Graduate Medical Education (WSU-SOM GME) program conducted a multi-station OSCE, utilizing the KEECC-A both as a scoring rubric and to facilitate SP oral feedback. This setting provided an opportunity to capture SP voice engaged in discussing elements of patient-centered

communication, framed by the KEECC-A. We analyzed transcriptions of SP feedback, guided by the following research question:

RQ1: What is the content and valence (negative vs. positive) of Standardized Patient feedback in discussing constructs of patient-centeredness as articulated in the adapted version of the Kalamazoo Essential Elements of Communication Checklist?

The OSCE consisted of four-stations and was offered to eight residency programs (see Table 1 for OSCE participation rates per medical / surgical specialty). The OSCE was designed to assess clinical competencies required of all U.S. residency programs, with a primary focus on communication and interpersonal skills. OSCE case content focused on four areas of non-specialty-specific criteria: (a) delivering bad news, (b) error disclosure, (c) informed consent, and (d) health care disparities, as they reflect topics generally applicable in all clinical environments (see Appendix B for OSCE Case Descriptions). Two of the cases focused on challenging communicative encounters (delivering bad news and error disclosure), while the other cases (informed consent and health care disparity) concentrated on everyday clinical communication.

Table 1	
<i>OSCE Participation Rates per Medical and Surgical Residency Programs ('S' indicates Surgical Specialty)</i>	
<u>Program</u>	<u>N of Residents:</u>
Dermatology	6
Family Medicine Residents	18
Internal Medicine	35
Orthopedics (S)	9
Otolaryngology (S)	12
Physical Medicine & Rehabilitation	9
Transitional Year Residents	15
Urology (S)	8
TOTAL:	112

For the assessment tool, the team selected the adapted version of the Kalamazoo Essential Elements Communication Checklist (KEECC-A), for its flexibility to provide quantitative assessment, serve as a mechanism for resident self-reflection, and form a framework for SP numeric assessment and oral feedback (Rider, et al., 2006). The OSCE design allowed multiple opportunities for the KEECC-A to be utilized. Following each 8-minute patient encounter, SPs used the KEECC-A to quantitatively rate residents' patient-centered communication skills and to formulate their verbal feedback, while simultaneously, residents used the KEECC-A to self-reflect / self-rate their own patient-centered communication skills. Following the SP rating / resident self-rating activity, residents returned to each patient room to obtain patient-centered feedback from the SP regarding residents' communication skills. All of the 4-minute patient-centered feedback sessions were video-recorded. It was during these oral feedback sessions that SPs had the opportunity to share their assessment of residents' communication skills, informed by KEECC-A criteria. Due to the time restriction of four minutes per feedback session, SPs were asked in training to limit their oral feedback to one or two of the resident's communicative strengths or weaknesses.

The prevailing point of inquiry in doctor-patient communication research focuses on communication between providers and the patient at the point of service (Braddock, Fihn, Levinson, Jonsen, & Pearlman, 1997; Gorawara-Bhat, Cook, & Sachs, 2007), or, post-hoc inquiry on doctors' and patients' perspectives outside of the dyadic encounter (Dong, Butow, Costa, Dhillon, & Shields, 2014; Vegni, Visioli, & Moja, 2005). Despite the fact that spoken feedback is a common practice in SP methodology (Bokken, Linssen, et al., 2009), there are no known studies which focus on this experience. SP feedback sessions provide a rare opportunity to capture lifeworld voice, specific to patient-centered communication, the valence and nature of

SP feedback, and, in the present research, the degree to which SPs applied constructs of the KEECC-A, and adhered to the training they received in providing patient-centered feedback.

Materials and Methods

The central phenomena of the present research are the content and valence of patient-centered feedback, specifically, the SP's voice in providing patient-centered feedback. To this end, while both residents and SPs participated in the feedback discussion, this research focuses exclusively on the voice of the SP. Using a deductive content analysis approach (see Krippendorff, 2004; Neuendorf, 2002) we addressed SP utilization of the KEECC-A in four-minute patient-centered feedback sessions, focusing on direct measures of patient-centered communication, namely, the communication competencies, and supporting sub-competencies⁶ articulated in the KEECC-A, as well as deductive measures of feedback valence (i.e., positive=strengths or negative=weakness feedback), which was addressed in SP training.

The unit of analysis for this research is complete statements made by the SP. To capture this, patient-centered feedback sessions were transcribed verbatim, later redacting resident comments that were superfluous (e.g., utterances, off-topic personal conversations) to feedback delivered by the SP, leaving only those resident comments that provided context to the delivered patient-centered feedback. A codebook was developed, reflective of the criteria in the KEECC-A, ensuring mutually exclusive codes for each of the categories and corresponding sub-competencies, as well as five additional codes reflective of SP training. For the purposes of this study, only one code (valence) from training was analyzed. Transcripts were reviewed and edited, inserting breaks between complete statements made by the SPs, to facilitate the goal of

⁶ It should be noted that prior psychometric assessments of the KEECC-A are limited to the communication competencies, but not the sub-competencies. This is the first known study to address this level of detail in the KEECC-A.

mutually exclusive coding, to the extent possible. Additionally, during transcription, all SP and resident identifiers were redacted and each transcription was assigned a unique identifier. Two coders, the researcher and one graduate student analyzed transcriptions using the codebook (see Appendix D for the full content analysis coding protocol).

Sample

A twofold purposeful sampling strategy was used for this research, resulting in 80 transcripts of SP feedback. The first level addressed case-type, in which feedback sessions from the informed consent and health disparities⁷ cases were selected, being most reflective of routine clinical experiences among all residents, regardless of specialty (n=222). During video review of feedback sessions for these two cases, we excluded a total of 43 cases, due to poor audio or video integrity (n=179 remaining videos). Noting an imbalance in SP participation, as well as varying numbers of residents by specialty, a maximum variation (heterogeneity) purposive sampling approach was applied, identifying key dimensions of variations among the patient-centered feedback encounters (Suri, 2011). These key dimensions included ensuring an equal representation of SPs used in these two specific cases, allowing for a variety of responses and feedback styles. Transcript selection also accounted for balanced representation of the eight participating medical and surgical residency programs. Additionally, residents' aggregate SP scores from the KEECC-A were assessed, to ensure the sample reflected a balanced distribution of high and low performing residents. Finally, SP encounters with female residents were over-sampled, particularly in the surgical specialties, due to their overall low numbers in the OSCE.

⁷ As both medical and surgical specialties participated in the OSCE, the team chose cases to be generally applicable in all clinical environments and, in the health disparities case, a unique surgical case was developed and used on a separate designated OSCE track (see Table 1 for participation rates per medical / surgical specialty)

The final sample consisted of 39 informed consent transcripts and 41 health disparity transcripts (see Tables 2 & 3 for SPs and Residents by case-type included in the sample).

Demographic Criteria	Informed Consent Feedback Sessions included in study sample	Health Disparities - Surgical Feedback Sessions included in study sample	Health Disparities - Medical Feedback Sessions included in study sample	Total Feedback (HD + IC) Sessions Included in study sample
SP Seniority 2-5 years ($n=3$)	24	7	2	33
SP Seniority ≥ 5 years ($n=4$)	15	12	20	47
TOTAL ($n=7$)	39	19	22	80

Demographic Criteria	Informed Consent Feedback Sessions included in study sample	Health Disparities - Surgical Feedback Sessions included in study sample	Health Disparities - Medical Feedback Sessions included in study sample	Total Feedback (HD + IC) Sessions Included in study sample
Female Residents ($n=41$)	23	5	13	41
Male Residents ($n=39$)	16	14	9	39
TOTAL ($n=80$)	39	19	22	80

Coding and Analysis

Codebook refinement. To ensure rigor and quality in coding, the primary researcher, first author (SB), ran a pilot test of codebook refinement, over several iterative phases (Neuendorf, 2002). Sixteen patient-centered feedback transcriptions from a prior year's run of

the same OSCE, were analyzed in the pilot phases. First, (SB) independently analyzed four of the pilot transcripts (two from each of the included cases) to reflect on and modify, as needed, operational definitions, and to ensure precision of coding instructions. Following this, two coders (SB) and (DSR) coded eight of the pilot transcripts, in two waves of four to resolve any issues of clarity and coding problems. A final pilot sample of four was run using SPSS to assess the final intercoder reliability (Neuendorf, 2002).

Inter-coder reliability and analyses. Multiple indices of intercoder reliability were used, (i.e., Cohen's Kappa and Krippendorff's alpha), as they represent both conservative and liberal measures of reliability. Minimal expected coefficients were set at .70, an acceptable level of agreement for exploratory research (Lombard, Snyder-Duch, & Bracken, 2002). Intercoder reliability was calculated using two indices (Cohen's Kappa and Krippendorff's alpha) for each of the three KEECC-A codes; (a) communication competencies; sub-competencies; and feedback valence (i.e., positive=strengths or negative=weakness feedback). During the pilot phase, we achieved a mean of .80 coding the competencies alone, .76 when coding for the competencies with the sub-competencies, and .78 for feedback valence. Having reached an acceptable level of reliability with the pilot data, coding continued with the final data. For the final data, one coder (DSR) coded all responses, while the second (SB) coded 20% of the responses. Reliability results for final data responses were .79 coding competencies alone, .72 when coding for the competencies with the corresponding sub-competencies, and .89 for feedback valence. Descriptive statistics, namely frequency counts, cross-tabulation were used in this research.

Findings

Of the 80 transcripts, a total of 395 KEECC-A competencies were coded in the patient-centered feedback transcripts, equally distributed between the two general case-types, Informed

Consent (IC) and Health Disparity (HD). Equal distribution was also noted within the HD case-types, between the medical (HD-M) and surgical (HD-S) specialties. In addition to the identified communication competencies, there were 550 occurrences of the unit of analysis (SP complete statements) that consisted of topics either not identifiable as one of the seven competencies, or not relevant to residents' communication and interpersonal skills (e.g., SP small-talk, comments on the OSCE, itself, or other off-topic elements). The analysis in the present study is limited to those identifiable elements of the KEECC-A. SPs averaged 3 competency-based feedback units per session.

Of the seven communication competencies reflected on the KEECC-A, three were most frequently identified in SP feedback across all three case-types. SPs primarily provided feedback reflective of the competencies *Building a Relationship* (27.6%), *Sharing Information* (37.2%), and *Understanding the Patient's Perspective* (15.4%). The competencies least-frequently used were *Providing Closure* (3.5%) and *Gathering Information* (2.8%) (see Table 4 for frequency of all KEECC-A communication competencies reflected in SP feedback).

<u>Communication Competency</u>	<u>Frequency</u>	<u>Percentage</u>
Builds A Relationship	109	27.6
Opens the Discussion	25	6.3
Gathers Information	14	3.5
Understands the Patients Perspective	61	15.4
Shares Information	147	37.2
Reaches Agreement	28	7.1
Provides Closure	11	2.8

Within each communication competency, the KEECC-A also articulates sub-competencies, which provide SPs with some context and specific criteria for scoring the

resident's performance and formulating their oral feedback. In many ways, these sub-competencies define the true educational utility of the KEECC-A, as they represent the detailed and nuanced criteria for each of the competencies, operationalizing specific positive and negative behavioral qualities designed to improve resident's overall communication and interpersonal skills. Thus, as they serve as key components of each competency, frequencies were also run on the sub-competencies (see Table 5 for frequencies of all KEECC-A defined sub-competencies reflected in SP feedback).

Table 5		
<i>Frequency of SP Feedback: KEECC-A Communication Sub-Competencies</i>		
Competency / Sub-competencies	Frequency	Percent
<i>Builds A Relationship (n = 109)</i>		
Greets and shows interest in patient as a person	13	11.9
Uses words that show care & concern throughout interview (verbal)	15	13.8
Uses tone, pace, eye contact, & posture that show care & concern throughout interview (non-verbal)	57	52.3
Undefined	24	22
<i>Opens The Discussion (n = 25)</i>		
Allows patient to complete opening statement without interruption	17	68
Asks "Is there anything else" to elicit full set of concerns	2	8
Explains and/or negotiates an agenda for the visit	5	20
Undefined	1	4
<i>Gathers Information (n = 14)</i>		
Begins with the patient's story using open-ended questions	7	50
Clarifies details as necessary with more specific and/or "yes/no" questions	1	7.1
Summarizes and/or gives patient opportunity to correct or add information	4	28.6
Transitions effectively to additional questions	0	0
Undefined	2	3.3
<i>Understands the Patients Perspective (n = 61)</i>		
Asks about life events, circumstances and / or other people that might affect health	18	29.5
Elicits patient beliefs, concerns and/or expectations about illness and/or treatment	21	34.4
Responds explicitly to patient's statements about ideas and/or feelings	20	32.8
Undefined	2	3.3
<i>Shares information (n = 147)</i>		
Assesses patient's understanding of problem, and/or desire for more information	1	0.7

Explains using words the patient can understand	15	10.2
Checks for mutual understanding of treatment plan	120	81.6
Asks if patient has any questions	1	0.7
Undefined	10	6.8
<i>Reaches Agreement (n = 28)</i>		
Includes patient in choices and decisions to the extent s/he desires	20	71.4
Asks about patient's ability to follow diagnostic and/or treatment plans	2	7.1
Identifies additional resources as appropriate	4	14.3
Undefined	4	7.1
<i>Provides Closure (n = 11)</i>		
Asks if patient has questions, concerns, and/or other issues	6	54.5
Summarizes / asks patient to summarize plans until next visit	0	0
Clarifies follow-up or contact arrangements	5	45.5
Acknowledges patient and closes interview	0	0
Undefined	0	0

In addition to the communication competencies and sub-competencies, valence of the feedback (i.e., if it was positive, negative, or neutral), was also analyzed. In training, SPs are encouraged to provide constructive feedback on communicative and interpersonal strengths and weaknesses. In this sample, most of the feedback was predominantly positive across the seven communication competencies (72% positive) (see Table 6 for frequencies of feedback valence among competencies and sub-competencies). Findings from each of the seven communication competencies (CC), as they are ordered on the KEECC-A are outlined below.

<u>Competency / Sub-competencies</u>	<u>Positive Feedback</u> (% within competency)	<u>Negative Feedback</u> (% within competency)	<u>Neutral Feedback</u> (% within competency)
<i>Builds A Relationship (n = 109)</i>			
Greets and shows interest in patient as a person	11 (10.1)	2 (1.8)	0 (0.0)
Uses words that show care & concern throughout interview (verbal)	15 (13.8)	0 (0.0)	0 (0.0)
Uses tone, pace, eye contact, & posture that show care & concern throughout interview (non-verbal)	52 (47.7)	5 (4.6)	0 (0.0)
Undefined	20 (18.3)	3 (2.8)	1 (0.3)

<i>Opens The Discussion (n = 25)</i>			
Allows patient to complete opening statement without interruption	8 (32.0)	9 (36.0)	0 (0.0)
Asks "Is there anything else" to elicit full set of concerns	1 (4.0)	1 (4.0)	0 (0.0)
Explains and/or negotiates an agenda for the visit	4 (16.0)	1 (4.0)	0 (0.0)
Undefined	0 (0.0)	1 (4.0)	0 (0.0)
<i>Gathers Information (n = 14)</i>			
Begins with the patient's story using open-ended questions	1 (7.1)	6 (42.9)	0 (0.0)
Clarifies details as necessary with more specific and/or "yes/no" questions	0 (0.0)	1 (7.1)	0 (0.0)
Summarizes and/or gives patient opportunity to correct or add information	0 (0.0)	4 (28.6)	0 (0.0)
Transitions effectively to additional questions	0 (0.0)	0 (0.0)	0 (0.0)
Undefined	0 (0.0)	1 (7.1)	1 (7.1)
<i>Understands the Patients Perspective (n = 61)</i>			
Asks about life events, circumstances and / or other people that might affect health	12 (19.7)	6 (9.8)	0 (0.0)
Elicits patient beliefs, concerns and/or expectations about illness and/or treatment	16 (26.2)	5 (8.2)	0 (0.0)
Responds explicitly to patient's statements about ideas and/or feelings	15 (24.6)	5 (8.2)	0 (0.0)
Undefined	1 (1.6)	1 (1.6)	0 (0.0)
<i>Shares information (n = 147)</i>			
Assesses patient's understanding of problem, and/or desire for more information	1 (0.7)	0 (0.0)	0 (0.0)
Explains using words the patient can understand	11 (7.5)	4 (2.7)	0 (0.0)
Checks for mutual understanding of treatment plan	79 (53.7)	40 (27.2)	1 (0.7)
Asks if patient has any questions	1 (0.7)	0 (0.0)	0 (0.0)
Undefined	7 (4.8)	3 (2.0)	0 (0.0)
<i>Reaches Agreement (n = 28)</i>			
Includes patient in choices and decisions to the extent s/he desires	18 (64.3)	2 (7.1)	0 (0.0)
Asks about patient's ability to follow diagnostic and/or treatment plans	2 (7.1)	0 (0.0)	0 (0.0)
Identifies additional resources as appropriate	3 (10.7)	1 (3.6)	0 (0.0)
Undefined	2 (7.1)	0 (0.0)	0 (0.0)
<i>Provides Closure (n = 11)</i>			
Asks if patient has questions, concerns, and/or other issues	0 (0.0)	6 (54.5)	6 (54.5)
Summarizes / asks patient to summarize plans until next visit	0 (0.0)	0 (0.0)	0 (0.0)
Clarifies follow-up or contact arrangements	4 (36.4)	1 (9.1)	5 (45.5)

Acknowledges patient and closes interview	0 (0.0)	0 (0.0)	0 (0.0)
Undefined	0 (0.0)	0 (0.0)	0 (0.0)
TOTALS	284 (71.9)	108 (27.3)	3 (.8)

CC 1: Builds a Relationship

Builds a relationship was the 2nd most frequently used competency in SP feedback during this OSCE, representing nearly one-third of all coded feedback. In the KEECC-A, this competency is defined by three unique sub-competencies; (a) greeting and showing interest in the patient as a person; (b) using both verbal (words), and (c) non-verbal (tone, pace, eye-contact, etc.) communication, demonstrating care and concern throughout the interview. Of these three defined sub-competencies, the one most frequently identified was non-verbal communication (52.3%). Here, SPs comments included the degree of eye contact, physical touch, pace of the conversation, and facial expressions. The other available sub-competencies, ‘greet and shows interest in patient as a person’, and ‘uses words that show care and concern throughout the interview’ were noted less frequently in SP feedback.

Building a relationship had the highest rate of positive feedback, constituting nearly 25% of all the positive feedback provided across the seven competencies. Of the three sub-competencies associated with this competency, the majority of positive feedback again centered on non-verbal communication (52%). Positive feedback on non-verbals ranged from focusing on the general (e.g., facial expressions, tone of voice) to small moments of non-verbal intimacy, such as when one SP in an Informed Consent feedback session stated:

“That little arm touch at the end, when you were walking out – that was nice. I appreciated that. It made me feel cared for.”

Of the minimal negative feedback provided on non-verbals, SPs commented primarily on discrete behavioral elements, such as residents talking too fast or positioning themselves (sitting, standing) too far away from the SP.

CC 2: Opens the Discussion

The ‘opens the discussion’ competency accounted for 6.3 % of the overall coded feedback. Here, the instrument is anchored to three defined sub-competencies covering (a) interruptions by the resident, (b) whether or not the resident elicits the full set of patients’ concerns, and (c) if the resident explained or negotiated an agenda with the patient. Of the identified sub-competencies, SPs most frequently commented on the degree to which the resident interrupted them during the encounter, often articulated by SPs as whether or not the resident allowed them to “tell their story”, and the degree to which these interruptions prevented a meaningful discussion of their fears and concerns about their disease or condition.

CC 3: Gathers Information (GI)

With only 14 total coded feedback elements, ‘gathers information’ was one of the least referenced competencies noted in SP feedback (3.5%). The sub-competencies reflect (a) whether or not the resident elicited the patient’s full history / story, (b) clarified details and areas of ambiguity, (d) summarized (recapped) what they understood the patient was describing, and (e) did so in a logical and organized manner evidenced by using transition statements (e.g., “Now I’d like to ask you about your past medical history...”) to move between topics. While feedback reflective of this competency was low overall, it is noted that not one SP provided feedback on whether or not the resident used transition statements.

Notably distinct from the prevailing trend of primarily positive feedback, most of the SP feedback provided in this competency was negative, with only one positive comment out of the

14 coded elements. Mirroring the finding from the ‘opens the discussion’ competency, most of the negative feedback here centered on elements of the patient’s story; when speaking to the degree the resident opened the discussion, SPs commented on interruptions in the SP story, here, SPs felt residents did not make an attempt to begin with the patient’s story, such as when one SP stated:

“Had you asked me ‘I see your blood pressure is high, what else are you in here for today besides your blood pressure?’ – then that way if there was anything else going on with me, I could have discussed it with you.”

CC 4: Understands the Patient’s Perspective

Understanding the patient’s perspective was the third most utilized competency (15.4%) identified in SP feedback. The three sub-competencies relative to ‘understanding the patient’s perspective’ address external (life events, circumstances, and/or other people) and internal (patient's beliefs, concerns and/or expectations about illness and/or treatment) that might affect health, and the extent to which the resident responds explicitly to the patient's statements about ideas and/or feelings. Here, all three sub-competencies were evenly distributed (discussed) throughout the feedback. Valence of feedback is reflective of the larger trend in this OSCE, with the majority being positive. Again, in this communication competency, the ratio of positive feedback to negative feedback is very evenly distributed among all three sub-competencies, with no one anchor standing out as most or least referenced.

CC 5: Shares Information

Shares Information was the single most used type of feedback in this OSCE (37.2%). Here, there are four listed sub-competencies. These consist of (a) the resident’s ability to assess a patient’s understanding of the problem and desire for more information; (b) the degree to which

the resident avoided jargon; (c) if the resident checked for a mutual understanding of the treatment plan and (d) whether the resident asked the patient if they had any questions.⁸ By a large margin, SPs most frequently discussed the degree to which the resident ensured a mutual understanding of the treatment plan (82%). Here, SPs provided feedback on whether or not they fully understood the pros and cons of therapeutic options, if they were given clear and concise information, if respect was provided in the sharing of information, and whether or not they felt validated and/or respected for their own cultural beliefs about the risks and benefits of therapy.

Again the majority of feedback was positive (67%), with most of the positive feedback reflective of a mutual understanding of a treatment plan. Here, positive comments focused on the decision-making partnership established with the resident, forged through (resident) demonstrations of respect, sincerity and educating the patient, providing options whenever possible. One SP in the Health Disparities (medical) scenario articulated many of these issues, stating:

“And you explained to me why I needed to start the blood pressure medication, because it was a priority and *why* it was a priority...it’s not like you ignored the stress, you did say ‘Ok, here’s what we’re going to about the stress, but I think we need to get on this *first*.’ You didn’t press your agenda on me – you told me why - and why I shouldn’t wait to do it and you let me make the decision, you didn’t make it for me.”

CC 6: Reaches Agreement

‘Reaches agreement’ was one of the least referenced competencies in this OSCE, identified a total of 28 times, constituting 7.1% of overall feedback elements. The sub-

⁸ Asking if the patient had any questions in the ‘shares information’ competency was emphasized in SP training as taking place throughout the interview, as opposed to asking “*is there anything else*” at the end of the interview, which is discretely anchored to the Provides Closure competency.

competencies reference (a) the degree to which the resident included the patient in choices and decisions, (b) if the resident asked about the patient’s ability to follow diagnostic and treatment plans, and (c) if the resident identified any relevant resources for the patient (e.g., brochures, information, social worker, etc.). SP feedback was, again, largely positive, with SPs expressing appreciation for being provided with clear expectations on the impact of treatment plans (e.g., “You made me aware that I’m going to have to follow this for the rest of my life”), meeting the patient half-way, and empowering the patient to be a true partner in making decisions for their own health and treatment.

CC 7: Provides Closure

Provides Closure was the communication competency least referenced in SP feedback, comprising only 11 of the coded 395 feedback elements. Of the three case scenarios, providing closure was identified in the Informed Consent scenario, and the Health Disparities – Medicine case, but was entirely absent in the Health-Disparities – Surgical case. The sub-competencies focus exclusively on the end of the interview, and consist of the resident (a) asking the patient if there are questions, concerns, etc.; (b) summarizing plans until the next visit; (c) clarifying follow-up / contact info; (d) acknowledging the patient and closing the interview. Two of the sub-competencies (summarizing and closing the interview) were completely absent in the SP feedback. Unlike most of the other categories, feedback valence was more negative than positive in nature and focused on two discrete points, (a) not asking the patient if they had any questions and (b) not clarifying follow-up plans. In particular, the SPs commented on wishing they had known if this doctor was going to be a part of their follow-up care.

Undefined Sub-competencies

Among the feedback, there were instances where a communication competency was identified that did not have a corresponding sub-competency listed in the KEECC-A. This was true for all categories except for the ‘provides closure’ competency. These unidentified sub-competencies (n=41) constitute for 10% of the feedback provided overall, being most frequently noted in the first listed communication competency, Builds a Relationship (n=24).

Discussion

The primary goal of this exploratory-deductive research was to investigate the nature of SP patient-centered feedback provided to residents regarding communication and interpersonal skills during a 3-station OSCE. To this end, content analysis methodology was used to determine the content and valence of feedback provided in the OSCE, as facilitated by the Kalamazoo Essential Elements Communication Checklist (KEECC-A). Thus, what is most salient to this research are those elements of the KEECC-A which are most and least frequently referenced in SP feedback, as well as the valence (positive or negative) of those feedback elements. Additionally, several units of analysis throughout the transcripts (n = 41) were coded as a specific communication competency, but were missing a behavioral anchor, warranting some discussion.

Highest Frequency Codes / Code Valence

Looking at competency counts across the three case types, (informed consent and health disparity – medical / surgical) the amount of SP feedback and usage of the competencies and sub-competencies was fairly well distributed, regardless of case type. Of the seven communication competencies, three were incorporated in feedback most often; in order of frequency, they were (a) Shares Information, (b) Builds A Relationship, and (c) Understands Patient’s Perspective. The valence of feedback was largely positive in nature, with some

variability in the sharing information competency. A common uniting theme of the sub-competencies most reflected in most frequently utilized categories, is that they all centered on constructs of interpersonal connection and building a physician-patient partnership.

Shares information was the single most referenced competency in this OSCE. This competency lists four unique sub-competencies for the SPs to consider, yet only one, ‘checks for mutual understanding of treatment plan’ was overwhelmingly prominent, representing 120 of the 147 times information sharing was identified in SP feedback. At first glance, this sub-competency does not intuitively speak to building an interpersonal connection. However, as articulated in feedback, SPs explicated that, when effectively ensuring a mutual understanding of the treatment plan, residents helped to forge a true partnership with the patient. Conversely, SPs expressed concern when residents did not ensure the patient understood therapeutic options, risks, benefits, as they may be serving to compromise not just the patient’s immediate health condition, but their confidence in the physician, and in health care practitioners, over time. For the most part, with regard to mutual understanding of the treatment plan, SPs provided positive feedback to residents (65.8%). However, another 33% expressed concerns with the manner in which the resident managed treatment plan discussions, representing the single highest areas of negative feedback noted across this research.

In the Builds A Relationship competency, the sub-competency referenced with greatest frequency was the degree to which the resident exhibited non-verbal communication (eye-contact, tone, pace, etc.). One explanation for the common usage of this sub-competency is that discrete non-verbal elements are relatively easy to identify and operationalize, thus explaining their frequency in feedback. However, closer reading of the context of this feedback shows that SPs did not merely comment on the presence or absence of non-verbals, but contextualized the

impact these behaviors had on the level of connection the SP experienced with the resident. It is interesting to note that non-verbal behaviors were referenced nearly four times more than verbal behaviors (using words that show care and concern), which reflects that what often matters more is not what you say, but how you say it (apologies to William Carlos Williams).

Understanding the Patient's Perspective, on the whole, is explicitly designed to assess the degree to which residents form an interpersonal connection with the patient. This is facilitated via three sub-competencies which serve to capture an understanding of the full context of patients' lives and the implications of external (family, job, social environment) and internal (fears, desires) factors on their health, as well as the degree to which the resident responded explicitly to the patient's concerns. Thus, unlike the two previously discussed competencies, interpersonal connection is implicit within this competency and its associated sub-competencies. Coding for 'understanding the patient's perspective' was evenly distributed across all the sub-competencies, and feedback valence was also fairly consistent 4:1 positive to negative feedback.

Lowest Frequency Codes / Code Valence

The least utilized competencies coded for SP feedback in this OSCE were 'Gathers Information' and 'Provides Closure'. Gathering information consists of four sub-competencies which focus almost exclusively on history taking skills, including asking open-ended questions, clarifying details of the history, and summarizing / transitioning from section to section of the patient's history (present illness, past medical history, family history, etc.) The 'provides closure' competency addresses resident communication demonstrated at the very end of the patient encounter, i.e., asking the patient if they have any questions, summarizing plans, clarifying follow-up information, acknowledging the patient, and closing the interview. Of note here, is that despite their low numbers, the vast majority of feedback valence in both of these competencies

and related sub-competencies, was negative. This finding lies in stark contrast to the largely positive SP feedback noted throughout the other referenced KEECC-A competencies. Of potential relevance to these findings, is that the KEECC-A was developed and modified over time to be applied to both graduate and undergraduate medical education environments (Calhoun et al., 2009). Both the ‘Gathers Information’ and ‘Provides Closure’ competencies and their sub-competencies represent communication skills that may be less challenging to residents who are operating at a higher level of communication skills than a third or fourth year medical student. Thus, when done properly, they simply may not be evident in the residents’ communication; conversely, on the rare occasion when they are performed poorly in a residency-level OSCE, they stand out, warranting (negative) comment by the SP.

Frequency and Valence of Unidentified Sub-Competencies

Among the feedback, there were instances where a communication competency was identified that did not have a corresponding sub-competency listed in the KEECC-A. These largely positive feedback elements constitute 10% of the feedback provided overall, and are most noted in the ‘Builds a Relationship’ (n=24). The only competency without an unidentified sub-competency was ‘provides closure’. In general, during coding, we found these elements challenging to code, as they tended to represent a variety of concepts (e.g., providing non-therapeutic comfort measures, broader discussions of culture, friendship, etc.) not operationalized in the KEECC-A. One notable construct particular to building a relationship, not included in the KEECC-A, was empathy. Empathy was identified most often in feedback reflective of the ‘Builds a Relationship’ competency, but surprisingly there was no corresponding sub-competency. Returning to the literature on the KEECC-A, empathy was, in fact, included in an earlier version of the Kalamazoo model, but was eliminated, as the authors

felt that empathy was ‘implicitly indicated in the Builds a Relationship element’ (Calhoun et al., 2009). This, despite the fact that, as noted by Calhoun et al, there is a great amount of literature that supports explicitly identifying empathy in communication as it is “an important consideration for families as a vital component of effective doctor-patient communication”.

Limitations

This is an exploratory study that focuses on one residency OSCE in a Midwestern School of Medicine. While we strove for maximum variation in the sampling approach, the fact remains that, due to the criteria for the cases selected for this particular OSCE, all of the SPs were female and middle-aged. Consequently, findings from this study are not generalizable to the broader population of SPs. Nevertheless, the findings provide some novel insights for both health communication scholars and medical educators with regard to exploring SP perspectives with regard to patient-centered communication.

Implications and Future Research

This research demonstrates an opportunity to further advance understandings of the KEECC-A as a measure of patient-centered communication. Up until this point, the KEECC-A was validated through every measure except the enacted voice of the ‘lifeworld’ (Mishler, 1984). The present study contributes to the body of work providing content and expert validation of the KEECC-A by exploring its use and application uniquely from the SP’s perspective. Through direct engagement with SP feedback, the KEECC-A is further validated in its purest definition of the word - by directly measuring (the lifeworld perspective) what one intends to measure (an articulation of patient-centered communication).

Furthermore, this is the first known study to move beyond the communication competencies and assess the utility and validity of the KEECC-A sub-competencies. SP feedback

in this study offers a first look at the saliency of each of the specific measures on the KEECC-A as assessment tool. Of the three most frequently referenced competencies, SP feedback most often spoke to non-verbal communication (under ‘builds a relationship’) and the degree to which the SP felt the resident ensured a mutual understanding of the treatment plan (under ‘shares information’). Conversely, other KEECC-A articulated sub-competencies were largely overlooked, both within these two competencies and others. While no hard and fast conclusions can be drawn from these findings, they do suggest further inquiry, to ensure the KEECC-A rubric reflects the most relevant and meaningful measures of patient-centered communication, among both the competencies and the sub-competencies.

With regard to the sub-competencies, future inquiry should be done to address the applicability of these elements among other types of OSCE-based scenarios and with different cultural populations, of both SPs and residents. Specific to the unidentified sub-competencies, empathy was the most notable ‘missing’ element, yet it is possible the SPs speak to other communicative elements that have yet to be articulated in expert-informed instruments, such as the KEECC-A. Engaging with other methodological approaches, e.g., thematic and/or narrative analysis, focus groups, and patient interviews may yield greater depth and understanding of those overlooked elements of communication, most essential to the lifeworld perspective.

An assessment of valence (positive vs. negative feedback) reveals that most feedback provided by the SPs was positive in nature, by a nearly 3:1 ratio. This is not entirely surprising, as SPs in this OSCE were trained to deliver feedback using the “feedback sandwich” approach (Dohrenwend, 2002). Here, feedback is provided by starting with a positive comment, providing constructive feedback for improvement, and ending with another piece of positive feedback. This finding serves as an indicator of the efficacy of SP training. For other SP programs using this

feedback approach, content analysis methodology may prove useful in verifying the degree to which SPs are adhering to benchmarks established in the training process.

In addition to the implications listed above, studies such as this one offer opportunities for improving educational practices. For example, one of the findings suggests that not all assessment items are necessarily relevant for all learner levels; careful attention should be paid to which items will best aid in appropriate assessment of learners across the spectrum of undergraduate and graduate medical education. Research such as this informs practical decisions, such as whether or not to tailor rubrics to different levels of learners, deciding which elements are most reflective of learner-specific educational objectives. Furthermore, being cognizant of the variation in checklist items allows medical educators to perhaps make purposeful evidence-based choices such as leaving in certain checklist items to best identify low or high performers, providing opportunities for those residents who may require extra help in basic communication skills.

SPs and OSCEs are commonplace in both graduate and undergraduate education, providing exciting opportunities for investigating qualities of lifeworld voice, specific to patient-centered communication. Research initiatives focused on the voice of the SP are practically non-existent. Future research should expand this methodology to explore various facets of doctor-patient communication, exploring constructs such as cultural elements of both the SP and the residents (e.g., ethnicity, gender, age) as well as those specific to the residents, such as medical / surgical specialty, level of education, etc. Additionally, consideration should be given to the types of OSCE cases developed, which may be tailored to specialties and should be cognizant of content, including cases that present dramatic or extreme conditions, as well as those suggested

by Makoul (2003) that focus on the every-day communications between patients and their physicians.

Conclusion

Patient-centered communication represents the gold standard for communication competency in medical education and practice (Eggly et al., 2009; Epstein et al., 2005). Measures such as the KEECC-A offer opportunities to assess and teach this competency to residents. While there have been several studies evaluating the psychometric validity of the KEECC-A, not one has engaged constructs of patient-centeredness from the lifeworld perspective, and none have assessed the utility of the sub-competencies. Just as SPs are utilized as proxies for learners in enacting patient scenarios, SP oral feedback should be valued as a mirror on the larger lifeworld community. By engaging with SP feedback, health communication scholars and medical educators have opportunities to enhance both the validity and the content of the KEECC-A and similar measures of patient-centered communication.

Chapter 4: A Thematic Analysis of Standardized Patient Feedback

In 1977 George Engel proposed clinicians and educators consider a paradigm shift away from the biomedical health model. Instead, Engel advanced the biopsychosocial model, a holistic approach to clinical care which encompasses the biomedical (illness) presentation, as well as elements of patients' psychological, environmental and cultural lives (Engel, 1977; Gray, 2011). Specific to clinical communication, Elliot Mishler (1984) contextualized biomedical vs. biopsychosocial approaches to language, highlighting an inherent tension between providers speaking the 'voice of medicine', characterized by a biomedical focus and technical jargon, versus patients who speak the 'voice of the lifeworld', reflective of their of daily experiences, cultures, and social lives. Here, Mishler invoked a critical perspective, noting that patients represent a marginalized group to the delivery and communication of healthcare, as their voices are often overlooked. He called on clinical practitioners and scholars to cast aside the inclination of medicine to develop 'expected categories' for patient behaviors, making room for patients to "...interrupt the voice of medicine and give priority to the voice of the lifeworld", arguing that direct engagement with lifeworld voices is a requirement towards developing more humane clinical practices.

Despite widespread acceptance of biopsychosocial approaches to clinical care and communication, some suggest adoption of these models has been largely superficial, and that reductionist, biomedical approaches persist in actual practice (Alonso, 2004; Barrier et al., 2003; David & Holloway, 2005; Greer, 2003). Scholars offer a number of reasons for this, including (a) lack of available funding for research initiatives specifically focusing on biopsychosocial approaches and (b) conservative attitudes to medical curricula changes, which focus more on that which is economically and politically expedient rather than innovative models that may (over

time) improve the overall quality of medical education and clinical care (David & Holloway, 2005). Kontos (2011) pointedly suggests biopsychosocial approaches have not taken hold due to Engel's lack of scholarly rigor in development of the model. Instead, he asserts that the biopsychosocial model is founded solely on vilifying biomedicine, essentially asserting a 'straw man' argument, devoid of any real substance or empirical foundation. Consequently, Kontos suggests that psychosocial curricula should be significantly scaled back, as they are overly ambitious and abstracted from the routines of everyday practice, which is (according to Kontos) inherently and justifiably focused on biomedicine.

Mishler (2005), offers a different perspective on the limited integration of biopsychosocial constructs. Reflecting on his explication of voices of the lifeworld vs. voices of medicine, twenty years later, he states:

“Looking back, it appears to me that although my contrast between the ‘voices’ of medicine and the lifeworld gained a place in the literature on patient–physician communication, there was much less attention given to...‘interrupt’ the voice of medicine and ‘empower’ patients. Among various reasons for this, I believe it indicates that there is no place in the limited conception of the ethic of humane care that gained prominence in the field for an approach that: values the functions of interrupting the voice of medicine; emphasizes the special and deep significance of the use of ordinary language; and proposes the empowerment of patients as the route to change medical practice.”

While Kontos' suggestion that 'less is more' may (under some circumstances) be an adequate solution for complex problems, I would suggest that the current state of integration of psychosocial models might best be served by a re-shifting of priorities. Here, I advocate for Mishler's original call and suggest that scholars and clinical educators consider repositioning

their lens to move outside of the voice of medicine, actively seeking out lifeworld opportunities, while serving to more effectively ground these approaches into enacted clinical experiences. One such location for doing so currently exists in the educational practice of SP methodology and, particularly, existing mechanisms for delivering spoken patient-centered feedback, as this type of feedback in an OSCE setting allows for enacted engagement with voices of the lifeworld.

In this article, I first give a brief overview of the foundations for patient-centered feedback, OSCEs and SP methodology. Specifically, I evaluate the application of the adapted version of the Kalamazoo Essential Elements of Communication Checklist (KEECC-A) in SP oral feedback sessions during a residency OSCE. Using the qualitative method of iterative thematic analysis (Tracy 2013), I analyze transcribed SP feedback, focusing explicitly on the voice of the SP engaged in explicit discussion of patient-centered communication. Here, I assess the degree to which SPs interrupt the voice of medicine, as they share through a lifeworld perspective, those elements patients desire most in communication with their doctors.

Patient-Centered Communication in Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) advances interpersonal and communication skills as one of six core clinical competencies required of all practicing physicians. Within this context, patient-centered communication is positioned as the gold standard for communication in clinical practice. Patient-centered communication represents a move away from the biomedically informed model of doctor-centered communication to one more reflective of the biopsychosocial model, addressing the full context of the patient's lived experience (Engel, 1977; Duggan, et al., 2006). The KEECC-A is a highly regarded instrument designed for the evaluation of patient-centered communication in both undergraduate and graduate learning environments, and is specifically advanced for use in the ACGME toolbox as

an exemplar of patient-centered communication assessment (Baribeau, et al., 2012; Berger, et al., 2010; Calhoun, et al., 2009). The KEECC-A is unique among other assessment tools, having evolved directly from the Kalamazoo Consensus Statement, developed by an interdisciplinary coalition of medical educational and health communication experts at an invitational conference sponsored by the Bayer-Fetzer Institute in Kalamazoo, MI. Here, participants developed a framework for teaching and assessing patient-centered communication skills across the span of medical education. Several consortium members had previously worked to develop models of patient-physician communication; through careful evaluation and analyses of common themes inherent in these a priori models, along with additional discussion of best practices in medical education, they developed the Kalamazoo consensus statement, delineating seven essential elements of communication skills (core competencies) for clinicians-in-training. Because of the depth of expertise among the attendees, the Kalamazoo model has established expert validity. Thus, the KEECC-A serves as a gold standard of patient-centered communication assessment, highly valued as valid, reliable, and flexible for multi-rater use (Calhoun et al., 2009; Joyce et al., 2010; Porcerelli et al., 2015). As such, the KEECC-A continues to be referenced directly and indirectly in a wide-range of patient-centered communication training and testing environments (Baribeau, et al., 2012; Berger, et al., 2010; Calhoun, et al., 2009).

Instruments such as the KEECC-A are designed to teach and assess patient-centered communication, by providing learners with a series of discrete communicative tasks to exhibit behaviors designed to elicit a deeper understanding of a patient's views and beliefs regarding their health and illness. As indicated in the Kalamazoo I report (Makoul, 2001), tasks preserve the individuality of the learners by providing them with communicative tools that are adaptive and flexible for a wide variety of patient settings. Additionally, tasks “provide a sense of

purpose” (Makoul, 2001, p. 391) for learning communication skills, and the task approach has been empirically supported since the 1980’s. What is unknown is the degree to which the tasks articulated in the KEECC-A, or other expert-developed models, is reflective of lifeworld sensibilities. This is the consequence of existing patient-centered communication assessment tools, including the KEECC-A being exclusively developed by medical and clinical educators, absent the inclusion of lifeworld participation in their creation.

Excluding patients from opportunities to directly inform or engage with the development of instruments such as the KEECC-A underscores Mishler’s concerns regarding continued lack of active engagement with lifeworld voices. Through this exclusion, even well intended scholars, dedicated to the tenets of biopsychosocial approaches, are marginalizing the very communities of people (i.e. patients) whose best interests they intend to serve. Furthermore, from a completely academic perspective, the fundamental definition of validity is the accuracy of the measure, or the degree to which an instrument measures that which it intended to measure. Wholesale exclusion of lifeworld voice in the development of patient-centered communication assessment tools thus calls into question the construct validity of existing measures.

OSCEs and Standardized Patient Methodology

OSCEs consist of multiple, timed, patient encounters designed to assess clinical competencies, (e.g., communication and interpersonal skills, professionalism, cultural competence, etc.). Here, patient roles are designed to present opportunities for learners to demonstrate patient-centered communication in a variety of medical interactions. OSCEs are highly valued by educators as they allow for objective observation of learners in a structured setting, using instruments such as the KEECC-A (Boulet, et al., 2003; Whelan et al., 2005; Zayyan, 2011).

Standardized Patients (SPs) are recruited to portray scripted 'patient' roles in OSCEs (Hodges, 2003; Rubin & Philp, 1998). SPs have no prior clinical or medical educational experience. Schwartz et al. (2014) note that SPs are highly valued as providing an equivalent communicative experience to that of actual patient encounters. As members of the lay community, SP's provide a unique opportunity for assessment, serving as proxy-patients in medical education curricula, allowing residents an opportunity to engage directly with a lifeworld perspective. Following each simulated encounter, SPs are trained to rate residents' communication and interpersonal skills using educator-developed assessment tools (e.g., the KEECC-A). In some formative OSCE settings, SPs are also trained to provide verbal patient-centered feedback to the resident. While there is no agreed-upon standard for delivering spoken feedback, (Bokken, Linssen, et al, 2009), it is often framed by the criteria of the assessment instrument, focusing on strengths and weaknesses in the resident's communication and interpersonal skills, with the SP providing suggestions for improvement from the perspective of the patient (Egener & Cole-Kelly, 2004; Hassell 2012).

The delivery of oral patient-centered feedback may also serve to create tension for the SPs, who are asked to provide feedback to the resident from the subjective role of the patient. Simultaneously, expectations exist for SPs to adhere to the objectivist tool (The KEECC-A) when delivering feedback. I work in the clinical skills training center in a large urban medical school in the Midwest; here, SPs frequently comment on the dis-connect they experience between the instrument they are trained to use when providing feedback (i.e., the KEECC-A), and what they would prefer to share, and sometimes do, with regard to residents' communication skills. Scholars such as Mishler (2005) and Kontos (2011) paint a picture of well-intended integration of psychosocial models into medical education practices that fall short of being

relevant for use by practicing physicians and patients, alike. Specific to this research, my curiosity was piqued with regard to the manner by which SPs were utilizing, or not, the KEECC-A to inform their delivered feedback.

The Present Research

Working at a large public university in the Midwest, In 2013 I collaborated with faculty from our university's GME program to develop and implement a 4-station OSCE. Eight residency programs, covering a range of medical and surgical specialties, participated. The cases in the OSCE reflected clinical competencies required of all U.S. residency programs, with a primary focus on communication and interpersonal skills. The team selected four non-specialty-specific cases: delivering bad news, error disclosure, informed consent, and health care disparities as they represent topics generally applicable in all clinical environments (see Appendix B for OSCE Case Descriptions). Two of the cases focused on challenging communicative encounters (delivering bad news and error disclosure), while the other cases (informed consent and health care disparity) concentrated on more common, everyday clinical communication

The team selected the Kalamazoo Essential Elements Communication Checklist (KEECC-A), given its flexibility to provide quantitative assessment, serve as a mechanism for resident self-reflection, and form a framework for spoken SP feedback (Dillon, Markova, Brennan, & Kokas, 2014; Rider, et al., 2006). The KEECC-A was used multiple times throughout the OSCE; following each eight-minute patient encounter, SPs used the KEECC-A to quantitatively rate residents' patient-centered communication skills and to formulate their spoken feedback. Simultaneously, residents used the KEECC-A to self-reflect and self-rate their own patient-centered communication skills. Following the SP rating / resident self-rating activity,

residents returned to each patient room to obtain spoken feedback from the SP regarding residents' patient-centered communication skills. All feedback sessions were video-recorded. It was during these patient-centered feedback sessions that SPs had the opportunity to share their assessment of residents' patient-centered communication skills, informed by KEECC-A criteria. Due to the time restriction of the feedback sessions, SPs limited their feedback to one or two of the resident's communicative strengths or weaknesses.

It is this point of inquiry that intrigued me the most; looking at the current literature, much of the focus for research on doctor-patient communication centers on communication at the point of service (Braddock, et al., 1997; Gorawara-Bhat, et al., 2007), or, post-hoc inquiry on doctors' and patients' perspectives outside of the dyadic encounter (Dong, et al., 2014; Vegni, et al., 2005). Despite the fact that SP feedback is a common practice in SP methodology (Barry et al., 2010; Bokken, Linssen et al., 2009), there are no known studies which focus on the engaged voice of the SP in providing feedback on patient-centered communication. Furthermore, while there have been several assessments of psychometric and curricular application of the KEECC-A, there are no known studies assessing the nature of verbal feedback provided using the KEECC-A. Patient-centered feedback sessions provide a rare opportunity to capture lifeworld voice specific to patient-centered communication, the nature of SP patient-centered feedback, and, in the present research, the degree to which SPs may have pushed the boundaries of the KEECC-A, potentially providing lifeworld insights into what patients desire most out of communication with their physicians.

RQ: What is the nature of feedback provided that is not covered by the Kalamazoo Essential Elements of Communication – Adapted checklist?

Methods

Using 80 transcripts I selected through a maximum variation (heterogeneity) purposive sampling approach for a previous quantitative content analysis study on this feedback, I applied Tracy's (2013) iterative approach to thematic analysis. In a previous study I evaluated these transcripts deductively, to determine the nature and valence of how the SPs used the existing elements of KEECC-A; the present study uses an inductive lens using the same transcripts, as a means to identify emergent themes that may not have been reflected in the KEECC-A. The central phenomena of the present research is the nature of patient-centered feedback, specifically, the lifeworld voice in providing patient-centered feedback. Thus, while both residents and SPs participated in the feedback discussion, this analysis focused exclusively on the voice of the SP.

Participants

A total of seven SPs representing the Informed Consent and Health Disparities cases were included in this study. We developed two Health Disparities cases, one specific to surgical specialties and one specific to generalists, thus feedback from three unique case scenarios were included in this analysis. All SPs in this OSCE are female, ages 59 – 71; most are White (n = 4); and three are African American.

Data Sources and Management

My data sources consisted of 80 transcriptions of four-minute feedback sessions. Feedback sessions were transcribed verbatim, later redacting resident comments that were superfluous (e.g., utterances, off-topic personal conversations) to feedback delivered by the SP, leaving only those resident comments that provided context to the delivered feedback. I used a computer-aided approach (as opposed to pen and paper) for data management. All of my analysis was conducted using Atlas.ti qualitative data analysis software. I opted for Atlas.ti after unsuccessful attempts to use MS Office based programs (i.e., Word and Excel), which turned out

to be too cumbersome for use. Atlas.ti was developed to be responsive to the cyclical and reflexive process imbedded in the iterative method, effectively integrating all transcripts, analytic memos, and generation of a 'living' codebook, automatically updating codes as they are restructured through the iterative analysis. I also maintained a series of paper notebooks (in my car, purse, and by my bedside) to record notes and inspirations for those times I was away from my computer, transferring the notes into Atlas.ti at a later time. Additionally, because I am a visual person, I often sketched out flowcharts and other sorts of diagrams to help facilitate my reflection and analysis.

Data Analysis

I followed the steps of iterative analysis (Tracy, 2013), which recognizes the important work of grounded theorists who advanced identifying emergent themes in the data (see Charmaz, 2006; Glaser and Strauss, 2009; Strauss and Corbin, 1998). Tracy extends grounded theory method pragmatically, encouraging researchers to iteratively alternate between emergent readings of the data (emic), and accessing external (etic) resources (i.e., literature, theories, active interests, granted priorities). The iterative pragmatic approach moves away from the mechanical process often associated with focusing solely on constant-comparison, creating a more reflexive approach for analyzing qualitative data.

My first analytical step was the 'data immersion' phase, which consisted of reading over my data sources multiple times, while concurrently participating in 'sensemaking', talking with people, being reflexive, asking open-ended questions, and considering several interpretations of the data. Because the data used in this study is a part of my larger dissertation research, immersion began with the initial act of reviewing the tapes for integrity, transcribing each of the 80 videos, and serving as a coder on the prior content analysis study. In some ways, I struggled

with the fact that I made the a priori determination to use the same sample for both the content analysis piece and the present qualitative study. Throughout the process of deductively analyzing the content of the KEECC-A, it was (initially) hard to keep my brain shut off from eventual act of inductive inquiry of emergent codes that extended the KEECC-A. I found the constant push and pull of dichotomous analytical thinking, at times, emotionally exhausting. My eventual solution was to keep a separate running diary of these random inductive thoughts, thus beginning the process of analytic memoing even prior to transitioning into the present research.

One of Tracy's recommended sensemaking practices, engagement with other people, helped fend off some of the stress associated with the data immersion and (later) initial coding phases. 'Other people' in my case included the obvious, such as my advisor and members of my dissertation committee, but also included fellow doctoral students, medical school faculty, Clinical Skills Center staff (including SPs), my family and friends. Some of the people I found the most valuable were those who were unfamiliar with qualitative research practices, yet curious about my research; having to explain my process to those who do not speak the vernacular of medical education and health communication scholarship, provided me the opportunity to explicate and fact-check my own understandings of some of the unique struggles I faced in this process.

Once past the data immersion phase, the iterative approach required attending to the data on a number of different levels, alternating between touching the data through a series of coding phases while concurrently and consistently referring to external theories, outside resources, and borrowing from "other fields, models and assumptions" (Tracy, 2013, p. 194). These analytical levels started with primary-cycle coding, whereby I generated 'first-level codes'. First-level codes describe the 'what is happening?' in the data. Throughout the process of first-level coding

(continuing into subsequent higher-levels of analytical coding) I applied the constant-comparison method. Constant-comparison provided me with methodological ‘room’ to modify and /or enhance first-level codes, as warranted by subsequent readings of the data.

Second-level coding was the next step, advancing from thinking strictly about the data descriptively, to asking the ‘why’ and ‘how’ questions of significance and interest of the data to the research. During second-level coding, I turned to pre-existing theories and concepts from the health communication and medical education literature, proving to be one of the most interesting, creative, and confounding aspects of the methodology – the ‘heavy lifting’ of my analytical thinking. Throughout this process, I developed hierarchical code families, which consisted of second-level codes grouped together under an umbrella category, each of which make “conceptual sense” (Tracy, 2013, p. 195). The final product of coding consists of these hierarchical code families; a series of umbrella categories each supported by two or more second-level codes.

Additionally, I frequently engaged in theoretical sampling which required me to return to the data, reading and re-reading transcripts to ensure I was not overlooking some contextual clues. I also periodically engaged in member-checking, engaging with some of the SPs who participated in the OSCE, to ensure that I was interpreting their statements correctly. Both theoretical sampling and member-checking helped to reinforce the integrity, application, and relevance of my analysis. I successfully reached the point of theoretical saturation, which is achieved when (a) no new codes emerge from the data; (b) I felt my categories were well developed; and (c) the relationships among categories were established and validated.

Throughout the process, I wrote analytic memos and stored them directly in Atlas.ti. This facilitated systematically organizing my ongoing, fluid etic and emic thoughts, reflections about

the data itself, and notations of external theories or other scholarly resources. Thus, my own thinking, analytic memos, interaction with external literature and resources all served to inform my codebook definitions (see Appendix E for the thematic analysis codebook). The analysis resulted in 5 hierarchical code families consisting of the following umbrella categories (a) Active Listening; (b) Enhanced Autonomy; (c) Culture; (d) Empathy; and (e) Communication as Comfort. Each of these umbrella categories is supported by various numbers of conceptually-linked second-level codes.

Results

In the following section I begin by explicating a full description of each of the five umbrella categories and related second-level codes. Throughout each umbrella category, I highlight specific quotes that I feel best illustrate each of the codes within the categories (see Appendix E for the complete thematic analysis codebook). All umbrella categories were identified throughout each of the three unique cases. The voices of all seven SPs who participated in this OSCE are reflected throughout the five categories and codes, to varying degrees, as explicated throughout this analysis. As I move through the description and discussion of the results, I refer to the SPs by pseudonyms. Two SPs, Lois and Morgan, represent the extremes of amount of coded feedback, reflected as the least and most coded, respectively. Lois' feedback provided the least amount of opportunity to code, due in large part to her feedback sessions running much shorter than the other SPs, generally using only 2-2.5 of the available four minutes. Conversely, Morgan pushed the limits of her feedback, often hitting the four-minute mark, at times taking a few extra seconds to squeeze in some final thoughts for the resident. Consequently, Morgan simply provided the most raw material to code. As all SPs are reflected throughout the scope of categories and codes, I attempted to reflect their voices in the exemplars

used in the following results. However, Barbara, Morgan, and Sybil provided some of the most descriptive and illustrative feedback of all the SPs. Thus, they are often the SPs I found myself turning to, to typify the various codes.

Active Listening

Active listening, requires involvement and engagement with a speaker and stands in contrast to ‘passive listening’ (Barker, 1971). Active listening is a purposeful and conscious choice requiring engagement with another person wholly, listening with one’s ears (to the verbal) as well as with one’s eyes (the non-verbal), giving full attention to cues and latent messages (Robertson, 2005). Clark (2007) suggests that listening is not some special demonstration of empathy, but that compassion emerges from the act of listening, and ultimately, physicians have a professional and ethical imperative to listen. The degree to which residents in this study embraced the professional and ethical imperative of listening was frequently noted throughout the transcripts. Here, I identified both verbal and non-verbal indications of active listening in SP feedback, but noted presence of non-verbal skills with greater frequency. Non-verbal iterations of active listening ran the gamut, covering constructs typically discussed in medical education training such as eye-contact, tone of voice, timing and pace, and body posture. However beyond noting the presence or absence of non-verbal cues, SPs largely contextualized them as indicators of engaged, active listening (see Table 7)

Table 7	
<i>Active Listening: Non-Verbal Cues</i>	
SP	Quote
Morgan	I liked your eye contact, it let me know that you were talking to me, you were listening to me - you let me know you heard everything I said. (<i>eye contact</i>)
Barbara	Um, at first when you came in you were so jolly and happy, I say ‘well, does she realize I have cancer?’ But then eventually when you gave me time to tell you what I was feeling and what was on my mind, I think you...got a good read on me. (<i>tone</i>)

Frances	I just felt a little rushed, like maybe you weren't going to listen to what I had to say (<i>pace</i>)
Morgan	I liked your body language, I liked that you were leaning into me, focused on me, you were listening to me, not in a hurry to get up and go away. (<i>posture</i>)

Verbal AL was noted in several different contexts in SP feedback, noting the degree to which the resident incorporated the patient's own words in follow-up questions, through the use of paraphrasing the patient's expressions of fears, anxieties, and life stressors. Verbal AL was also noted when the resident gave the patient options and/or compromised with the patient on therapies that acknowledged her perspective. While most of the feedback referencing AL was positive, there were times when SPs felt the resident was not providing any indication of listening, evidenced when the resident stuck to their own biomedically informed agenda, with disregard for any indications that they had heard the patient's questions or concerns (see Table 8).

Table 8	
<i>Active Listening: Verbal Cues</i>	
<u>SP</u>	<u>Quote</u>
Frances	You were listening to me, because you uh, asked me questions about my life, my situation, and you had suggestions and you compromised with me. So I really thought like, 'ok he has his ears on, he's listening to what I have to say'
Morgan	I didn't have to be saying 'I'M GONNA GET FAT! I'M NOT GONNA TAKE THAT MEDICATION!' – you heard me...when you said "we're going to monitor your weight", well then I knew you were listening to everything I said.
Sybil	And I liked the fact that you gave me the options of what I could do to keep this from happening again...you were listening to me and you didn't just *poof* blow me off -- you understand me.
Frances	And, during the conversation, when I mentioned to you that I want something for my stress, I heard you continue, um, the conversation about my blood pressure and... I felt you weren't listening because, I had mentioned stress and I mentioned it several times, and it was like I felt like, um, you weren't hearing what I was saying enough to ask me why was I feeling this stress? What's going on in my life?

Enhanced Autonomy

Over the past 40 years, medical practice has shifted dramatically away from the practicing *beneficent paternalism*, wherein physicians made all treatment decisions for their patients, based on what the physician felt was in the patient's best interest (Chin, 2002). The priority in present day clinical practice is on patient autonomy, considered a fundamental cornerstone of medical ethics (Quill & Brody, 1996). In its purest sense, patient autonomy mandates an *independent choice model*, whereby the physician informs the patient of the risks and benefits of different therapeutic options, refraining from language that may influence the patient's decision. The independent choice model suggests that patients have internal values that must be honored (exclusively), without undue coercion of values and opinions the physician may hold (Quill & Brody, 1996).

There are some scholars who argue that the notion of independent choice is simply not realistic, as most important and difficult decisions (i.e. choosing the most appropriate course of treatment) are rarely made in an internalized vacuum (Epstein & Street, 2011; Quill & Brody, 1996). Rather, considering options and making important decisions requires dialogue with relevant others. Patients need to hear a variety of opinions and values from family, friends, and particular to health care, patients often desire honest and frank conversations with their physicians, giving great value to the physician's point of view. Quill and Brody (1996) advance the concept of *enhanced autonomy*, which recognizes the important role physicians play in helping patients decide on treatment options. The key to successfully managing this process, however, rests not only in the physician's ability to inform (educate) the patient about risks and benefits, but also to offer a perspective, an opinion on what they (the physician) would recommend, and to do so with profound respect for the agency and personhood of the patient. Respect, in this setting, requires actively listening to the patient's unique story, but also assessing

the degree to which the choices being discussed are relevant to the patient's values, experiences, and current stage of life. Enhanced autonomy does not frame patient values as static, but rather dynamic across the continuum of life; although a patient may value life at any cost when they are young and generally healthy, there are unique and profound considerations in terms of quality of life, as they age and get closer to death. Within the lifespan arc, there are countless variations dependent on multiple cultural and psychosocial factors. SP feedback in this research strongly reflects the desire for enhanced autonomy, articulated by the duality of being informed (i.e., of treatment options, risks and benefits) and of being respected (i.e., as an adult, capable of making decisions, forming opinions).

Informed and invested. Of particular note to being informed, SP feedback reflected a desire for the resident to share their own medical opinion as to the best course of treatment, regarding the physician's opinion as one of the most important factors in making a wholly informed decision. With regard to the resident making an investment in the SP, providing them with information from the medical perspective, SPs specifically noted the degree to which the resident made an educational investment by devoting time for educating the patient and/or family members to discuss any areas of ambiguity or misunderstanding about the medical model vs. the patient's own cultural understandings of health. Conversely, SP's articulated frustration when they felt they weren't being given any sort of direction or personal opinion from the resident as to what treatment option(s) they would recommend (see Table 9)

Table 9	
<i>Enhanced Autonomy: Informed and Invested</i>	
SP	Quote
Barbara	You demonstrated that you were willing to go over and above and go that extra mile, making yourself available to me and my family, to help us with our feelings of not knowing, that was an educating moment for me and my family. You were willing to do that, and that was coming out of your valuable time, which is over

	and above to me. ⁹
Morgan	Where it got kind of gray is when you were saying you would give me people to talk to, and I could talk to people in support groups - but I'm here to talk to the surgeon – I trust him more than what a support group is saying because, you know, obviously I don't want to die, I don't want to <u>not</u> do anything. I want the surgeon to tell me something that makes sense...I'm saying 'ok, air gets to it and it spreads', well somewhere in the back of my mind that makes sense, but I don't want to <u>die</u> , you know, so I just kind of need some information to help me with the decision....you kept saying, 'I'm not trying to convince, we don't do that, we don't try to convince people', but maybe that's what I needed – I needed to know, ok 'if I go to stage 4 I'm gonna die', you know.

Respect. Respect was referenced directly and indirectly, identified by those moments where SP feedback reflected the patient feeling as though the resident treated them as a person with agency and intelligence, empowering them to make their own decisions about treatment options (see Table 10)

Table 10	
<i>Enhanced Autonomy: Respect</i>	
<u>SP</u>	<u>Quote</u>
Morgan	Ok, y'know, you showed a lot of respect to me as a patient. You didn't assume I was so dumb that I couldn't make my own decision. You gave me the information and allowed me, you asked me, you know, well, "what makes you apprehensive?" and "I understand about your mom" and you were even apologetic about my mom, so I appreciated all of that - that's really good.
Sybil	But I did like your style of explaining everything, where you didn't sound like a robot with statistics, this and this and this, you telling me the facts that you knew, but in a very um, comforting way, that it was nothing to worry about but not patronizing me, like "oh, tsk now, now, now" You were very, very good explaining that it was my decision in the long run, that this is what you thought in your professional decision, so I thought you did a very good interview and conducted yourself very professional but also not um, minimizing my concerns.

Culture

⁹ The concept of altruism also appeared periodically in this research. While not a compelling finding in the present research (it was only noted by a couple of different SPs and not widespread), it is an attribute of professionalism standards that may bear some future inquiry as a communication skill.

SP Feedback frequently reflected the importance of culture, or what Mishler (1984) would refer to as lifeworld considerations. Dutta's (2008) culture-centered approach to health communication, speaks to grounded cultural meanings of health, defined by lifeworld elements such as family, job, stress, understandings of illness and disease, etc., each reflecting to various degrees, an integral part of patients' lives, sometimes creating obstacles, other times offering support, but always having great influence on the health and well-being of patients.

Cultural references in this study were complex, resulting in emergent codes that revealed themselves in nuanced and specific ways, all holding fast to one another, staying conceptually linked. Here, SP feedback referred to the influence and impact of family, which at times spoke to the importance of including family in discussions of the patient's health. At other times, residents failed to consider including family in the larger conversation, overlooking the patient's desire for engaging those who she trusts the most (see Table 11)

Table 11	
<i>Culture: Family</i>	
<u>SP</u>	<u>Quote</u>
Barbara	You were willing to go over and above by talking to my family since we all had this misconception about um cancer spreading it and that air hitting it would make it spread more and it would grow quickly and I thought you handled all that part of it very, very well
Wendy	"Um, the only thing I could suggest was um, you did talk about follow-up but, it would have been nice...first of all, to have you say, you know, 'you wanna call your husband? Is there somebody to call?' or whatever...just because you weren't aware that I was totally competent, or I was unsure, you weren't sure if I was foggy or scared or whatever."

Two SPs, Sybil and Barbara, also spoke to considerations of gender. While this was one of the least noted codes addressing cultural factors, they both speak to an important lifeworld consideration. Here, these SPs spoke to both their own gender (female) and the gendered expectations of accommodating to illness, as well as in one instance, Barbara spoke to the gender

of the resident. Additionally, there were three references made by Sybil and Wendy, referring to outdated, generational beliefs and/or being “a senior patient”. Again, while not a commonly noted code independently, by speaking to their age and/or generational beliefs, these SPs spoke to the larger picture of their cultural standpoint as older adults, with unique (generationally-informed) viewpoints. (see Table 12)

Table 12	
<i>Culture: Gender & Age</i>	
SP	Quote
Barbara	I think you understood my perspective coming from a woman, to a woman - about the family situation. My point was that I stay healthy for my family and for my job, and a lot of times things fall, and maybe because I am the female in the family it just becomes a little difficult sometimes. (<i>gender</i>)
Sybil	Cuz I'm from that generation of people who get horrible diseases from a blood transfusion, but you explained all that well so I would have gone through with the transfusion because of your sincerity and listening. (<i>age</i>)

Feedback pertaining to culture also referenced two other considerations, (a) life stressors including, but not limited to work, and (b) references to patients' culturally informed illness narratives. As reflected in the series of feedback exemplars listed in Table 13, SPs perceived residents, in some instances, as sensitive to these lifeworld issues, while at other times residents seemed to miss or dismiss the importance of these factors in the patient's lives.

Table 13	
<i>Culture: Life Stressors</i>	
SP	Quote
Frances	You hit on just what I was going to mention to you which is about...asking and inquiring about my stress, because I didn't hear you ask about my stress – I mean you asked what type of job I did but not what the stress was – with my family, um, and stress with the job.
Morgan	And you explained to me why I needed to start the blood pressure medication, because it was a priority and why it was a priority. And then it's not like you ignored the stress, you did say 'Ok, here's what we're going to do about the stress, but I think we need to get on this first.' You didn't press your agenda on me – you told me...why I shouldn't wait to do it and you let me make the decision - you

	didn't make it for me
Barbara	You took time to clarify things did and not make me feel inadequate and even though I'm dealing with an old wife's tale that's been floating around the community, you were very respectful of it. You were going to look it up because (you said) 'There could be something to this but still and all, I haven't heard it. In my training I haven't come across that yet, but I'm going to take the time' - that was wonderful, that really was.

Despite the fact that these are enacted, fictionalized roles that do not necessarily reflect the lived experiences of the SPs, as members of the lay community, SPs were nonetheless drawn to specific lifeworld issues imbued in the design of the cases. When we train SPs to give feedback, we hold them to the expectation of giving constructive, helpful feedback. We do not tell the SPs to 'be sure to discuss family during feedback' or 'don't forget to emphasize the stress of your job when talking to the resident', but clearly, SPs are drawn to these issues, explicating them with more passionate specificity than was required or anticipated.

Empathy

Theresa Wiseman (2007) suggests that empathy is ability to connect with others, to feel with people. She advances four inherent qualities of empathy, (a) *Seeing the world as others see it*: the ability to see the perspective and truth of another person, or minimally, recognize another's perspective as their truth; (b) *Commitment to being non-judgmental*: staying out of judgment of the other's perspective and truth; (c) *Understanding another's feelings*: recognizing emotion in others; and (d) *Communicating Understanding*: communicating that emotion.¹⁰

In this study, empathy was the most frequently noted category in SP feedback. It was evident at different stages of the clinical encounter in over 65 instances, providing ample opportunity for rich analysis. Analyzing empathy in the context of SP feedback through the lens

¹⁰ For a beautifully animated video of scholar-storyteller Brene Brown speaking to Wiseman's framing of empathy, I recommend <https://www.youtube.com/watch?v=1Evwgu369Jw> (accessed from the internet, 11/22/14.)

of Wiseman's taxonomy, I found SPs fundamentally reflected her framework. What follows is a brief description of how each of Wiseman's four indicators of empathy was reflected by the SPs. For feedback exemplars of each code, see Table 14:

Seeing the world as others see it. This code was applied to feedback that recognized when residents moved away from the oft-cited reductionist tendencies (see Wear, 2007) of the voice of medicine, and instead made an empathic connection to the patient's lifeworld perspective. This code also reflects the degree to which the patient felt they were more than just a "checkbox" or "a statistic" to the resident; that the resident perceived them as full, complex human beings, above and inclusive of their presenting complaint.

Commitment to being non-judgmental. Here, SP feedback centered on the degree to which the resident demonstrated empathy by remaining non-judgmental of the patient's perspective, (knowledge, beliefs, emotions, etc.). When handled effectively, residents balanced offering their medical opinion while not passing judgment of the patient's beliefs and opinions.

Understanding another's feelings. This code represents feedback exploring the degree to which the resident recognized the patient's emotional / psychological feelings. Specific to the content of many of these cases, one predominant emotion discussed was fear; fear of the treatment and/or of the disease based on previous life experiences; fear of traditional medicine's interventions.

Communicating understanding. The final of Wiseman's codes represents feedback wherein the resident moved beyond mere recognition of the patient expressing emotion, instead effectively communicating a clear understanding of the patient's emotion. Communicating that emotional understanding could be done verbally or non-verbally, or through a combination of the two.

Table 14		
<i>Empathy</i>		
Qualities of Empathy (Wiseman, 2007)	SP	Quote
Seeing the World As Others See it	Sybil	But you are a very, very good listener, very compassionate. You know, so, I felt very comfortable getting somebody like you for this type of problem especially because you were listening I felt, you were giving me the feeling like “I know how you feel, we’re going to take care of the issue, make sure you feel better.
Commitment to Being Non-judgmental	Morgan	“You were like... ‘ok, this is what should be – well, you didn’t even use the word ‘should’! You said “this would be the better, the better outcome, if you did it this way”, and that way it felt to me like we were partners, you were helping me come to the decision – intelligently. Ok? You didn’t say “Well – there’s no such thing as air hitting that!” - you know, you just kind of heard it, and I <u>know</u> you heard it because you acknowledged it, without telling me ‘Aw your people are crazy!’”
Understanding Another’s Feelings	Barbara	“Mmhm – kinda felt me out a little bit to see where I was coming from, where my head was at and where my head was located. And I felt that was very good because it gave me time to let you know that I was fearful and frustrated, and of course you could bounce off of that and work off of that, and give me what you felt I needed to have.”
Communicating Understanding	Morgan	“You know, you sat there, let me say what I had to say...you never changed your facial expression, you know like ‘get out of here!’ – you just listened and you let me say it and you said, ‘Well, first of all, if anything happens, it’s not the air’ and then you told me about the possible things that could go wrong, y’know, and you didn’t just put your hands in the air like ‘This will be ok, this will be fine!’ you know, you were like ‘This can happen, that can happen, we have blood’ and so you know, that just alleviated aaaalll that anxiety.”

Communication as Comfort

Ragan, Wittenberg-Lyles, Goldsmith and Sanchez-Reilly (2008) offer compassion-based communication strategies for end-of-life care and palliative measures, in their book, *Communication as Comfort: Multiple Voices in Palliative Care*. Here, they advance that comfort communication can be a very powerful clinical skill, bringing solace to a patient who is out of curative options for their illness. Although none of the fictionalized cases in the present study pertain to chronic pain management or end-of-life issues, it is notable that SP feedback revealed a desire for the resident to focus on communication forging a deeper, more compassionate connection. Here, connecting with the patient requires residents to attend to issues beyond the specific illness and therapy, encompassing emotional issues, putting the patient at ease, and engaging with them as a friend or a partner. SPs regular referencing of comfort measures indicates that even during routine office visits, when a patient desires to ‘get well’, they don’t want physicians to simply express care or concern, nor do they only desire a cure; they also hope for a physician who is committed to keeping them as comfortable and reassured as possible on an emotional level. Examples of each of the three second-order codes associated with Communication as Comfort are listed in Table 15

Nonverbal and verbal demonstrations. SP feedback identified communication as comfort through the many uses of phrases such as “you comforted me” or “you were supportive”, or used in the context of putting the patient at ease, lessening their anxiety, or addressing their fears. Additionally, SPs noted non-verbal expressions of comfort by commenting on generally small moments or reflections of comfort communication such as the resident adopting a “soothing tone of voice”, handing a distraught patient a Kleenex, or offering reassurance by offering a light touch on the arm.

Friendship / partnership. Comfort communication was also reflected in SP references to forging an emotionally-based partnership with the resident. Examples of these elements of feedback include SPs positioning themselves and residents as “being on the same team”, or engaging in moments of friendship and intimacy such as when Sybil stated:

“You were very calm, like we were having a cup of coffee together. You asked me like, what was going on, you know, you listened, you didn’t make judgments, you didn’t make opinions while I was talking, um I liked that, that you allowed me to tell you my...life history.”

Abandonment. Lastly, SPs frequently made reference to not wanting to feel alone or abandoned, emphasizing the value of the resident being there for the patient, to ameliorate their fear and anxiety. There are multiple references to physician abandonment throughout doctor-patient communication literature, connecting it to patient satisfaction as well as a critical component of building an effective therapeutic relationship. Although the majority of available literature is on fear of physician abandonment during end-of-life and palliative care, (Curtis, Wenrich, Carline, Shannon & Ambrozy, 2001; Giacomini, DeJean, Simeonov & Smith, 2012) there are discussions of abandonment in routine clinical care (Lee, Moriarty, Borgstrom & Horwitz, 2010; Rabow & McPhee, 1999), as was reflected by SP feedback in this research.

Table 15		
<i>Communication as Comfort</i>		
Second-Order Codes	SP	Quote
Nonverbal and Verbal Demonstrations	Lois	And, you showed a lot of concern, you know, handing me a Kleenex and everything. And, uh, you just, you made good eye contact and, you know, made me feel a little bit better
	Bette	But what I really liked was this (touches shoulder) I really liked that I think that was very good. That was the frosting on the cake - that really, really made it. Because that really meant a

		lot – that I wasn't just being pushed through, you were trying to do what was best for me, and I think (touches shoulder again) this gave me extra reassurance
Friendship / Partnership	Barbara	You kept me upbeat because you're so upbeat and that was good, I thought – I needed to have someone lift me up because I came in here wanting to cry, not know which way to go, um and I felt you were a new friend who was going to walk me through this.
	Barbara	I felt comfortable and I felt supported and that was very, very important. In other words, if I didn't feel supported I'd leave on out of here and do what I want to do. I won't accomplish anything if you didn't make me feel you were on my team and you were going to help me through this.
Abandonment	Wendy	I would have liked to have heard that you were going to be with me through this, because you had established this relationship and I developed this trust in you, and it's like, please be there to see me through, because I'm scared and nervous, and so please say you're gonna come back.
	Bette	And another thing was when you said you would stay that was like the, the icing on the cake. Well I thought that was excellent. Knowing how busy a doctor's schedule is in the ER, when they mention they will stay I was like oh:h.

Discussion

The ultimate goal of teaching and assessing resident's patient-centered communication skills is to ensure residents are providing the best quality of care for their patients. Engaging with lifeworld voice via SP feedback reveals several opportunities for enriching and extending the KEECC-A and potentially, other current patient-centered communication assessment tools. In the following discussion I explicate two identified overarching findings. First, the degree to which SP Feedback allows for a rethinking of communicative tasks. Second, I will discuss the insights I gained about the KEECC-A and the original Kalamazoo Consensus Statement through

theoretical sampling. Following the discussion of these global insights, I provide further discussion of each of the identified categories and accompanying codes.

SP Feedback: Rethinking Communicative Tasks

Widening the lens on the construction of the identified themes, it appears that similar to the KEECC-A and other current existing rubrics for teaching and assessing patient-centered communication, SPs identified communication skills that could be framed in terms of specific tasks; (a) engaging in active listening; (b) demonstrating components of enhanced autonomy (c) acknowledging culture grounded in the lifeworld; (d) demonstrating empathy; and (e) providing comfort through communication. What is unique about these SP-articulated tasks is that although some of them are loosely related to the tasks included in the KEECC-A, none of them are literally (verbatim) present in any of the seven core competencies or sub-competencies that comprise the KEECC-A. I found this especially intriguing because several of the identified categories and codes (e.g., active listening, empathy, respect) are widely supported by the doctor-patient communication literature as necessary components of effective patient-centered communication (Beach, Roter, Wang, Duggan & Cooper, 2006; Dyche, 2007; Fassaert, van Dulmen, Schellivis & Bensing, 2007). Their absence is conspicuous, particularly considering that the KEECC-A was directly informed by the findings from a consortium of leading health communication and medical educational scholars, convened because of their knowledge, who theoretically should be well-versed in evidence-based constructs of patient-centered communication. The process of theoretical sampling, discussed in the next section, offered some insight into this finding.

Revelations of Theoretical Sampling

All of my final determinations about how best to frame and name identified categories and codes in this research included the process of theoretical sampling. Theoretical sampling is a necessary step in ensuring methodological rigor (Tracy, 2013). Here, I juxtaposed what I considered to be identified themes and codes against what currently exists in the KEECC-A. This allowed me to gain a firmer grasp on which codes were novel, offering completely new insights from the lifeworld perspective of patient-centered communication, and which codes offered new understandings or extended existing competencies and sub-competencies in the KEECC-A rubric. Regardless of whether codes were completely new or offered new insights into existing elements of the KEECC-A, SPs instinctively and consistently advanced Mishler's call to 'interrupt the voice of medicine', challenging the academically articulated constructs in the KEECC-A, by providing lifeworld sensibilities, using specific terms and phrases grounded in a lay-perspective.

What was most compelling about these rearticulated intersections of feedback, is that while the KEECC-A offers largely generic description of behaviors (e.g., "uses tone, pace and eye contact"), and fairly vague contextualization of the desired impact of those behaviors on the patient (e.g., "to show care and concern"), SPs deepened the meaning and application of desired behaviors. This deepening was accomplished by providing more complexity than simply stating 'what' was happening, by adding 'how' something was happening, as well as offering richer considerations as to 'why' those behaviors either were or were not effective in connecting with the patient. Throughout my discussion of the individual categories, I will make note of specific occurrences of this deepening of the 'how' and the 'why', as reflected in the feedback.

As part of my theoretical sampling strategy, I also revisited the article outlining the original Kalamazoo Consensus Statement (Makoul, 2001), as it was the primary source material

in the development of the KEECC-A. Interestingly, I noted that many of the codes and categories that emerged from SP feedback were, in fact, present in the original descriptors of the seven core competencies in the original consensus statement. What this suggested to me is, in response to my initial point of confusion, the members of the consortium naturally were familiar with the full range of elements that are routinely associated with patient-centered communication. However, at some point, through the process of defining relevant and meaningful communicative tasks for use in the adapted assessment tool, the decision was made by some combination of the scholars involved in the development of the original Kalamazoo statement and/or the KEECC-A, to eliminate the communicative criteria which, at least in terms of the present research, proved to be most relevant and meaningful to the SPs. Something of a mystery remains, as between the work that was done by the consortium and the development of the KEECC-A what happened to these elements? I could speculate, but ultimately I suggest it is not the job of this research to investigate the case of the missing descriptors, but rather a task for the authors of the Kalamazoo consensus statement and the KEECC-A to embark on, as they so desire. Instead, this research can begin to offer understandings as to which elements of the original consensus were in fact, most salient from the patient's perspective, and consider means by which future iterations of the KEECC-A, or altogether new instruments, can be revised or developed, ensuring a sensitivity to the language and communicative priorities of the voices from the lifeworld.

Explicating the Results: Discussion of the Umbrella Categories

In the following discussion of the umbrella categories identified in this research, I will frame each through a discussion of my articulated global findings. Specifically, I will elucidate the task element of the category and supporting codes. I will also explore the 'how'

communicative behaviors were happening, and ‘why’ those behaviors either were or were not effective in connecting with the SP, as well as evaluating the degree to which categories or codes were or were not included in the original Kalamazoo consensus statement and /or the KEECC-A.

Active Listening. Active Listening is one of the emergent categories that was referenced in the original Kalamazoo consensus statement, but was not included in the KEECC-A. In the original consensus statement, active listening was reflected under the competency of “Gathering Information” noting the importance of active listening through both (a) verbal and (b) non-verbal communication skills, mirroring exactly the two corresponding second-order codes identified in this research. Active listening is widely recognized as one of the essential tasks for effective clinical communication, and a critical and necessary component of patient-centered communication (Fassaert, et al., 2007), which makes its absence from the KEECC-A even more notable.

The manner by which it SPs identified active listening expands the scope of opportunities under which practitioners can apply it, moving beyond gathering information, covering the full depth and breadth of the patient encounter. Specifically, SPs identified how active listening can be applied as a natural element of all KEECC-A competencies, from ‘builds a relationship’, where non-verbals can be used to demonstrate listening, to ‘providing closure’, where summarizing the next steps is also an indicator of active listening.

Enhanced Autonomy. I identified the umbrella category of ‘enhanced autonomy’ in the transcripts as supported by two secondary codes: (a) information and investment and (b) respect. To a certain degree the KEECC-A competency ‘shares information’ (which was also included in the original Kalamazoo consensus statement) begins to address the former of the two emergent codes, however SPs enhance the ‘shares information’ competency by specifically mentioning the

investment of time residents made when sharing of information. Furthermore, the KEECC-A task of sharing information as a stand-alone competency does not offer much context either to the resident who receives the feedback or the SP who delivers it. By anchoring information sharing + investment of time to the larger competency of enhanced autonomy, the learner gains deeper insights as to ‘how’ (by taking the time to educate) and ‘why’ (to ensure patient autonomy), sharing information matters to the patient.

The second half of enhanced autonomy, respect, is another one of the central foundations of effective communication that is conspicuously missing from the KEECC-A. Respect for patients is a considered a cornerstone of clinical professionalism (Branch, 2006), a critical component of demonstrating humanism in medical practice (Weissman, Haidet, Branch, Gracey & Frankel, 2010) and a significant contributor to overall patient satisfaction (du Pre, 2010). Similar to active listening, respect, (in general terms) could conceivably be present throughout the various competencies in the KEECC-A, and was in fact anchored to the ‘builds a relationship’ component in the original Kalamazoo consensus statement. However, SP feedback in this study consistently and uniquely tied respect to the process of making treatment decisions, which is why I made the choice to anchor it to enhanced autonomy.

Culture. Discussions of the umbrella category of culture are not explicitly noted in the KEECC-A. At first blush, the KEECC-A competency of ‘understands the patient’s perspective’ appears to relate to cultural considerations of health, but it does so quite generically, which could result in the specific and nuanced nature of culture being overlooked. Understanding the patient’s perspective is described in the KEECC-A as the degree to which the resident (a) “asks about life events, circumstances, other people that might affect health.”; (b) “elicits patient’s beliefs, concerns, and expectations about illness and treatment.”; and (c) “responds explicitly to patient’s

statements about ideas and feelings.” SP feedback, regardless of specific SP or case type, generally avoided discussing generalized concepts of ‘perspective’ or the generic ‘circumstances or people that might affect health’, which Mishler may argue are more reflective of the “voice of medicine”. Instead, the SPs interrupted the medical voice by providing lifeworld specificity of detailed and grounded feedback about cultural considerations, naming specific relationships, reflecting on gender, speaking to identified job stressors, etc.

The term ‘culture’ did appear in the original Kalamazoo consensus statement, lumped together with several other descriptors of “exploring contextual factors”, all anchored to ‘understanding the patient’s perspective’. Even in that context, the supportive terms were all largely one-dimensional, and slightly confusing as ‘culture’ in the consensus statement was listed as a descriptor next to other items that are largely considered elements of culture, e.g. age, gender and religion, leaving me to wonder what the authors understood culture, as a stand-alone construct, to be.

In the present study, SPs provided pathways to ‘how’ residents could effectively address issues of culture, namely by listening to and acknowledging the patient’s cultural understandings of health. As for the ‘why’ residents would choose to engage cultural aspects into patient communication, as SPs suggested the residents’ exploration of cultural concepts was critical to identifying unspoken factors (e.g., stressors of job, family, etc.) and as a means to address and potentially alleviate culturally-informed fears about illness and/or therapeutic measures.

Empathy. Returning to the literature on the KEECC-A, it is notable that empathy, an identified umbrella category in the present research, was not mentioned in either the Kalamazoo consensus statement or included in the KEECC-A. However, there is a clue regarding the omission of empathy, provided by Calhoun et al. (2009), who reports that empathy had been

considered during the development of the Kalamazoo model, but was not included as the developers of the original consensus statement felt that empathy was "...implicitly indicated in the 'builds a relationship' element" (Calhoun et al., 2009, p. 24). Builds a relationship is advanced as "the fundamental communication task" in the original Kalamazoo report, an "ongoing task within and across encounters" undergirding all other competencies (Makoul, 2001, p. 391). Thus, because empathy was implicit in building a relationship competency, and since this particular competency was foundational to all other tasks, the architects of the original consensus statement and subsequently, the KEECC-A opted to leave empathy out of the rubric, altogether.

SP feedback bears out that empathy is, indeed, an ongoing task, as I identified facets of empathy reflected in all aspects of the clinical encounter, from beginning to end, reflecting the degree to which SPs felt the resident identified with the patient as an individual and connected on some level, to feeling with the patient, during their time of illness and suffering. Thus, while I recognize the choice the members the consortium made in omitting the word 'empathy' follows an inherent logic, I think its omission is significant. As noted by Calhoun et al. (2009), there is a significant amount of literature explicitly identifying empathy in communication as it is "an important consideration for families as a vital component of effective doctor-patient communication" (p. 24). Demonstrations of empathy are consistently supported in medical educational and health communication literature, valued not merely as a tool or gimmick for connecting with patients, but as an essential way of being present with the patient (Dyche, 2007; Keller & Carol, 1994; Makoul, 2003). Considering the critical role empathy plays in clinical practice, its association as a mark of quality among scholars, and now, overwhelmingly

referenced by SPs in this study, I would suggest it should be made explicit, an articulated touchstone in any valid measure of communication skills.

Communication as Comfort. Providing comfort through communication is the one umbrella category offering an entirely unique finding in this analysis, as no similar construct is noted in either the original Kalamazoo statement or the KEECC-A. This may be due to the fact that the literature on comfort communication is predominantly framed by discussions of chronic pain management or end-of-life (EOL) care (Considine & Miller, 2010; Finlay, 2005), and not by clinical care in a general, ongoing sense. I can imagine that comfort communication would not have been on the radar for the members of the original Kalamazoo consortium, as their goal was to develop essential communicative elements that could be used in a variety of clinical settings, and not particular to pain management / EOL care. However, during my initial read-through of the transcripts, I was struck by the consistent integration and many iterations of the word comfort (e.g., “you made me feel comfortable”, “you provided a level of comfort”, “I felt comfortable with you”). Despite multiple readings and reflection, and instinctively sensing its importance, I could not conceive of where or how this would fit in the analysis.

Turning to the literature, I revisited *Communication As Comfort: Multiple Voices in Palliative Care* (Ragan et al., 2008), which provided the much needed framework for considering this particular element of SP feedback. While this book is largely reflective of the corpus of literature on palliative care, I was able to identify a number of elements that reflected and resonated with the SP feedback speaking to comfort communication in routine clinical encounters. Namely, the elements of fear, cultural considerations, and lifeworld stress all require a unique form of communication, regardless of the clinical setting:

- Comfort communication in the traditional (EOL) context, often addresses fears – fears of dying, of being in pain, of saying goodbye to loved ones. In the context of the current research, SPs often referenced being afraid; in this particular setting, SPs expressed fear of disease outcomes as well as overwhelming and potentially invasive treatment options. Regardless, then of the source of patient fears, comfort communication can serve as an important resource in recognizing and addressing patient fears, as well as forging a stronger relationship.
- Communication as comfort during EOL care often makes a significant difference in acknowledging cultural expectations and beliefs about death and dying; Patients represented in the current OSCE also struggled to manage the traditional medical models that directly conflicted or challenged their cultural understandings of health. Simply acknowledging the emotion that goes along with cultural expectations being challenged appeared to be articulated in the SP feedback as providing comfort.
- Family dynamics and other lifeworld stressors (socioeconomic stress, job-related stress) often result in patients resisting therapeutic options, both at the end-of-life and in routine care (Mishler, 2005). Options for declining any intervention are becoming more and more accepted at the end of a patient’s life, as the focus shifts from cure-by-any-means necessary to assessing what would provide the greatest quality of life for the dying patient (Finlay, 2005; Young & Rodriguez, 2006). What SP feedback indicates in the present research is a desire for the doctor to (minimally) acknowledge and understand the patient’s perspective, understanding the compelling nature of some of these lifeworld stressors, as the patient works through the available therapeutic options.

While the identification of communication as comfort in this context of routine clinical care is a novel finding, I would suggest it would enhance the KEECC-A rubric if added as a sub-competency to the KEECC-A competency of ‘builds a relationship’. Not only does it resonate with the foundations of building a strong relationship, but it also raises the expectations of the this competency by asking the learner to consider the full range and complexities of human emotion, beyond potentially superficial demonstrations of care and concern.

Limitations

The identified categories and themes in this research are based on a 4-station OSCE at one urban Midwestern medical school. Consequently, these local and regionalized findings cannot be transferable to all environments, nor claim to reflect all SP programs, or all lifeworld perspectives with regard to patient-centered communication. Additionally, the structure of the fictionalized patient roles in this OSCE included only older (>50) women. Furthermore, although there was fairly equal representation of both black and white SPs, all SPs spoke English as their first language and were born and raised in the United States. Clearly more research is indicated, including different genders, ethnicities, and other facets of cultural background (e.g., age, non-English speaking or English as a second language, and geographic location).

Another important consideration is my role as investigator. Although I engaged in as many avenues as possible to ensure academic rigor with the methodology of iterative pragmatic inquiry (i.e., theoretical application, member-checking, theoretical sampling, reflexivity and diligent analytic memoing, just to name a few) I am only one person, with a unique history, fixed set of experiences, and cultural particularities, all of which limit the scope of potential conclusions possible from this research undertaking. There is no way around this inherent

limitation of being human and situated in my own social-historical context, but it bears stating as an organic limitation in this, and I would argue, any research study.

Implications: Where Do We Go from Here?

The multiple findings associated with this research offer several opportunities for pragmatic application and future research. These consist of (a) reconsidering best approaches in designing communication skills assessment tools; (b) expanding future research with SPs, and, (c) engagement with actual patient populations.

Reimagining Rubrics

Reimagining communication assessment tools, specific to this research, could be approached in a couple of different ways. The first is to reimagine and rework the KEECC-A, itself, integrating elements of lifeworld voice. While the solution may appear obvious - simply reinstate the elements advanced by the original Kalamazoo Consensus Statement that were eliminated in the KEECC-A, in reality that would be just one more example of the voice of medicine making choices on behalf of the voice of the lifeworld. Ultimately, to truly engage in the process of re-imagining the KEECC-A would necessitate working in concert with SPs, determining collaboratively if anything in the current iteration of the KEECC-A should be eliminated or re-articulated, or, if SP-generated lifeworld categories and codes should be added or integrated into the existing categories. Once choices have been made, the revised rubric should be tested in various OSCE opportunities to gain understanding as to which elements seem relevant for all cases, and which ones may be applicable only under specific clinical settings. I would imagine that this would be an ongoing work in progress, with educators, researchers, and SPs iteratively visiting and re-visiting, reflecting and rearticulating opportunities for incorporating lifeworld voice.

The second opportunity for reimagining a communication skills rubric is to start with a ‘clean slate’. In order to embrace a truly grounded approach in the development of a lifeworld-articulated assessment tool, multiple methods would be required. Methods may include running focus groups, holding in-depth interviews, and/or conducting ethnographic studies of SPs in their various environments (in training, during encounters, in debriefing, or even in casual conversations with other SPs and staff). While completely ignoring prior bodies of clinical communication research is unrealistic, the goal here would be to keep the possibilities open for completely new approaches or understandings.

Future Research Using SP Methodology

As evidenced by this research, SPs provide a valuable and yet largely underutilized resource for engaging with lifeworld voice. However, the KEECC-A is not the only communication assessment instrument currently in use in medical education practice, nor are these SPs entirely reflective of all SP populations. Future studies could assess the utility of other educator-developed measures of patient-centered communication, including the many ‘home-grown’ assessment tools developed in medical educational programs across the United States. SPs provide not only unique insights and perspectives, but provide another level of validation of instruments as they represent the very population who benefits from patient-centered communication, the patients, themselves. Additionally, lifeworld feedback from OSCEs that include greater diversity in terms of patient roles, gender, age, and ethnicity would provide a larger breadth of insight into what constitutes effective patient-centered communication.

Engagement with Patients

Another recommendation for further inquiry shifts the focus from SPs as agents of the patient community to exploring patient-centered communication in actual clinical settings.

Moving in this direction has the potential for gaining deeper and more robust understandings of what patients who are facing actual health and illness challenges most desire in communication with their physicians. Working with patients would also fully embrace Mishler's desire to make room for the (actual) lifeworld voices. A major hurdle to engaging with this approach are the complex challenges with recruitment, which can run the gamut from patients being too sick to participate, the potential burden on vulnerable and stigmatized populations, and the limitations of access to patient populations, imposed by HIPAA (Donovan, Miller & Goldsmith, 2014). Additionally, one of the benefits of working with SPs on constructs of patient-centered communication is that there is a built-in, shared language between researcher and participant. While not an impossible obstacle to overcome, research with actual patients regarding patient-centered communication needs to be mindful of structuring interventions to be sensitive to the jargon associated with educational constructs. Donovan et al. (2014) suggest that semi-structured interview methodology provides an ideal opportunity for health communication scholars to engage with patients, as there is ample opportunity for ensuring mutual understanding throughout the process of the interview.

Conclusion

Teaching and evaluating clinical communication skills is a daunting task. Communication is an evolving, subjective, wholly human undertaking that does not always fit neatly into tidy assessment rubrics. And yet, the practice of medical education, reflective of the trend of education in general, is largely driven by outcomes measures. Accordingly, choices have to be made about what stays in and what stays out of assessment tools. The challenge to communication and medical education scholars is to ensure representation of those who are most

affected by patient-centered communication, and to create space for meaningful exploration of lifeworld voices.

Using SP methodology, this research offers a first-look at patient-centered communication through the lifeworld perspective. In doing so, the research attempts to honor the voices of the lifeworld, providing them an opportunity to step out of their position as a marginalized participant into the clinical encounter. Furthermore, as SP programs are mainstays of medical education in the U.S. and other countries, exploration of SP voice provides a tangible opportunity for medical educators to make room for Mishler's (2005) advancement of lifeworld voices to interrupt the voice of medicine, potentially providing momentum for an engaged application of Engel's (1977) biopsychosocial model of healthcare.

Chapter 5: A Narrative Analysis of Standardized Patient Feedback

There is general consensus among medical educators and health communication scholars that strong communication skills are integral to good clinical practice. Over the past 10 years there has been increasing pressure on medical educators to provide outcomes-based evidence of communication competence among learners (Lurie, 2003). This emphasis on outcomes is driven by several factors, including standards set by accreditation agencies, greater demands for patient safety and satisfaction, lowering malpractice suits, and maintaining Medicare reimbursement (Accreditation Council for Graduate Medical Programs Common Program Requirements, 2013; Liaison Committee on Medical Education, 2012; Rau, 2011). Consequently, the current landscape of medical educational approaches assessing learners' communication competency is thick with competency-based curricula, clinical skills exams, and standardized checklists. The expectation to demonstrate effective communication skills starts as early as the medical school admissions process, continuing through undergraduate medical education, licensure exams, and is now commonplace in all U.S. residency training programs (Accreditation Council for Graduate Medical Programs Common Program Requirements, 2013; Eva, Rosenfeld, Reiter & Norman, 2004; Wear & Varley, 2007). To support this massive undertaking, medical educators invest a great many resources on testing and retesting communication skills among learners. A primary modality for this effort is through the use of simulation, employing Standardized Patients (SPs) to portray fictionalized patient roles in Objective Structured Clinical Exams (OSCEs).

While recognizing the legitimate factors for assessing communication competence, there are some who question medical education's "obsession with measurement" (Wear & Varley, 2007, p. 154), obtained through multiple iterations of clinical skills exams (Hanna and Fins,

2006; Wear & Varley, 2007). Wear and Varley (2007) assert this fixation on outcomes distracts us from asking equally, if not more important questions about the effects of these kinds of examinations. Specifically, they argue that checklists developed for and used in OSCEs fundamentally reflect the values of medical education, with competence being defined and redefined via a checklist mentality, conveying to students what is most valued and valid in their skill sets. Behaviors denoted in OSCE checklists have the potential for greatly influencing what students take away as ‘acceptable’ communication and interpersonal skills. The risk we run in the frenzy for achieving outcomes is that a richer more nuanced understanding of interpersonal communication with patients will be wholly overlooked; as Wear and Varley (2007) posit: “What is potentially lost in these transactions? Anything that does not or cannot appear on the checklist.” (p. 155)

As an alternative to simulation and checklist-driven methods, some scholars advance greater inclusion of narrative methods for exploring communication and interpersonal approaches with learners (Goyal, et al., 2008; Rose & Wilkerson, 2001). Here, they argue that although outcomes-based assessment plays a role in communication assessment, true communication expertise is best served through creating opportunities for learners to engage with patients narratively. Narrative opportunities provide learners with a greater experience of communicative depth, allowing them to engage in the complexities and nuances of grounded, lived experiences. As an interpretive scholar, I profoundly appreciate the value of narrative experiences. However, I would assert that the discussion between narrative vs. outcomes driven approaches does not necessarily need to be dichotomous. In this article, I suggest there may be narrative possibilities imbedded within checklist-driven simulated encounters through the inclusion of Standardized Patient (SP) feedback during OSCE encounters. Here, I start by

positioning both of these approaches side-by side. First, I review current trends in communication skills assessment, specifically the use of SPs, OSCEs and SP-delivered feedback. I also speak to the nature of the adapted version Kalamazoo Essential Elements of Communication Checklist (KEECC-A), a highly regarded communication assessment checklist. This is followed by a review of narrative approaches in medical education, namely Rita Charon's (2006) advancement of *narrative medicine*. I then expound on my own research inquiry, which focused on SP feedback, as analyzed through the lens of narrative analysis.

Current Trends in Communication Skills Assessment

Standardized Patients and OSCEs. Standardized Patients (SPs) and Objective Structured Clinical Exams (OSCEs) are widely used in medical education for assessing resident communication skills. SPs are generally healthy lay people, trained to portray the fictionalized role of an ill patient. OSCEs are clinical skills examinations consisting of multiple SP encounters, designed to represent communicative challenges found in actual clinical settings. SPs are used in a variety of teaching and testing OSCEs to portray a patient role, rate the communication and interpersonal skills of the learners, and are often asked to provide spoken patient-centered feedback to learners. SPs have been found to be a highly reliable tool for both teaching and assessing communication competence and medical educators value SPs, for providing standardized presentations suitable for assessment. (Barry et al., 2010; Harter & Kirby, 2004; Klamen & Yudowsky, 2002; van Zanten, et al., 2007)

Kalamazoo Essential Elements of Communication Checklist (Adapted). One highly regarded checklist used for SP rating of resident communication skills is the adapted version of the Kalamazoo Essential Elements of Communication Checklist (KEECC-A). Advanced for use in the ACGME toolbox as an exemplar of patient-centered communication assessment, the

KEECC-A represents a gold standard for assessment instruments. The KEECC-A is highly valued as a psychometrically-validated instrument, designed to allow for global ratings of learners' communication skills. Having been developed through an interdisciplinary group of leading communication and medical educational scholars, the KEECC-A also has established expert validity. (Calhoun et al., 2009; Joyce et al., 2010; Makoul, 2001; Porcerelli et al, 2015). The KEECC-A continues to be referenced directly and indirectly in a wide-range of patient-centered communication training and testing environments (Baribeau, et al., 2012; Berger, et al., 2010; Calhoun, et al., 2009). Instruments such as the KEECC-A are designed to teach and assess patient-centered communication, and are used by educators both to score communication skills and to provide a framework for SP feedback.

Patient-Centered Feedback. SPs provide a unique perspective in the development of residents' communication skills, serving a dual role as insiders to the educational process, but also as members of the lay patient community. In the latter of these roles, SPs serve as informal ambassadors, or liaisons to the general patient community, providing opportunities for residents to gain insights into a non-clinical perspective on elements of patient-centered communication. SP feedback is a common formative element added to many OSCE programs. While some programs limit SPs to providing written feedback, others allow time for SPs to engage in spoken feedback directly with learners (Klamen & Yudowsky, 2002; Park, Son, Kim & May, 2011). SP feedback generally takes place immediately following each patient encounter, providing an opportunity for SPs to directly share their reflections on residents' communication skills. Oral feedback may be facilitated utilizing the same checklists used to score communication skills (Egener & Cole-Kelly, 2004; Hassell 2012). Medical educators and residents have reported favorably on the verbal feedback provided by SPs, (Bokken, Linssen, et al., 2009; Lane &

Rollnick, 2007). However, a review of available SP literature reveals that little is understood about the exact form of SP feedback, particularly the degree to which SPs adhere to the framework of checklist-informed feedback, or provide feedback in a different form altogether. Thus, while we may have outcomes measures that inform us SP feedback is highly regarded, we have little evidence as to why it is so well received, or, more specifically, the form in which it is actually delivered.

Narrative Approaches in Medical Education

Narrative theory suggests that people live storied lives, and through stories people share powerful messages about the things that sustain their culture (gender, race, class, and health) (Bochner, 2002; Fisher, 2002; Meyer, 2009). In the case of health, they share stories about what the disease means to them (Charon, 2006). With specific regard to her advancement of narrative medicine, Rita Charon (2006) asserts that narrative knowledge is both enriching and dialectical, as it can provide universal insights achievable by committing oneself to listening to a patient's individualized stories. The importance of narratives is they provide the listener not with some fashion of universal truth but are more revealing of singular, meaningful situations, which serve to "illuminate the universal by transcending the particular" (p. 9).

While most of the scholarship conducted on narratives in healthcare is naturally focused on actual patients, there are some who suggest that SPs may also provide opportunities for exploring narratives in teaching and providing learner feedback regarding communication skills. Namely, nearly 15 years ago, Rose and Wilkerson (2001) advocated for broadening the scope and usage of SP methodology, including turning toward the narrative of SP encounters and the SPs, themselves, when evaluating residents' grasp of facilitating patient-centered communication. In his paper on the narrative nature of SP Programs, Meyer (2009) recommends

means by which narrative can be advanced pedagogically, suggesting important considerations for expanding narrative teaching via SP programs. Despite these calls for combining narrative inquiry with SP methodology, there are no known studies that have taken up this charge.

In summary, there exist two potentially dichotomous approaches to teaching and assessing communication expertise; narrative approaches and simulation / outcomes-based approaches. A review of the literature reveals that while residency programs and learners report favorably on spoken feedback opportunities (see Bokken, Linssen, et al., 2009; Lane & Rollnick, 2007) little is known about the form of SP feedback delivery. Furthermore, narrative theory asserts that people are storied, by nature. As such, is it possible that SP Feedback is, in some way, a storied experience for the learners? Prior calls for creating opportunities for integrating SP and narrative methodology have been largely ignored, thus it is unknown if SP methodology provides a viable narrative opportunity.

In my own experience working with the development and training of SPs, we have developed several OSCE programs wherein SPs provide feedback to residents. In training, we ask SPs to first score resident communication using the KEECC-A. In training, they are asked to facilitate their oral feedback by anchoring it to the KEECC-A rubric. I recently completed both a (deductive) content analysis and (inductive) thematic iterative analysis, each looking at the content of SP feedback using the KEECC-A. Here, I found that whereas the nature of some SP feedback reflects content found in the KEECC-A, other feedback-delivered elements extend beyond the KEECC-A criteria. Furthermore, these initial studies challenged my assumptions regarding the form used in delivering oral feedback. My original assumption was that SP feedback would mirror the bulleted-approach of the KEECC-A checklist, however initial reviews of transcribed feedback revealed SPs were largely conversational in feedback delivery, posing

narrative possibilities. Consequently, my interest was piqued beyond just the content of delivering feedback based on the KEECC-A, to the form of feedback delivery, as well. To this end, I pose the following research question:

RQ: What is the form of feedback provided not covered by the KEECC-A?

The Present Research

Working at a large public university in the Midwest, In 2013 I collaborated with faculty from our university's Graduate Medical Education (GME) program to develop and implement a four-station OSCE. Eight residency programs, covering a range of medical and surgical specialties participated. The cases in the OSCE reflected clinical competencies required of all U.S. residency programs, with a primary focus on communication and interpersonal skills. The OSCE team selected four non-specialty-specific cases: delivering bad news, error disclosure, informed consent, and health care disparities as they represent topics generally applicable in all clinical environments (see Appendix B for OSCE Case Descriptions). Two of the cases focused on challenging communicative encounters (delivering bad news and error disclosure), while the other cases (informed consent and health care disparity) concentrated on more common, everyday clinical communication

The OSCE design allowed multiple opportunities for patient-centered feedback. Following each eight-minute patient encounter, SPs quantitatively rated residents' communication skills using the adapted version of the Kalamazoo Essential Elements of Communication Competence (KEECC-A) checklist and then took a few minutes to formulate their verbal feedback. Simultaneously, residents used the KEECC-A to self-reflect and self-rate their own patient-centered communication skills. Following the SP rating / resident self-rating activity, residents returned to each patient room to obtain spoken feedback from the SP. All of

these four-minute feedback sessions were video-recorded. It was during these sessions that SPs had the opportunity to share their assessment of residents' communication skills. In training, SPs were instructed to generate feedback as informed by KEECC-A criteria, limiting their feedback to one or two of the resident's communicative strengths or weaknesses.

Little is known about the form in which SPs deliver feedback to learners. In fact, little is known about SP feedback in general, as the primary focus for research on doctor-patient communication centers on communication at the point of service (Braddock, et al., 1997; Gorawara-Bhat, et al., 2007), or doctors' and patients' perspectives outside of the dyadic encounter (Dong, et al., 2014; Vegni, et al., 2005). Despite the fact that SP feedback is a common practice in OSCEs (Barry et al., 2010; Bokken, Linssen, et al., 2009), there are no known studies which focus on the engaged voice of the SP in providing feedback on patient-centered communication. Feedback sessions provide a rare opportunity to capture SP voice specific to patient-centered communication, in general, and, in the present research, the degree to which SPs may have incorporated Charon's (2006) advancement of narrative medicine, potentially providing opportunities for educators to recognize narrative opportunities for reinforcing the nuanced complexities imbued in human communication.

Methods

Using a narrative lens, guided by Charon's tenets of narrative medicine, I analyzed SP feedback from 80 transcripts I selected through a maximum variation (heterogeneity) purposive sampling approach for two previous studies. In the previous studies I evaluated these transcripts deductively and inductively, to better understand and explore the content and valence of how SPs engaged with and/or extended the competencies and sub-competencies articulated in the KEECC-A. It was during these initial studies, particularly the inductive study, which took an

iterative approach to identifying emergent themes, when I began to recognize possible elements of narrative imbedded in SP feedback. Form of SP feedback is the central phenomena of the present research. Thus, while both residents and SPs participated in the feedback discussion, this analysis focuses exclusively on the voice of the SP.

Participants

A total of seven SPs representing the Informed Consent and Health Disparities cases were included in this study. We developed two Health Disparities cases, one specific to surgical specialties and one specific to generalists, thus feedback from three unique case scenarios were included in this analysis. All SPs in this OSCE are female, ages 59 – 71; most are White (n = 4); and three are African American.

Data Sources and Management

My data sources consisted of 80 transcriptions of four-minute feedback sessions. Feedback sessions were transcribed verbatim, later redacting resident comments that were superfluous (e.g., utterances, off-topic personal conversations) to feedback delivered by the SP, leaving only those resident comments that provided context to the delivered feedback. I managed the data for the deductive analysis in Atlas.ti, a qualitative data analysis software. Atlas.ti was developed to be responsive to the cyclical and reflexive process imbedded in any narrative analysis, completely integrating all of the transcripts, and providing an integrated space for recording analytic memos or narrative ‘asides’ as I moved through my analysis.

Analysis

In framing narrative medicine, Charon (2006) advances five features unique to narrative knowledge in a medical setting. She suggests that each of these five elements must be present for a text to be considered narrative in nature. The first, *temporality*, addresses patients’ articulation

of time, which could be expressed in a variety of ways; years lived, years remaining to live, time spent with a doctor, respect for the patient's time in the office, the waiting room, etc. The second feature, *singularity*, acknowledges the unique quality of a patient's story, of their illness / condition. Singularity is in direct opposition to what Charon states as "the medical impulse toward replicability and universality" (p. 46). The third feature, *causality / contingency* refers not just to the 'plot' of a story, but the context and causal relationships inherent in them. *Intersubjectivity*, the fifth feature is reflective of social constructivism, in that it occurs when two subjects meet and interact, creating new understandings and ways of knowing that could not occur otherwise. An awareness of intersubjectivity acknowledges possibilities for new knowledge and understandings that are generated from the interaction. The final element, *ethicality* emerges only after the establishment of intersubjectivity. Ethicality refers to the moral choices one makes when hearing or telling a story of health and illness, how they choose to hear or share, and what they decide to do with this information. Charon herself acknowledges these five features are abstracted in nature, but advances them as a means to understand the structure and criteria of narrative in a medical setting.

A final important factor associate with my analysis included member checking with the SPs. Member-checking served as a quality measure to ensure I was reading and applying meaning to the narrative elements of their feedback, as they intended.

Findings

My preliminary awareness of the narrative possibilities of patient-centered feedback occurred during the prior iterative thematic analysis I conducted with these same feedback transcripts. Here, I noted five emergent categories and themes wherein SPs identified communication skills that could be framed in terms of specific tasks; (a) engaging in active

listening; (b) demonstrating components of enhanced autonomy (c) acknowledging culture grounded in the lifeworld; (d) demonstrating empathy; and (e) providing comfort through communication. Iterative analysis demands multiple readings of source data and rigorous documenting of findings. In this process, I began noting what appeared to be the presence of narrative elements in SP feedback. This was largely unanticipated because, during SP training, we never discuss feedback as a storied experience. Rather, we focus on feedback in a more or less bullet-pointed fashion. SPs are instructed to mention one or two items from the KEECC-A during the brief opportunity they have in the feedback sessions, sharing where they felt residents demonstrated effective communication as well as where the resident could use some improvement in communication with the SP. Instead, what I discovered in my multiple readings of the transcriptions is the remarkable manner with which SPs so effectively stayed ‘on task’, providing feedback focused on the details of the role they just portrayed, but infusing it with the passion of having lived through (either personally or through a loved one), similar health experiences. The fact that SPs instinctively engaged in a narrative approach while delivering feedback allowed for a greater breadth and depth of feedback than I had expected.

Applying Rita Charon’s (2006) advancement of the five features of narrative medicine, I identified the following elements throughout the SP feedback: (a) temporality; (b) singularity; (c) causality / contingency; (d) intersubjectivity; and (e) ethicality. Revisiting the feedback through this narrative lens, it is evident that SPs organically reflected each of these elements throughout the many feedback sessions. I structure the following discussion of the findings through these elements of narrative, including passages of SP feedback pulled directly from the transcriptions, while referring back to the previously identified thematic categories as a touchstone for elucidating each of the narrative elements.

The voices of all 7 SPs who participated in this OSCE are reflected throughout these findings, to varying degrees. As I move through the description and discussion of each of the narrative elements, I refer to the SPs by pseudonyms. I attempted to reflect their voices in the exemplars used in the findings, however, three SPs, Barbara, Morgan, and Sybil provided some of the most descriptive and illustrative feedback of all the SPs. Thus, theirs are the exemplars I found myself turning to, to typify the various codes.

Temporality

Speaking to the importance of temporality in narrative discourse, Charon (2006) states:

“Time is medicine’s necessary axis – in diagnosis, prevention, palliation, or cure. Time is, as well, the irreplaceable ingredient in the healing relationship: time to listen, time to recognize, time to care. Medicine becomes transformed if it is practiced with a real respect for time and timeliness” (p. 44).

This framing of time was specifically and consistently noted throughout SP feedback, as SPs commented on the resident making “an investment” (of time) in educating them or “going above and beyond” by taking the time to explain complicated terminology or treatment options to the patient and/or her family. Additionally, temporality was noted in residents taking the time to actively listen to the patient’s story. Barbara articulated this directly by stating:

“You know, that point just stuck with me. I said ‘she’s taking the time’ - because you know in your practice you could have a waiting room full of people and you know sometimes doctors just don't take the time - they give out the information, they throw the pills at you and get out – the next person is coming in and, uh, you took the time and that was very, very key to me.”

Singularity

Charon positions singularity as the antidote to the medical tendency for replication and clinicians' inclination to draw universal conclusions about their patients suffering and disease. Singularity, as its name infers embraces the subjective, unique qualities of each patient, acknowledging the unique quality of a patient's story, of their illness / condition. Singularity was noted in four different context points throughout the feedback sessions. The first was in the ability of the resident to actively listen and engage with the patient's story. Active listening conveys a genuine interest in the patient's story, and requires the resident to be engaged and responsive to the unique considerations of the patient (Robertson, 2005). Here, feedback spoke to the capacity of residents to actively listen both verbally when Frances said,

“You were listening to me, because you uh, asked me questions about my life, my situation, and you had suggestions and you compromised with me. So I really thought like, ‘ok he has his ears on, he’s listening to what I have to say’.”

and non-verbally, as articulated by Morgan :

“I liked your eye contact, that you were talking to me, you were listening to me – you heard everything I said, you weren’t rushing me, weren’t shushing me.”

The second time SPs noted singularity was when their feedback touched on the degree to which the resident demonstrated respect for them as individuals. Respect is reflective of singularity, in seeing the patient as a partner in the process of discussing therapeutic options and as a component of the articulated tenet of patient autonomy, which at its core, is the essence of singularity. Singularity as demonstrated through respect is evident in the following feedback from Barbara:

“You emphasized the repercussions of not taking the medication and you told me where the numbers should be and I thought, ok through patient education and the facts that you

gave me, um you respected me enough as an adult, as an intelligent person and let me make the decision.”

Singularity was also identified in patient feedback with regard to empathy, where the resident took note of patient fears or apprehension, expressing an understanding or a connection with the patient’s state of mind. Often entwined with empathy were moments of comfort measures extended to the patient that moved beyond focusing on cure or treatment, ameliorating the patient’s anxiety. Here, singularity is noted at those small opportunities during the encounter that fall in between the cracks of facts and dates and discussions of therapy - the intersections of time when the resident forged a connection with the SP by verbally or non-verbally acknowledging the deep and raw emotional and psychological elements of the illness narrative. The following quote from Wendy hints at the construct of singularity through demonstrations of both empathy (recognizing the patient’s fears), and comfort (offering to be a continued part of the ongoing care for this one, singular patient):

“I’ll see you in a little while”, that was such a nice little touch, ‘cause it made me feel like, I mean, you told me you’d get the nurse at the end and get the transfusion going and that, but it was like you’re not leaving me alone high and dry and that told me more than anything that you um, empathized with, you know, how scared and nervous I was about having the transfusion; it was like “don’t worry, I’ll be around, I’ll be back to check on you” – whatever, that eased my mind more than anything – and it was just a little thing and it came at the very end. I just smiled after you left, I was like oh that made me feel really good.”

Causality & Contingency

Causality and contingency in this feedback were entirely rooted to discussions of cultural health models, or other cultural considerations including the patient's family, gender, age, etc. Charon (2006) argues that causality and contingency are often at the heart of the 'plot' of a patient's story. Thus, in the two cases specific to health disparities, the central objective, or defining plot line, were the cultural beliefs of the fictional patient role (i.e., the belief that air will make a tumor grow in the surgical case; the fear of taking high blood pressure pills, in the medical case). Barbara illustrates an example of causality / contingency in the health disparity – surgical case, when she states:

“You took time to clarify things...did not make me feel inadequate - and even though I'm dealing with an old wife's tale that's been floating around the community, you were very respectful of it. You were going to look it up because “this could be something to this but still and all, I haven't heard it. In my training I haven't come across that yet, but I'm going to take the time” - that was wonderful, that really was.”

In the informed consent case, the plot revolved around ensuring the patient understood the treatment options, which was confounded by the patient's unfamiliarity with the medical jargon coupled with their trepidation about receiving a stranger's blood via a transfusion. SP feedback was largely positive when the resident demonstrated sensitivity to the patient's cultural standpoint, as indicated when Sybil stated:

“And I liked your approach on being thorough – your explanations. Yeah, that's what it was – hemoglobin – at first you were, uh – a lot of people don't know what that is. I used to think it was a medical name for blood - why are they using this long name, y'know? But you explained that it's a component of the blood, that carries oxygen. So that would

make a big impression on somebody who just thinks ‘I’m losing all this blood it’s no big deal, I’ll be ok, I’ll get through the day, I’ll function’”

Conversely, SP feedback, such as the following quote from Bette, was critical when the SP felt the resident overlooked one of the central ‘plot’ lines:

“Um, but still in my mind I told you I was afraid, I didn’t want someone else’s blood in me and stuff like that. I think um, when you did say this was the best option it was like, well what else is there? I mean cause in my mind I’m like isn’t there something else cause I didn’t want to have somebody else’s blood in me.”

By narratively addressing the causality and contingency of culture in their feedback, SPs provided pathways to ‘how’ residents could effectively address issues of culture by listening to and acknowledging the patient’s cultural understandings of health. Causality / contingency were also reflected in the ‘why’ residents should speak directly to cultural considerations, as SPs suggested the residents’ exploration of cultural concepts was critical to identifying unspoken factors (e.g., stressors of job, family, etc.) and as a means to address and potentially alleviate culturally-informed fears about illness and/or therapeutic measures.

Intersubjectivity

Charon (2006) notes that intersubjectivity between providers and patients is only achievable if clinicians commit to “listening to what patients (sic) tell us” (p. 53). This sentiment was accordingly noted in SP feedback. When SPs noted active listening was fully engaged by the resident, intersubjectivity was effectively realized, helping to positively foster the doctor-patient relationship as articulated by Sybil :

“But I did like your style of explaining everything, where you didn’t sound like a robot with statistics, this and this and this, you telling me the facts that you knew, but in a very

um, comforting way, that it was nothing to worry about, but not patronizing me, like “oh, tsk now, now, now”. You were very, very good explaining that it was my decision in the long run, that this is what you thought in your professional decision, so I thought you did a very good interview and conducted yourself very professional but also not um, minimizing my concerns, you were listening.”

Conversely, as discussed by Frances, when listening was not present, intersubjectivity was not realized, resulting in the forming of communicative barriers between the doctor and the patient:

“And, during the conversation, when I mentioned to you that I want something for my stress, I heard you continue, um, the conversation about my blood pressure and ((pause)) I felt you weren’t listening because, I had mentioned stress and I mentioned it several times, and it was like I felt like, um, you weren’t hearing what I was saying enough to ask me why was I feeling this stress? What’s going on in my life?”

Patients noted the degree to which the resident demonstrated both empathy and respect towards them also reflected intersubjectivity. Both respect and empathy require the dialogic process of balancing two perspectives. With regard to respect, particularly in making treatment decisions, physicians often need to balance the Western medical model with a patient’s culturally-informed health model. With regard to empathy, physicians should recognize the patient’s emotion, sensitizing it with their own responses, essentially maintaining clinical professionalism while connecting with the patient’s emotional state. In the following passage, Morgan’s feedback reflects that the resident appropriately demonstrated both respect and empathy, thus achieving an authentic state of intersubjectivity with the patient:

“So, what you did, I felt like, as a doctor, you educated me – and that did more to convince me to have surgery – that it was absolutely necessary...you heard me, and let me make the decision. You showed a lot of respect to me as a patient. You didn't assume I was so dumb that I couldn't make my own decision. You gave me the information and allowed me, you asked me, you know, well, “What makes you apprehensive?” and “I understand about your mom” and you were even apologetic about my mom, so I appreciated all of that - that’s really good - and if that’s the way you treat your patients just keep doing what you’re doing

Ethicality

The final element, *ethicality* emerges only after the establishment of intersubjectivity. Ethicality refers to the moral choices one makes when hearing or telling a story of health and illness, how they choose to hear or share privileged patient information, and what they decide to do with this information (Charon, 2006). As SPs noted when residents intersubjectively engaged in active listening and/or demonstrated respect for patients choosing treatment options, they were often, subsequently, speaking to residents’ demonstrations of ethicality. Specifically, ethicality was noted by SPs at those moments when residents offered to work with the patient’s family in understanding the full picture of the treatment options or when they were willing to stay with the patient during an invasive or scary therapy. Sybil offers an example of ethicality, stating:

“So I thought you were very, very understanding. You made me feel like you weren’t in a hurry to get out of here just like, “just do what I say” - you made me feel like this was an office visit, not an emergency room and gave me options, of um, you know, in talking to my family and explaining everything, that you’d be here, for me.”

Limitations

The narrative elements identified in this research are based on a 4-station OSCE at one urban Midwestern medical school. Consequently, these local and regionalized findings cannot be taken to reflect all SP programs, and certainly not all patient perspectives on patient-centered communication. Additionally, the structure of the fictionalized patient roles in this OSCE included only older (>50) women. While there was fairly equal representation of both black and white SPs, all SPs spoke English as their first language and born and raised in the United States. Clearly more research is indicated, including different genders, ethnicities, and other facets of cultural background (e.g., age, non-English speaking or English as a second language, and geographic location) to explore the nuanced ways in which narrative elements may or may not be present among other SP groups.

Implications

A primary concern for many educators committed to ensuring depth and breadth in patient-centered communication is the wholesale emphasis on outcomes-based approaches to establishing communication competence. The fear being, that the nuanced, complex character of meaningful doctor-patient communication may be completely overlooked in the array of checklists, simulated encounters, and outcomes data, currently privileged in communication training initiatives (Wear & Varley, 2007). The present research provides a first look at the form of OSCE-based SP feedback using the KEECC-A. In training, SPs are encouraged to facilitate feedback through the framework of the KEECC-A, which might lead to the conclusion that feedback would also be bullet-pointed, presented in a standardized format. Instead, SPs in this OSCE instinctively adopted a wholly narrative approach in providing feedback, integrating the five elements of Charon's advancement of narrative medicine in their feedback, namely (a) temporality, (b) singularity, (c) causality / contingency, (d) intersubjectivity, and (e) ethicality.

These findings offer a twofold opportunity for programs currently incorporating spoken SP feedback in OSCEs. Here, residency programs can continue to meet the expectations of accreditation, providing standardized opportunities to observe and rate clinical communication skills among residents, while providing richer, more nuanced discussions of communication competency via SP feedback. Additional considerations focus on enhancing the role SPs can play in providing narrative opportunities for learners, as described in detail, below.

Enhancing Narrative Possibilities with SPs

Particular to SP methodology, there have been specific calls for exploring narrative possibilities with SP methodology, turning toward the narrative of SP encounters and the SPs, themselves, when evaluating patient-centered communication (Meyer, 2010; Rose and Wilkerson, 2001). The present study is the first known research endeavor to directly engage SP voice as a means of informing greater understanding of patient-centered communication, but by no means should be the last. The two methodological suggestions that follow only scratch the surface of possibilities for incorporating narrative into the fabric of any existing SP program.

Narrative road-mapping. In terms of direct application, I have already started the process of engaging SPs in our program by working with them to further discuss and integrate some of the preliminary findings from this research. To this end, I have created opportunities to be more directly involved with training SPs, considering narrative elements imbedded in patient-centered feedback. Here, I have adopted a largely SP-centered approach to exploring the fictionalized OSCE roles from their perspective, working with SPs to formulate narrative roadmaps, with the hopes of providing greater utility and grounded understandings of how to use and apply the constructs in rubrics used for assessing communication skills, such as the KEECC-A.

During these sessions, I ask the SPs to consider and discuss their understanding, initially, of the competencies and sub-competencies reflected in the KEECC-A. Moving on to exemplars reflective of findings from the present research, I then ask SPs to consider concepts such as the degree to which the resident saw the patient as a unique individual (singularity), making treatment decisions cooperatively (intersubjectivity). Together, we explicate these and other potentially ambiguous terms in relation to the specific case content and role portrayal. In an attempt to infuse a narrative thread, I ask SPs to consider the degree to which the fictionalized role reflects their own lived experience. Additionally, we access videos of previous OSCE encounters and related patient-centered feedback sessions, to gain more insights and perspectives into the relevant communicative points of each case. Following these narrative roadmap discussions, I try my best to capture the SP's voice, documenting and explicating elements of our discussion, distributing the roadmap for SPs to review and provide feedback (e.g., clarifying points I may have misinterpreted or overlooked altogether) (For an example of a completed narrative roadmap recently completed on a newer OSCE case, see Appendix F). I have only recently embarked on this process with SPs, but my goal is to continue with this method through various OSCE cycles, updating roadmaps as new SPs, new voices, and new perspectives are introduced. I am committed to the fact that these roadmaps are a work in process, continuing to evolve, resulting in ongoing iterations.

Extending Charon: opportunities for parallel feedback. Parallel charts are a writing exercise Rita Charon (2006) created for medical students in their clerkship year (3rd year) of medical school. Parallel charts are an opportunity for students to reflect on patient interactions above and beyond documenting clinical findings in legal hospital charts. Parallel charting requires students to create a separate narrative chart, a journal of sorts, in which they record their

impressions, feelings, and reactions to clinical patient encounters. Charon uses parallel charts as an enhancement to traditional charting methods, allowing students to engage evocatively in ways that are not permissible when documenting facts and findings in the patient chart. Following every patient encounter, students and residents are expected to chart a patient's findings using conventions established by medical and legal communities, reducing the patient's experience to a series of differential diagnoses, lab tests, and acceptable chart notations. Similarly in OSCEs, SPs are often required to deliver patient-centered feedback, which as indicated in the findings of this research are far more narrative in nature than I had previously assumed to be true. What remains true is that due to the constraints of OSCE frameworks, feedback sessions are restricted to the arbitrary nature of available time in the OSCE, which in the present research was four minutes per feedback session. These limits to frameworks, whether restricted by time (in the OSCE) or by language (in clinician charting) are essential to establishing one lens of understanding of their respective environments, yet neither can begin to address the full complexities and nuances imbued in the discourse between physician and patient. Parallel Charts, or, as they can potentially be extended within the context of SP methodology, Parallel Feedback, present an opportunity for forging new insights into these communication-based feedback, offering the potential of yielding new understandings of what patients desire when communicating with their physicians.

The operationalization of Parallel Feedback exercises could take on many forms. To mirror Charon's implementation of Parallel Charting provides one 'ready-made' approach. Here, after assessing a student with a rubric, SPs would then have an opportunity to write, in their own words, and in any style of their choosing (a letter to the resident, poetry, prose etc.), the feedback they would have given the resident, inclusive of and / or beyond the structured feedback of

KEECC-A. SPs would be asked contextualize their narrative of feedback, to reflect on the nuances of the interaction, and most importantly, SPs would be given ‘permission’ to dig deeply and evocatively as they explore their responses. Ideally, SPs would be given flexible amounts of time to engage in this process. The entire premise behind SP feedback is to enrich the learner’s understanding of their communicative strengths and challenges, so unlike Charon’s Parallel charts, which are not shared with patients, some version of the written charts should be shared with learners, preferably by the SPs, themselves. Understanding how best to facilitate this sharing would take some considerable thought and reflection, to ensure learners are receiving substantive feedback that enriches their understanding of communicative elements that matter most to their patients, whether standardized or in actual clinical settings.

Conclusion

Teaching and evaluating clinical communication skills is a daunting task. Communication is an evolving, subjective, wholly human undertaking that does not always fit neatly into tidy assessment rubrics or the fabricated parameters of simulation environments. However, as this research indicates, there are narrative opportunities available even within these academically constructed patient simulations. Additionally, as SPs are a mainstay of medical educational practices, it is in our best interest to continue to identify opportunities for expanding possibilities in communication skills training and assessment, whether by applying narrative approaches or other humanistically-oriented paradigms.

Chapter 6: Widening the Lens: Crystallized Implications of SP Feedback

I have always gravitated toward multiple perspectives, diverse interpretations, and various understandings of phenomena. This search for multiplicity is prominent in the nature of health communication scholarship I am drawn to, as evidenced by the use of crystallization (Ellingson, 2009) applied in the present body of research. Professionally, I have worked for over the past 25 years in various facets of medical / health / research fields, but have found my academic and professional home in medical education, developing and implementing curricula for training and assessing patient-centered communication skills. As such, I am acutely aware of inherent contradictions that exist in the development of medical educational communication training and assessment approaches. In theory, best practices for training and assessing clinical communication are reflective of the biopsychosocial model, recognizing the patient as contextualized by complex factors of their biomedical (illness) presentation, as well as their personal life and social environment (Engel, 1977; Gray, 2011). In practice, however, communication training programs and assessment tools remain anchored to reductionist traditions of the biomedical approach, reflected in checklists used to measure discrete communication and relational skills. Additionally, despite assumptions that learners should be educated and assessed on the degree to which they position the patient at the center of the communicative encounter, there is not one known communication assessment measure directly informed by what Mishler (1984) refers to as voices from the “lifeworld”. Instead, clinical communication scholars implicitly honor the biomedical tradition of beneficence, speaking on behalf of lifeworld voice, advancing criteria as experts in patient-centered communication, believed to best represent the lifeworld perspective.

My dissertation research fixes a direct lens on patient-centered feedback provided by standardized patients (SPs) during a residency-level Objective Standardized Clinical Exam (OSCE). On a meta-methodological level, my analysis is informed by Laura Ellingson's (2009) advancement of crystallization. Here, I dendritically explore three different facets of SP voice as enacted through patient-centered feedback. Crystallization allows for rich exploration of phenomena through multiple methods of analysis, embracing possibilities across the scope of qualitative approaches ranging from analytical to performative. In this research, two of the methodologies utilized, (a) iterative thematic analysis, and (b) narrative analysis, fall within the qualitative spectrum of research inquiry. The third methodology, content analysis, takes a deductive approach. Through incorporation of this quantitative methodology, I extend the boundaries of crystallization by stepping out of the realm of qualitative, positioning an epistemologically divergent way of knowing.

In the following discussion, I address the findings of the research itself, not restating the particular outcomes of each study, but rather widening the lens. Here, I focus on the larger picture and ways in which these findings speak to one another, potentially forging new understandings of reductionism and reconstituted narratives. Additionally, I offer suggestions based on these crystallized findings for moving forward, with specific considerations for extending the KEECC-A as well as considering other communication-focused assessment and programmatic initiatives. Lastly, I suggest avenues for further scholarship for both health communication and medical education scholarship.

In representing these final thoughts, I shift gears, once again, with regard to representation. Providing a form of parallelism with the poetic introduction in the preface of this research, in this final chapter I take the opportunity to weave in additional artistic and reflective

elements. Here, I frame each section with a personal reflection or philosophical musing from scholars and literature used to inform this dissertation research. In doing so, I hope to honor through this (purposeful) aesthetic, the beauty of multiplicity and the singularity of my individual research journey while discussing the various facets of my findings.

Reflections on Reductionism

I (Simone) remember the unique study identifier of the first woman I ever enrolled in a breast cancer research study. 30036. She was not the first woman placed in the study, but she was the first subject I ever, personally, enrolled. I also remember her name, which of course I will not speak to here, or anywhere, being bound to confidentiality. I am sure 30036 has long since passed away, although I would have no clue as to when, where, or how she may have died. But I do find myself thinking about her, from time to time and wondering about the trajectory of her life, and whether or not she was a happy person, a kind person, a lonely person. What I do know about her is that she was a part of a large-scale study that provided invaluable insights into estrogen receptors and breast cancer risk, and consequently she has had a profound impact on the health and well-being of generations of women struggling with a diagnosis of breast cancer.

Often, when I consider reductionism, I reflect back on study participant #30036. Here, I consider the ways in which reductionist approaches are respected for synthesizing findings, providing novel insights and understandings (often partial, but understandings, nonetheless) of compelling questions about health and illness. I also acknowledge the concerns about reductionism, the manner in which it serves to remove nuance and context, particularly in the scope of health communication (Goyal et al, 2008). I fully embrace the view that patient-provider communication is complex, fluid, historically and culturally situated. I also

acknowledge that the current climate in which we conduct and publish clinical communication research is heavily outcomes-based. Although I share in some of the misgivings of the prevailing emphasis on checklist data serving as the most accurate measure of effective communication, I acknowledge that this kind of inquiry presents one viable way of knowing about learners' communication skills. Furthermore, I acknowledge that a dramatic reversal of this outcomes-dependent culture is not going to happen overnight. From this standpoint of accepting reductionism as one illuminating facet of the crystal, I equally suggest as an imperative, that we acknowledge and include communicative elements that resonate most with lifeworld experiences.

In this research, I focused on lifeworld voice by engaging with Standardized Patient (SP) feedback as SPs referenced the unique elements of the adapted version of the Kalamazoo Essential Elements of Communication Checklist (KEECC-A). Addressing the findings of the content analysis as a stand-alone study, SPs consistently and notably expressed a desire for forging an interpersonal connection with the resident. Here, relational elements were imbedded in the most frequently referenced elements of the KEECC-A, namely the areas of sharing information, building a relationship, and gaining understanding the patient's perspective constituted the majority of KEECC-A informed feedback.

Comparing these findings with findings from the two other methods, a more complex picture of the doctor-patient communicative relationship emerged. The desire for interpersonal connection was again identified, revealed (a) through the thematic finding of building intimate partnerships with physicians through comfort communication and enhanced autonomy, and (b) through the narrative element of inter-subjectivity. Adding some complexity to this idea of a partnership, the thematically emergent category of enhanced autonomy revealed that patients had

a desire for residents to serve as a clinical-expert guide for the patient, ushering them through difficult therapeutic decisions while being respectful of the patient's independence and ensuring to maintain their autonomy. Additional findings from the thematic analysis bring front and center gaps in the KEECC-A instrument related to forging an interpersonal connection through identified themes of patient desire for greater empathy, acknowledging cultural constructs, and the appeal for elements of empowered autonomy (i.e., respect & being informed and invested). By considering all of these findings it is evident that SPs reflect a desire for communication to move beyond what Goyal et al. (2008) refer to as "the static aspects of the doctor-patient relationship" (p. 735) instead, looking for communication that is situated in the fluid and dynamic context of their lived experience.

Reconstituting Narratives

"Basically, what you're supposed to do is take a walking, talking, confusing, disorganized (as we all are) human being...take it all in, put it in the Cuisinart and puree it into this sort of form that everyone can quickly extrapolate from. They don't want to hear the story of the person. They want to hear the edited version." (3rd year medical student, quoted in Taylor, 2003 p. 558)

Patients enter the clinical world with stories to tell; stories about body, identity, illness and health (Geist-Martin, Ray, & Sharf, 2002). As passionately explicated by the anonymous student in the above quote, despite the call for embracing patient narratives and conducting patient-centered interviews, a prevailing initiative of medical practice is to reduce the patient to a discrete set of history and physical exam 'findings' all of which support a clear and concise differential diagnosis, succinctly recorded in a patient chart. To this end, in medical-educational environments, these stories are used to inform the development of fictionalized patient roles for

OSCEs, upon which assessments about clinical competence can be made. Evaluation tools such as the KEECC-A are developed to specifically assess communication and interpersonal competence; in an effort to make them manageable for use, all of the complexity and chaos of patient stories are whittled down to finite lists of items, easy to check off a box, or quantify on a Likert scale of 1-5. Such is the pragmatic method of an outcomes-based culture.

In some OSCE environments, such as the ones conducted at my own home institution, SPs have an opportunity to provide spoken patient-centered feedback to the learners, following the patient encounter. While there appear to be no known studies evaluating the content of this feedback, there is a great deal of research indicating favorable responses to SP feedback (Bokken, Linssen, et al., 2009; Harter & Kirby, 2004; Lane & Rollnick, 2007). The question remains: what are the qualities of SP feedback sessions that appeal to learners' sensibilities?

Looking at the form of feedback included in my research, I identified a narrative thread, wherein SPs reconstituted the narrative spirit that was lost during the process of reducing the encounter to fit on a checklist. What these findings indicate is the power of SP feedback to reconstitute the narrative that is fragmented through the development of the KEECC-A and other similar assessment tools. Gray (2011) suggests that patient narratives offer a construction of meaning; thus, by reconstituting the elements of the KEECC-A into a narrative framework, SP feedback allows for a lived context, providing relevance and instilling meaning in their discussions with residents.

With regard to content, through this narrative feedback, residents in this OSCE were invited to understand in a storied way, the discrete elements of the KEECC-A that mattered most – and least - to the SP. As evidenced by the outcomes of the content analysis, residents heard, across all cases, those communicative elements most utilized – and potentially most valued - by

SPs. The thematic analysis deepened and extended the meaning of these checklist items. An example of this is the most frequently referenced KEECC-A competency, ‘Sharing Information’. This item was fleshed out by the emergent category of enhanced autonomy; here SPs didn’t simply speak to a static notion of sharing information as articulated by the KEECC-A. Instead, patients expressed the desire for information, including all the risks and benefits, coupled with the resident providing their expert opinion, while still respecting the right of the patient to make the final (therapeutic) decision. This concept of enhanced autonomy is further reinforced narratively through a coalescing of the elements of singularity (seeing the SP as a unique individual), intersubjectivity (working together toward a therapeutic decision) and ethicality (giving the SP the final, autonomous, choice).

Additionally, the narrative reconstitution of feedback provided residents with extensions of communicative elements that extended the limits of the KEECC-A, elements that would have been unaddressed absent the feedback opportunity. Specifically, SPs openly shared with residents those times when they neglected to offer alternatives to the patient, or left the patient wanting for greater displays of empathy or comfort. For those residents who successfully built a connection with the patient, they heard firsthand the nuanced ways in which they forged that connection, sometimes through an honest discussion of therapeutic pros and cons, other times through a simple gesture such as a touch on the shoulder or handing the patient a tissue. Essentially, SP feedback carves out an opportunity for the learner to, as Charon (2006) advances, ‘bear witness’ to the patient’s inner thoughts, to forge pathways to those communicative intersections of human connection. DasGuptas (2008) speaks to the concept of ‘narrative humility’, where clinicians enter in to the suffering of the patient’s lived experience. SP feedback

creates an opening for those moments, demonstrating pragmatically that connecting with patients on a deeper level may be attainable in clinical practice.

Interrupting the Voice of Medicine: Essential Elements of Lifeworld Communication

“You can hitch your wagon to the stars, but you can’t haul corn or hay in it if its wheels aren’t on the ground” – Miles Horton, “The Long Haul”

Reflective of the prevalent trend in development of communication assessment tools, the KEECC-A was expert developed, devoid of engagement with lifeworld voices. As implied by Mishler (2005), by not making room for lifeworld voices, we run the risk of overlooking grounded elements of lived experience, elements that may be most relevant to the health and well-being of patients. Furthermore, the wholesale dependence on expert-driven criteria may be one reason biopsychosocial approaches have yet to gain meaningful traction in medical education and clinical practice.

One of the primary goals of this research was to engage with SP feedback as a means of exploring lifeworld considerations specific to patient-centered communication. To this end, I conducted multiple analyses not only of the expert-articulated communication competencies, but the sub-competencies as well. To a large degree, the sub-competencies define the true educational utility of the KEECC-A, as they represent the detailed and nuanced criteria for each of the competencies, operationalizing specific positive and negative behavioral qualities designed to improve resident’s overall communication and interpersonal skills. This is the first known study to explore the sub-competencies, and having done so under the meta-method of crystallization allowed for deeper, more nuanced findings than may have been realized from just one form of inquiry. Here, the content analysis created an opportunity to understand which sub-competencies were most / least frequently accessed by SPs as represented in these specific OSCE

cases. Analyzing the same transcripts through an iterative, thematic lens provided a richer understanding of these elements, and engaging with narrative analysis contextualized them, providing deeper understandings of the elements as storied opportunities.

For example, engaging with content analysis identified ‘a mutual understanding of the treatment plan’ was by far the most referenced sub-competency. The thematic analysis explicated the term ‘mutual understanding’ as an indicator of the emergent theme of enhanced autonomy, wherein the resident respectfully informed the patient, investing time ensuring the patient understood (a) options for treatment and (b) what they (the resident) would recommend. Narrative analysis further enriched the importance of this sub-competency as a marker of singularity, or seeing the patient as an individual, with unique needs.

Additionally, engaging with multiple forms of inquiry allowed for findings to move beyond explicating and enriching existing sub-competencies, identifying communicative elements reflected in SP feedback that had been removed or overlooked by the authors of the KEECC-A. Findings from the content analysis revealed the existence of undefined characteristics of some of the competencies. Thematic analysis not only filled in some of these ‘gaps’ by identifying missing sub-competencies (e.g., empathy, active listening, culture), but also yielded an entirely new element for consideration, that of ‘communication as comfort’. Narrative analyses provided the much-needed cohesion for each of these, serving to validate SP feedback as a storied opportunity for learners, providing context and meaning to the KEECC-A’s reductionist elements.

Gaining this richer understanding of the various findings of this research can be directly applied to extending and enhancing the KEECC-A by incorporating the language of the lifeworld. Consideration should be given to piloting a new version of the KEECC-A, replacing

some of the more abstracted sub-competencies articulated in the existing checklist. For example, as indicated, the competency of ‘shares information’ is explicated with the abstracted concept such as ‘mutual understanding of a treatment plan’; this can be replaced with sub-competencies reflective of the lifeworld findings in the present research such as ‘provided pros and cons of possible treatment options’ and ‘respected patient to make final treatment decision’. Furthermore, reintegrating essential communicative elements initially included in the original Kalamazoo Consensus Model such as empathy, active listening, and culture would strengthen the utility of the KEECC-A both as more reflective of the body of existing communication scholarship (see Calhoun et al., 2009; Fassaert, et al., 2007) as well as a grounded and salient measure of lifeworld voice.

Advancing Scholarship in Health Communication & Medical Education

Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry [we] pursue in the world, with the world, and with each other – Paulo Freire

The findings from this dissertation research offer a wealth of opportunities for future inquiry, for both health communication and medical education scholars. Despite providing new and exciting insights into rubrics such as the KEECC-A and SP feedback, knowledge gained through this process is ultimately partial. Some of the inherent limitations in this body of research include the SP sample being largely homogenous (Midwestern, older females, exclusively native English speaking), limited to feedback reflective of three cases reflective of everyday communication. Health communication scholars such as myself, imbedded in medical education environments can extend and expand the scope and possibilities of similar research,

exploring a variety of cases, working with a range of SPs reflective of different regions, ages, and cultural backgrounds.

Methodologically, this research embraces and extends Ellingson's (2009) articulation of crystallization, which promotes accessing methodologies across the paradigmatic continuum of qualitative approaches, including analytic, performative, interpretive, postpositive, and artistic, but stops short of post-positive / quantitative research. As an interpretive scholar working in a medical educational environment, I am faced with the reality that to forge a scholarly connection with traditional scholars that dominate this field, it is a pragmatic necessity that I engage in forms of inquiry that have a hope of being published. Additionally, I acknowledge that reductionism provides a unique way of knowing about phenomena. In extending crystallization through post-positive inquiry, I hope to encourage other scholars to continue pushing epistemological and ontological boundaries, ultimately recognizing that knowledge gained through any form of inquiry is contingent, partial, and ultimately just one aspect of a much larger 'conversation' between scholars.

Conclusion

Teaching and evaluating clinical communication skills is a daunting task. Communication is an evolving, subjective, wholly human undertaking that does not always fit neatly into tidy assessment rubrics. And yet, the practice of medical education, reflective of the trend of education in general, is largely driven by outcomes measures. Accordingly, choices have to be made about what stays in and what stays out of assessment tools. To date, available measures of communication skills have been developed exclusively by medical educators. Using a crystallized approach to inquiry, the findings from the multiple studies included in this research reveal opportunities for rethinking form and content of assessment measures. Using SP

methodology, this research offers a first-look at patient-centered communication through SP feedback as reflective of the lifeworld perspective. In doing so, this research attempts to honor the voices of the lifeworld, providing them with an opportunity to step out of the academically imposed margins, realizing both Mishler's (1984) original call for interrupting the voice of medicine and potential advancement of Engel's (1977) vision for a biopsychosocial model of patient care.

APPENDIX A

Kalamazoo Essential Elements Communication Checklist (adapted)*

How well does the learner do the following:					
	<u>1</u> Poor	<u>2</u> Fair	<u>3</u> Good	<u>4</u> Very Good	<u>5</u> Excellent
A. Builds a Relationship (includes the following):					
<ul style="list-style-type: none"> • Greets and shows interest in patient as a person • Uses words that show care and concern throughout the interview • Uses tone, pace, eye contact, and posture that show care and concern 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Opens the Discussion (includes the following):					
<ul style="list-style-type: none"> • Allows patient to complete opening statement without interruption • Asks “Is there anything else?” to elicit full set of concerns • Explains and/or negotiates an agenda for the visit 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Gathers Information (includes the following):					
<ul style="list-style-type: none"> • Begins with patient’s story using open-ended questions (e.g. “tell me about...”) • Clarifies details as necessary with more specific or “yes/no” questions • Summarizes and gives patient opportunity to correct or add information • Transitions effectively to additional questions 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Understands the Patient’s Perspective (includes the following):					
<ul style="list-style-type: none"> • Asks about life events, circumstances, other people that might affect health • Elicits patient’s beliefs, concerns, & expectations about illness & treatment • Responds explicitly to patient’s statements about ideas and feelings 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Shares Information (includes the following):					
<ul style="list-style-type: none"> • Assesses patient’s understanding of problem and desire for more information • Explains using words that patient can understand • Checks for mutual understanding of treatment plan • Asks if patient has any questions 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Reaches Agreement (if new/changed plan) (includes the following):					
<ul style="list-style-type: none"> • Includes patient in choices and decisions to the extent s/he desires • Asks about patients ability to follow diagnostic and/or treatment plans • Identifies additional resources as appropriate 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Provides Closure (includes the following):					
<ul style="list-style-type: none"> • Asks if patient has questions, concerns or other issues • Summarizes / asks patient to summarize plans until next visit • Clarifies follow-up or contact arrangements • Acknowledges patient and closes interview 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Adapted from Essential Elements: The Communication Checklist, ©Bayer-Fetzer Group on Physician-Patient Communication in Medical Education, May 2001, and from: The Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education. Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement. *Academic Medicine* 2001; 76:390-393. **Contact:** Elizabeth Rider, MSW, MD – elizabeth_rider@hms.harvard.edu (member, Kalamazoo Consensus Group) 3/2007

APPENDIX B

Wayne State University School of Medicine Graduate Medical Education
OSCE Case Descriptions

OSCE Cases	Case Synopses
Informed Consent (IC)	Ida Creswell is a perimenopausal patient, 51, who has been admitted to ER because of dizziness. Patient has orthostatic hypotension (dizziness). When tested, her hemoglobin is 5.4, which is dangerously low. The patient discloses that her OB has prescribed iron to her in the past, but that she doesn't usually take it. The physician explains what anemia is, how serious it can be and how it can be treated; that recommended treatment for this level of severity is transfusion. The patient expresses concern about needing a transfusion, with a belief that it could be risky.
Error Disclosure (ED)	Edna Davenport is a 56-year old African American woman currently in the ICU following a heart attack. Upon arrival at the hospital she made sure that her iodine and iodine derivatives allergy was clearly identified in her chart. Ms. Davenport required an arterial blood gas due to respiratory distress; this was initially attempted in her right (dominant arm). However, skin was prepped with Betadine (an iodine derivative) and the patient developed severe blistering in the area. The site now requires burn care. The ABG had to be performed on the other arm. The error will cause permanent scarring and temporary pain. The burn area is in pain. Error happened under sedation.
Delivering Bad News (DBN)	Dena Roberts is a 71-year old woman currently in the hospital being treated for congestive heart failure (CHF). This is her third admission in the past six months. Despite the doctors' best efforts, including trying many different drugs and drug combinations Dena is not getting any better, and is, in fact, worsening. Earlier today the medical team met to discuss the case and they determined that medical science could do nothing more for the patient. The resident is coming to your room to discuss the team's findings and to discuss a "code status".
Health Disparities – Medical Residents (HD-M)	Terry Phillips is a middle-aged (age range 40's – 60's), overweight patient and is in the office for work (Department of Transportation) PE. Terry is under a great deal of stress and recently attended a community health screening where she was told she had high blood pressure. The patient feels she needs medication to help reduce the stress levels and reports that she is managing the HBP with garlic tabs. The patient does not believe she has much control over her weight as she thinks a "fat gene" runs in her family.
Health Disparities – Surgical Residents (HD –S)	Casey Denham is a middle-aged patient, 51, and is in the office for a surgical consult for a gastrectomy. Casey had seen her primary care physician previously with complaints of loss of appetite, nausea, and

	<p>heartburn. An upper GI series and gastroscopy / biopsy showed stage 2 adenocarcinoma of the stomach. The patient does not want the surgery due to her mother having died from stomach cancer; Casey believes that the surgery her mother underwent exposed the cancer to air, which caused the cancer to metastasize. The patient expresses concern about needing this surgery, maintaining that it is more dangerous than the cancer itself.</p>
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APPENDIX C

Wayne State University School of Medicine Graduate Medical Education OSCE Overview

Prior to the OSCE

SPs received the following training*:

- Case (role) portrayal
- Assessing residents' communication and interpersonal skills using the KEECC-A tool
- Providing verbal patient-centered feedback to the residents, using the framework of the 7 communication competencies / supporting sub-competencies on the KEECC-A. As SPs are allowed only four minutes in which to discuss feedback with the resident, they were instructed to pick one or two items from the rating scale that they particularly wished to emphasize each resident.

Total training time per SP: 4 - 6 hours

Residents attended an OSCE orientation session, which included*:

- An overview of the educational goals and objectives of the OSCE.
- Overview of the OSCE logistics.
- A discussion of KEECC-A scale, to make them aware of the scoring and feedback rubric.
- Residents were also required to complete on-line modules covering Communication and Interpersonal Skills, Professionalism, and Systems-based practice offered via GME Today, a third-party vendor utilized by the WSU-SOM GME Programs.

The OSCE

Residents arrived 15 minutes prior to the start of the OSCE to obtain their exam booklets*, which included patient 'door notes'.

After reading instructions, residents were escorted to the patient corridor. Each resident rotated through all 4 of the patient encounters.

Each patient interview lasted 9 minutes.

Immediately following each interview, residents exited the room to give the patient 3 minutes to complete the rating form. During this time, the resident also completed a self-reflection (using the KEECC-A rubric) at a computer terminal.

Residents then returned to the room where they were given 4 minutes to hear and discuss patient-centered feedback, with the SP.

OSCE Debriefing

Immediately following completion of all four stations, residents were required to attend a 30-minute group debriefing. Debriefing was conducted by Residency Program Director(s) and a WSU-SOM GME faculty member. During this debriefing, Residents were asked to reflect on the OSCE and were encouraged to continue using the KEECC-A as a framework for communication and interpersonal engagement with actual patients.

*Author may be contacted for copy of OSCE Resident Instruction Booklet.

APPENDIX D

CONTENT ANALYSIS CODING PROTOCOL

Residents participate in Objective Structured Clinical Examinations (OSCE) at the Kado Clinical Skills Center at Wayne State University School of Medicine (WSU-SOM). These examinations are fictionalized doctor-patient encounters, during which an SP plays the role of a patient with a health problem.

There are three types of doctor-patient encounters:

1. Informed Consent
2. Health Disparities- Surgical
3. Health Disparities-Medical

Immediately after the doctor-patient encounter, an SP provides feedback to the resident. The SP informs the resident about both strengths and weaknesses in the exhibited communication, from the patient's perspective, as well as possible suggestions for improvement. The feedback is given face-to-face in the allotted four minutes. SPs have been trained to provide feedback grounded on the adapted version of the Kalamazoo Essential Elements of Communication Checklist (KEECC-A).

For this project you will be coding transcripts of feedback provided by Standardized Patients (SPs) to medical and surgical Residents.

To facilitate and streamline the coding process, you will code the Feedback transcripts in three batches, each batch will contain transcripts for one case type.

To orient you to OSCE process as experienced by the residents and SPs, you will be provided with the complete SP training materials for each case. It is important that you read over the case materials before coding, as the SPs refer regularly to the case content and objectives established for the residents relative to each case. You will also be provided with a copy of the KEECC-A which was used by the SPs in evaluating the residents' communication and interpersonal skills.

When beginning to code a feedback session, start by reading the entire transcript.

You will be coding the feedback deductively, meaning the codes and the definitions of the codes have already been determined. The codes are established by the KEECC-A instrument and clarified by the formal training the SPs were required to attend at the Clinical Skills Center.

The unit of analysis for this coding project is '**complete statements**' made by the SPs. Usually, each box of SP text corresponds to a unit of analysis. The resident's side of the conversation is included to provide context only, and is not to be coded.

Coding the KEECC-A elements:

The KEECC-A is divided up into 7 defined Communication Competencies (CC).

Each of the 7 competencies is defined by a series of “Sub-Competencies” (SC), developed to provide users of the KEECC-A with some operationalized understanding of the corresponding category. The coding process should be as follows:

- Ensure you have read over the appropriate case materials prior to coding.
- Read the entire feedback transcript before beginning to code complete statements.
- Code ALL SP ‘complete statements’ **only** (NOT the resident’s statements)
- CCs and SCs are defined in the K-Table (attached)
- CCs should be coded first
- Corresponding SCs are coded next
- In some cases a CC may be identified with no corresponding KEECC-A defined SC – in this case the SC should be coded as NA.
- The final coded element is the *valence* of the specific feedback provided:
 - Is the SP feedback generally positive (something the SP liked about the resident’s communicative behavior)
 - Is the SP feedback generally negative (something the SP did not like / would like the resident to change with regards to their communicative behavior)
 - Is the SP feedback neutral (SP commented but did not qualify if it was positive or negative in nature)
- Be aware that in some of the SP complete statements, the SP does not specifically reference either a CC **or** a SC; in those cases, code all fields as “99”.
- In other statements, there may be **multiple codes**. Sometimes the feedback is intertwined within one complete statement, reflecting more than one CC and/or SC in the SP’s narrative – these can be tricky to isolate, but this will be addressed in training and, hopefully, through discussion and practice, you will have a keener sense of how to code these challenging passages.

Coding the Miscellaneous (SP Training-based) Elements:

- Following the K-Table coding, there are several miscellaneous categories, which are reflective of SP training. Please reference the Miscellaneous Codes Table, to code these categories.
- It is important to re-read or reference the entire transcript when coding these variables and not to assume you can recall accurately.

General notes about coding for this project:

- The voice we are focusing on is the **voice of the SP giving feedback** – understanding that the SP may adopt up to two distinct voices, which may be interchangeable; that of the patient role they just portrayed **and** that of themselves, through the lens of their own lived experiences either as a patient and /or as a lay educator.

- Reference the Resident’s textual passages to help provide context for coding some of the SP feedback.

K-TABLE

KEECC-A Behavioral Anchor Codes

NOTE: Code all fields ‘99’ if SP complete statement is not reflective of any CC / SC.

KEECC-A Communication Competency 1: Builds a Relationship – if present, code “1” in CC Column		
**For each CC/SC identified indicate if feedback is positive (= 1) negative (=2) or neutral (=3) **		
Sub-Competencies for “Builds a Relationship”	SC Code	Clarifying information
<i>Greets and shows interest in patient as a person</i>	If present, code = 1	Use this code anytime the SP comments on <i>listening skills in general</i> (e.g., SP states “you are a very good listener”)
<i>Uses words that show care and concern throughout the interview</i>	If present, code = 2	Verbal
<i>Uses tone, pace, eye contact, and posture that show care and concern</i>	If present, code = 3	Non-verbals; Include mention of facial expressions, touching, hand-shakes
<i>No KEECC-A defined SC identified</i>	Code = NA	

KEECC-A Communication Competency 2: Opens the Discussion – if present, code “2” in CC Column		
**For each CC/SC identified indicate if feedback is positive (= 1) negative (=2) or neutral (=3) **		
Sub-Competencies for “Opens the Discussion”	SC Code	Clarifying information
<i>Allows patient to complete opening statement without interruption</i>	If present, code = 1	Use only if SP explicitly comments on <i>interruptions</i> or being <i>cut off</i> by the resident. This is easy to confuse with #33.
<i>Asks “Is there anything else” to elicit full set of concerns</i>	If present, code = 2	Note: this is different from asking “is there anything else” at the CLOSE of the interview. This refers to the resident making sure they covered all bases during the interview – ensures the resident is keeping the <i>dialogue open throughout the interview.</i>
<i>Explains and/or negotiates an agenda for the visit</i>	If present, code = 3	Resident states <i>at the beginning of the interview</i> exactly what they are going to discuss and address with the patient during this patient visit.
<i>No KEECC-A defined SC identified</i>	Code = NA	

KEECC-A Communication Competency 3: Gathers Information – if present, code “3” in CC Column		
**For each CC/SC identified indicate if feedback is positive (= 1) negative (=2) or neutral (=3) **		
Sub-Competencies for “Gathers Information”	SC Code	Clarifying information
<i>Begins with the patient’s story using open-ended questions (e.g., “tell me about...”)</i>	If present, code = 1	
<i>Clarifies details as necessary with more specific and/or “yes/no” questions</i>	If present, code = 2	
<i>Summarizes and/or gives patient opportunity to correct or add information</i>	If present, code = 3	Pertains to allowing (giving time to) the SP to clarify / add relevant information . It is not quite the same as interrupting the SP, which is covered under #21, and is more about keeping the discussion open and balanced.
<i>Transitions effectively to additional questions</i>	If present, code = 4	
<i>No KEECC-A defined SC identified</i>	Code = NA	

KEECC-A Communication Competency 4: Understands Patient Perspective – if present, code “4” in CC Column		
**For each CC/SC identified indicate if feedback is positive (= 1) negative (=2) or neutral (=3) **		
Sub-Competencies for “Understands Patient Perspective”	SC Code	Clarifying information
<i>Asks about life events, circumstances, and/or other people that might affect health</i>	If present, code = 1	Pertains to criteria external to the portrayed patient’s lived experience (outside the patient’s consciousness / psyche) (e.g., Resident asks SP if their family / friends are supportive, or discusses SP’s stress)
<i>Elicits patient’s beliefs, concerns and/or expectations about illness and/or treatment</i>	If present, code = 2	Pertains to criteria internal to the portrayed patient’s lived experience; their internalized medical / illness model. (e.g., Resident taps into what the SP thinks / believes about their illness and/or possible treatments being discussed)
<i>Responds explicitly to patient’s statements about ideas and/or feelings</i>	If present, code = 3	Use this code anytime the SP comments on the resident listening to specific criteria . (e.g., SP states “you really listened to me when I mentioned XXX” or “you really heard that I was scared about XXX”)
<i>No KEECC-A defined SC identified</i>	Code = NA	

KEECC-A Communication Competency 5: Shares Information – if present, code “5” in CC Column		
**For each CC/SC identified indicate if feedback is positive (= 1) negative (=2) or neutral (=3) **		
Sub-Competencies for “Shares Information”	SC Code	Clarifying information
<i>Assesses patient's understanding of problem, and/or desire for more information</i>	If present, code = 1	Resident asks what the SP thinks the problem is – what is causing the problem and/or if the SP even wants to know more about the problem.
<i>Explains using words the patient can understand</i>	If present, code = 2	Use this code anytime they mention jargon and/or when they comment on the degree to which the resident explained something to them in lay-terms
<i>Checks for mutual understanding of treatment plan</i>	If present, code = 3	Resident ensures the SP understands what the treatment would involve (e.g., risks, benefits)
<i>Asks if patient has any questions</i>	If present, code = 4	Use this code when the SP comments on the resident asking clarifying questions during the course of explaining something to the SP – this is not the same as the ‘closure’ question (under “Provides Closure”)
<i>No KEECC-A defined SC identified</i>	Code = NA	

KEECC-A Communication Competency 6: Reaches Agreement – if present, code “6” in CC Column		
**For each CC/SC identified indicate if feedback is positive (= 1) negative (=2) or neutral (=3) **		
Sub-Competencies for “Reaches Agreement”	SC Code	Clarifying information
<i>Includes patient in choices and decisions to the extent s/he desires</i>	If present, code = 1	
<i>Asks about patient’s ability to follow diagnostic and/or treatment plans</i>	If present, code = 2	Resident discussed the degree to which the SP’s lifestyle could accommodate the testing and treatment they (the resident) is suggesting.
<i>Identifies additional resources as appropriate</i>	If present, code = 3	Examples – resident states they may call in a social worker, or provide the SP with some brochures.
<i>No KEECC-A defined SC identified</i>	Code = NA	

KEECC-A Communication Competency 7: Provides Closure – if present, code “7” in CC Column		
**For each CC/SC identified indicate if feedback is positive (= 1) negative (=2) or neutral (=3) **		
Sub-Competencies for “Provides Closure”	SC Code	Clarifying information
<i>Asks if patient has questions, concerns, and/or other issues</i>	If present, code = 1	Use this code when SP specifically comments on the resident asking <i>“is there anything else?”</i> or the <i>“doorknob comment / question”</i> at <u>the end</u> of the interview. Coding instructions: If the SP mentions <u>near the end of the feedback session</u> that the doctor asked “Is there anything else”, generally they are referring to the CLOSURE.
<i>Summarizes / asks patient to summarize plans until next visit</i>	If present, code = 2	
<i>Clarifies follow-up or contact arrangements</i>	If present, code = 3	Use this code if the SP comments on the resident providing contact information (business card, phone number, email) for follow-up or if the SP comments on the resident doing a final re-cap on follow-up or contact arrangements.
<i>Acknowledges patient and closes interview</i>	If present, code = 4	
<i>No KEECC-A defined SC identified</i>	Code = NA	

APPENDIX E

Thematic Analysis Codebook

Active Listening w/ non-verbal cues	This describes those moments when residents indicated they were engaged with the patient's story by demonstrating non-verbally (e.g., eye-contact, body language) the degree to which they were engaged and listening. Note: A resident could be actively listening non---verbally without necessarily being empathic	Simone Brennan
Active Listening w/ verbal cues	This describes the degree to which residents demonstrated an engagement with the patient's story by asking relevant questions / making comments that indicated the degree to which they were engaged and listening. Note: A resident could be actively listening without necessarily being empathic.	Simone Brennan
Comm as Comfort: Abandonment	This code reflects the degree to which the SP did not feel abandoned by the R. Previous notes: The specific, evocative, intimate thing here takes a little bit of a different angle and that is not being abandoned at a point where the patient is feeling anxious, overwhelmed or scared.	Simone Brennan
Comm as Comfort: Friendship / Partnership	This code refers to when SPs commented on feeling comfortable with the resident as a friend, partner, or teammate. These statements connote an emotionally---based connection with the resident. It is differentiated from other discussions of Partnership wherein the resident made a cognitive or functional connection -e.g., with the patient's knowledge, insights & ability to share in the decision-making process. See D. Main's article on friendship and the practice of medicine	Simone Brennan
Comm as Comfort: Non---Verbal and Verbal	This code reflects the degree to which non-verbals e.g., eye contact, tone, pace, etc. brought comfort to the patient. In some cases, related to 'listening' with non-verbals, but always contextualized by an emotional component -feeling warmth from the resident, or supported by some gesture (e.g., handing a Kleenex) or reassured by a tender pat on the back, etc. at moments that the patient was feeling overwhelmed, anxious, or scared.	Simone Brennan
Culture: Age (being an older patient)	This code reflects the cultural (generational / older) paradigm of the patient, and all of the context that goes with it -how the needs and beliefs of the patient are at a different place than younger people might be.	Simone Brennan
Culture: Being a Woman	This code reflects the cultural (female) paradigm of the patient, and is reflective of women as accommodating to others and their health issues, women from older generations with different models for understanding disease and risks.	Simone Brennan
Culture: Culturally Informed Illness Experience	This code captures feedback that spoke directly to the extent that the resident engaged with and /or respected the patient's explanatory model of health (culturally informed illness experience), e.g., fears that when air hits the tumor the cancer will spread, that the patient will get AIDS from the transfusion, that the patient has a 'fat gene'. (See Kleinman, explanatory models of health, illness narratives)	Simone Brennan

Culture: Family	This code reflects the cultural (importance of family) paradigm of the patient and the degree to which the R noted or did not note the role of family. It also reflects the patient's perceptions of the role of family in the context of health and treatment options.	Simone Brennan
Culture: Job / Work	This code reflects the importance and profound influence of all aspects related to jobs and working; the degree to which the patient feels safe on the job, needs the job, enjoys their job. In feedback, this code reflects the degree to which the resident acknowledged it as a factor in health / tx / quality of life issues	Simone Brennan
Culture: Life Stressors	This code pertains specifically to degree to of social stressors which influence the patient's state of mind and well-being. The code is applied specifically to feedback, which includes the extent to which the resident did or did not further elucidate stressors in the patient's life.	Simone Brennan
EA: Informed and Invested	This code reflects the degree to which the resident dedicated time in the encounter to not just share information but invested time in educating the patient and/or the patient's family. (feedback that specifically comments on the time given to education) In some cases, the feedback indicates the doctor's willingness to invest time into educating the entire family. SPs often found this a reflection of empowering them to make an (enhanced) autonomous decision.	Simone Brennan
EA: Respect for pt (tx decisions	Resident demonstrated respect for the patient's opinions in making treatment decisions. Respect is demonstrated by showing some element of deference to patient's preferences, treating them as people, with agency and intellect.	Simone Brennan
Empathy: Communicating Understanding	Using Wiseman's Taxonomy: This code represents feedback centered on the degree to which the resident communicated an understanding of the patient's emotion. Communicating that emotional understanding could be done verbally or non-verbally.	Simone Brennan
Empathy: Non-judgmental	Using Wiseman's Taxonomy: This code represents feedback centered on the degree to which the resident remained non-judgmental of the patient's perspective, (knowledge, beliefs, emotions, etc.) The degree to which the resident accepted the patient for who they were and honored their perspective.	Simone Brennan
Empathy: Seeing the World as Others See It	Using Wiseman's Taxonomy: This code represents feedback centered on the degree to which the resident is demonstrates a connection to the patient's perspective (in general terms). Looping it back to Mishler --- this feedback pertained to residents who were able to step away from apriori "voice of medicine" approaches and engage / connect with the patient beyond the checklist and as a full human being. This aspect of empathy is a push against reductionism and a move toward humanism. This code reflects the degree to which the Resident listened to the patient's illness narrative with ears of biomedicine or ears sensitized to the lifeworld. Includes quotes from the	Simone Brennan

	previous 'checkbox' code which was defined as: This code reflects the degree to which the patient felt they were more than just a 'checkbox' or a statistic to the resident; that the resident heard them as a full, complex human being above and inclusive of the presenting complaint. Also reflects times the resident assumed an 'academic' or 'scholarly' presentation --- instead of listening and engaging with the patient, they opted for talking AT them, 'schooling' the patient, not engaging. Serves as a more grounded understanding of "Understanding the Patient's Perspective"	
Empathy: Understanding Another's Feelings	Using Wiseman's Taxonomy: This code represents feedback centered on the degree to which the resident recognized the patient's emotional / psychological feelings. Due to the content of many of these cases, one predominant emotion discussed was fear; fear of the treatment, of the disease; fear of traditional medicine's interventions.	Simone Brennan

APPENDIX F

Sample of Narrative RoadMap

NARRATIVE ROADMAP: MARY LOPEZ (SURGICAL CONSENT CASE – ANKLE INJURY)

KEECC-A COMPETENCY	KEECC-A SUB-COMPETENCIES	RECOMMENDATIONS FOR FEEDBACK: NARRATIVE ROADMAP
Builds A Relationship	<ul style="list-style-type: none"> • Greets and shows interest in patient as a person • Uses words that show care and concern • Uses tone, pace, eye contact, and posture that show care and concern 	<ul style="list-style-type: none"> • The resident should show interest in you and use caring and concerned words and non-verbals throughout the interview • Showing empathy for <u>your</u> situation (the impact on your lifestyle, kids, job) is <u>really</u> important in building a relationship. • Timing matters a LOT here, too – in this case, you are in a lot of pain and really worried about what the surgery will mean for you. You want the problem resolved, but you also want the doctor to be sensitive to the fact that you need to process all the ramifications of the treatment (surgery). You need the resident to be patient, give you time to consider fully.
Opens The Discussion	<ul style="list-style-type: none"> • Allows patient to complete opening statement without interruption • Asks “Is there anything else?” to elicit full set of concerns • Explains and/or negotiates an agenda for the visit 	<ul style="list-style-type: none"> • The resident asks you to ‘tell your story’ – to describe the reasons you are here, as well as any fears or concerns you might have. • The agenda is basically a ‘preview’ of what the resident wants to discuss. It can be as simple as “I’m here to get your consent for surgery”.
Gathers Information	<ul style="list-style-type: none"> • Begins with patient’s story using open-ended questions • (e.g. “tell me about...”) • Clarifies details as necessary with more specific or “yes/no” questions • Summarizes and gives patient opportunity to correct or add information • Transitions effectively to additional questions 	<ul style="list-style-type: none"> • Using open-ended questions throughout the interview is also really important. Again, if the resident is primarily asking close-ended questions, then they are demonstrating a lack of interest in hearing from you, about you. Many SPs have talked about this happening in real life – it’s almost like the doctor has his / her mind made up about your diagnosis, so they quit engaging with you as a unique person. • In these cases, summarizing can be very subtle. It can consist of the resident

		<p>repeating your words back to you or recapping even small amounts of discussion (e.g. “Ok, you are concerned about being out of work and needing help with your kids”) – summarizing basically demonstrates to you that the resident is engaged and actively listening to and with you.</p> <ul style="list-style-type: none"> • Transition statements may also be difficult to identify – basically you are evaluating if the flow of the interview ‘hangs together’.
Understands the Patient’s Perspective	<ul style="list-style-type: none"> • Asks about life events, circumstances, other people that might affect health (things EXTERNAL to you that matter – e.g., hobbies that you cannot do, external stressors like work or family, etc.) • Elicits patient’s beliefs, concerns, and expectations about illness and treatment (things INTERNAL – your state of mind, concerns, internalized stress, etc.) • Responds explicitly to patient’s statements about ideas and feelings 	<ul style="list-style-type: none"> • In this case, you should expect they would discuss – and recognize / show concern for at least some the following EXTERNAL ‘life’ concerns with having this surgery: <ul style="list-style-type: none"> ○ You are on your feet at work all day – you cannot afford to miss work ○ Your high insurance co-pay ○ You have 3 active children ○ Your husband is on the road a lot – you need help with the kids • In this case, you should expect they would elicit / recognize at least some the following INTERNAL ‘life’ concerns with having this surgery: <ul style="list-style-type: none"> ○ This is very stressful and overwhelming for you to have to think about – you never would have expected surgery would be required! ○ You have normal anxieties associated with having surgery
Shares Information	<ul style="list-style-type: none"> • Assesses patient’s understanding of problem and desire for more information • Explains using words that patient can understand • Checks for mutual understanding of treatment plan • Asks if patient has any questions 	<ul style="list-style-type: none"> • Goes over all the elements of informed consent • Does not use jargon (or explains right away!) • Clarifies that you and s/he (the resident) are on the same page with the risks and benefits of the surgery.
Reaches Agreement	<ul style="list-style-type: none"> • Includes patient in choices and decisions to the extent s/he desires • Asks about patients ability 	<ul style="list-style-type: none"> • The resident should respect your choice and honor your concerns – offering some resources is not just a ‘nice’ thing to do, but there are some professional and

	<p>to follow diagnostic and/or treatment plans</p> <ul style="list-style-type: none"> • Identifies additional resources as appropriate 	<p>ethical responsibilities to do so. Some of the resources the resident can offer are:</p> <ul style="list-style-type: none"> ○ To let you discuss with family ○ To talk to a social worker / administrator to discuss financial and support resources ○ To write a letter to your employer restricting you to 'light duty'
Provides Closure	<ul style="list-style-type: none"> • Asks if patient has questions, concerns or other issues • Summarizes / asks patient to summarize plans until next visit • Clarifies follow-up or contact arrangements • Acknowledges patient and closes interview 	<ul style="list-style-type: none"> • The closing may be very short and sweet, but they should NOT just walk out • Just as in the beginning, the resident needs to acknowledge you as a unique person from beginning to end.

REFERENCES

- Accreditation Council for Graduate Medical Programs. (2013, July 1). ACGME common program requirements. ACGME. Retrieved from <http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf>
- Alderson, P. (1998). Theories in health care and research: The importance of theories in health care. *BMJ: British Medical Journal*, 317(7164), 1007.
- 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(2), 239–244. [http://doi.org/10.1016/S0738-3991\(03\)00146-0](http://doi.org/10.1016/S0738-3991(03)00146-0)
- Astin, J. A., Sierpina, V. S., Forys, K., & Clarridge, B. (2008). Integration of the biopsychosocial model: Perspectives of medical students and residents. *Academic Medicine*, 83(1), 20–27. <http://doi.org/10.1097/ACM.0b013e31815c61b0>
- Baribeau, D. A., Mukovozov, I., Sabljic, T., Eva, K. W., & Delottinville, C. B. (2012). Using an objective structured video exam to identify differential understanding of aspects of communication skills. *Medical Teacher*, 34(4), e242–e250. <http://doi.org/10.3109/0142159X.2012.660213>
- Barker, L. L. (1971). *Listening behavior*. Englewood Cliffs, N.J: Prentice-Hall.
- Barrier, P. A., Li, J. T.-C., & Jensen, N. M. (2003). Two words to improve physician-patient communication: What else? *Mayo Clinical Proceedings*, 78, 211–214. <http://doi.org/12583531>
- Barry, C. T., Avissar, U., Asebrook, M., Sostok, M. A., Sherman, K. E., & Zucker, S. D. (2010). Use of a standardized patient exercise to assess core competencies during fellowship

- training. *Journal of Graduate Medical Education*, 2(1), 111–117.
<http://doi.org/10.4300/JGME-D-09-00001.1>
- Barzansky, B. (2010). Abraham Flexner and the era of medical education reform. *Academic Medicine*, 85, S19–S25. <http://doi.org/10.1097/ACM.0b013e3181f12bd1>
- Beach, M. C., Inui, T., & Relationship Centered Care Research Network. (2006). Relationship-centered Care: A constructive reframing. *Journal of General Internal Medicine*, 21(S1), S3–S8. <http://doi.org/10.1111/j.1525-1497.2006.00302.x>
- Beach, M. C., Roter, D. L., Wang, N.-Y., Duggan, P. S., & Cooper, L. A. (2006). Are physicians' attitudes of respect accurately perceived by patients and associated with more positive communication behaviors? *Patient Education and Counseling*, 62(3), 347–354. <http://doi.org/10.1016/j.pec.2006.06.004>
- Berger, J. S., Blatt, B., McGrath, B., Greenberg, L., & Berrigan, M. J. (2010). Relationship express: A pilot program to teach anesthesiology residents communication skills. *Journal of Graduate Medical Education*, 2(4), 600.
- Bissell, P., Traulsen, J. M., & Haugbølle, L. S. (2002). Sociological Theory and pharmacy practice research: (2) An introduction to functionalist sociology: Talcott Parsons' concept of the "sick role." *International Journal of Pharmacy Practice*, 10(1), 60–68. <http://doi.org/10.1111/j.2042-7174.2002.tb00589.x>
- Bokken, L., Linssen, T., Scherpbier, A., van der Vleuten, C., & Rethans, J.-J. (2009). Feedback by simulated patients in undergraduate medical education: a systematic review of the literature. *Medical Education*, 43(3), 202–210. <http://doi.org/10.1111/j.1365-2923.2008.03268.x>
- Bokken, L., Rethans, J. J., van Heurn, L., Duvivier, R., Scherpbier, A., & van der Vleuten, C.

- (2009). Students' views on the use of real patients and simulated patients in undergraduate medical education. *Academic Medicine*, 84(7), 958–963.
- Bonner, T. N. (1989). The historical reputation of Abraham Flexner: 1866-1959. *Academic Medicine*, 64(1), 17–18.
- Borrell-Carrio, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *The Annals of Family Medicine*, 2(6), 576–582. <http://doi.org/10.1370/afm.245>
- Boulet, J. R., De Champlain, A. F., & McKinley, D. W. (2003). Setting defensible performance standards on OSCEs and standardized patient examinations. *Medical Teacher*, 25(3), 245–249. <http://doi.org/10.1080/0142159031000100274>
- Braddock, C. H., Fihn, S. D., Levinson, W., Jonsen, A. R., & Pearlman, R. A. (1997). How Doctors and Patients Discuss Routine Clinical Decisions. *Journal of General Internal Medicine*, 12(6), 339–345. <http://doi.org/10.1046/j.1525-1497.1997.00057.x>
- Branch Jr. W. T. (2006). Viewpoint:: Teaching Respect for Patients. *Academic Medicine*, 81(5), 463–467.
- Branch, W., & Paranjape, A. (2002). Feedback and reflection: Teaching methods for clinical settings. *Academic Medicine*, 77(12), 1185–1188.
- Calhoun, A. W., Rider, E. A., Meyer, E. C., Lamiani, G., & Truog, R. D. (2009). Assessment of communication skills and self-appraisal in the simulated environment: Feasibility of multirater feedback with gap analysis: *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*, 4(1), 22–29.
<http://doi.org/10.1097/SIH.0b013e318184377a>
- Carvalho, I. P., Pais, V. G., Almeida, S. S., Ribeiro-Silva, R., Figueiredo-Braga, M., Teles, A.,

- ... Mota-Cardoso, R. (2011). Learning clinical communication skills: Outcomes of a program for professional practitioners. *Patient Education and Counseling*, 84(1), 84–89.
<http://doi.org/10.1016/j.pec.2010.05.010>
- Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango). *Social Science Medicine*, 44(5), 681–692.
- Charmaz, K. (2006). *Constructing grounded theory : a practical guide through qualitative analysis*. London; Thousand Oaks, Calif.: Sage Publications.
- Charon, R. (2006). *Narrative medicine: Honoring the stories of illness*. New York, NY: Oxford University Press.
- Chin, J. J. (2002). Doctor-patient relationship: from medical paternalism to enhanced autonomy. *Singapore Medical Journal*, 43(3), 152–155.
- Clark, A. J. (2007). *Empathy in counseling and psychotherapy: perspectives and practices*. Mahwah, N.J: Lawrence Erlbaum Associates.
- Cohen, J., Black, E. R., Holyst, M., & Krackov, S. K. (2000). Introduction to human health and illness: A series of patient-centered conferences based on the biopsychosocial model. *Academic Medicine*, 75(4), 390–396.
- Considine, J., & Miller, K. (2010). The Dialectics of Care: Communicative Choices at the End of Life. *Health Communication*, 25(2), 165–174.
<http://doi.org/10.1080/10410230903544951>
- Curtis, J. R., Wenrich, M. D., Carline, J. D., Shannon, S. E., & Ambrozy, D. M. (2001). Understanding physicians' skills at providing end-of-life care: Perspectives of patients, families, and health care workers. *Journal of General Internal Medicine*, 16, 41–49.

- David, A., & Holloway, R. (2005). The biopsychosocial model in medicine: Lost or reasserted? *Families, Systems & Health: The Journal of Collaborative Family HealthCare*, 23(4), 422–425.
- Dillon, L., Markova, T., Brennan, S., & Kokas, M. (2015). Aligning Institutional OSCEs with Clinical Learning Environment Review Focus Areas and Competencies. *MedEdPORTAL Publications*. http://doi.org/10.15766/mep_2374-8265.10025
- Dohernwend, A. (2002). Serving up the feedback sandwich. *Family Practice Management*, 9(10), 43.
- Dong, S., Butow, P. N., Costa, D. S. J., Dhillon, H. M., & Shields, C. G. (2014). The influence of patient-centered communication during radiotherapy education sessions on post-consultation patient outcomes. *Patient Education and Counseling*, 95(3), 305–312. <http://doi.org/10.1016/j.pec.2014.02.008>
- Donovan, E., Miller, L., & Goldsmith, D. (2014). “Tell me about a time when...”: Studying health communication through in-depth interviews. In B. B. Whaley (Ed.), *Research Methods in Health Communication: Principles and Application* (pp. 21–40). New York, NY: Routledge.
- Doukas, D. J., McCullough, L. B., & Wear, S. (2010). Re-visioning Flexner: Educating physicians to be clinical scientists and humanists. *The American Journal of Medicine*, 123(12), 1155–1156. <http://doi.org/10.1016/j.amjmed.2010.05.027>
- Duffy, F. D., Gordon, G. H., Whelan, G., Cole-Kelly, K., Frankel, R., Buffone, N., ... Langdon, L. (2004). Assessing competence in communication and interpersonal skills: the Kalamazoo II report. *Academic Medicine: Journal of the Association of American Medical Colleges*, 79(6), 495–507.

- Duggan, P. S., Geller, G., Cooper, L. A., & Beach, M. C. (2006). The moral nature of patient-centeredness: Is it “just the right thing to do”? *Patient Education and Counseling*, 62(2), 271–276. <http://doi.org/10.1016/j.pec.2005.08.001>
- du Pré, A. (2001). Accomplishing the impossible: Talking about body and soul and mind during a medical visit. *Health Communication*, 14(1), 1–21.
- du Pré, A. (2010). *Communicating about health : Current issues and perspectives*. New York : Oxford University Press, 2010. Retrieved from <http://proxy.lib.wayne.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat01223a&AN=wsu.b4443209&site=eds-live&scope=site>
- Dutta, M. (2008). *Communicating Health: A Culture-centered Approach* (1st ed.). Polity.
- Dwamena, F. C., Mavis, B., Holmes-Rovner, M., Walsh, K. B., & Loyson, A. C. (2009). Teaching medical interviewing to patients: The other side of the encounter. *Patient Education and Counseling*, 76(3), 380–384. <http://doi.org/10.1016/j.pec.2009.07.026>
- Dyche, L. (2007). Interpersonal Skill in Medicine: The Essential Partner of Verbal Communication. *Journal of General Internal Medicine*, 22(7), 1035–1039. <http://doi.org/10.1007/s11606-007-0153-0>
- Egener, B., & Cole-Kelly, K. (2004). Satisfying the patient, but failing the test. *Academic Medicine*, 79(6), 508–510.
- Eggle, S., Brennan, S., & Wiese-Rometsch, W. (2005). “Once when I was on call. . .,” Theory versus reality in training for professionalism. *Academic Medicine*, 80(4), 371–375.
- Eggle, S. S., Albrecht, T. L., Kelly, K., Prigerson, H. G., Sheldon, L. K., & Studts, J. (2009). The role of the clinician in cancer clinical communication. *Journal of Health Communication*, 14(sup1), 66–75. <http://doi.org/10.1080/10810730902806778>

- Ehrenreich, B., & English, D. (2010). *Witches, midwives, and nurses (second edition): A history of women healers*. New York, NY: Feminist Press.
- Ellingson, L. L. (2009). *Engaging crystallization in qualitative research : An introduction*. Thousand Oaks: Sage Publications.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, *196*(4286), 129–138.
- Epstein, R. M. (2006). Making communication research matter: What do patients notice, what do patients want, and what do patients need? *Patient Education and Counseling*, *60*(3), 272–278. <http://doi.org/10.1016/j.pec.2005.11.003>
- Epstein, R. M., Franks, P., Fiscella, K., Shields, C. G., Meldrum, S. C., Kravitz, R. L., & Duberstein, P. R. (2005). Measuring patient-centered communication in patient–physician consultations: Theoretical and practical issues. *Social Science & Medicine*, *61*(7), 1516–1528. <http://doi.org/10.1016/j.socscimed.2005.02.001>
- Epstein, R. M., & Street, R. L. (2007). *Patient-centered communication in cancer care: Promoting healing and reducing suffering*. Bethesda, MD: National Cancer Institute.
- Eva, K. W., Rosenfeld, J., Reiter, H. I., & Norman, G. R. (2004). An admissions OSCE: the multiple mini-interview. *Medical Education*, *38*(3), 314–326.
- Fassaert, T., van Dulmen, S., Schellevis, F., & Bensing, J. (2007). Active listening in medical consultations: Development of the Active Listening Observation Scale (ALOS-global). *Patient Education and Counseling*, *68*(3), 258–264. <http://doi.org/10.1016/j.pec.2007.06.011>
- Finlay, I. (2005). Quality of life to the end. *Communication & Medicine*, *2*(1), 91–95.
- Fisher, W. R. (1987). *Human communication as narration : toward a philosophy of reason*,

- value, and action*. Columbia, S.C.: University of South Carolina Press.
- Geist-Martin, P., Ray, E., & Sharf, B. F. (2002). *Communicating health: Personal, cultural and political complexities*. Belmont, CA: Wadsworth Pub.
- Giacomini, M., DeJean, D., Simeonov, D., & Smith, A. (2012). Experiences of living and dying with COPD: a systematic review and synthesis of the qualitative empirical literature. *Ontario Health Technology Assessment Series, 12*(13), 1.
- Glaser, B. G., & Strauss, A. L. (2009). *The discovery of grounded theory: strategies for qualitative research* (4. paperback printing). New Brunswick: Aldine.
- Gorawara-Bhat, R., Cook, M. A., & Sachs, G. A. (2007). Nonverbal communication in doctor–elderly patient transactions (NDEPT): Development of a tool. *Patient Education and Counseling, 66*(2), 223–234. <http://doi.org/10.1016/j.pec.2006.12.005>
- Goske, M., Reid, J., Yaldoo-Poltorak, D., & Hewson, M. (2005). RADPED: an approach to teaching communication skills to radiology residents. *Pediatric Radiology, 35*(4), 381.
- Goyal, R. K., Charon, R., Lekas, H.-M., Fullilove, M. T., Devlin, M. J., Falzon, L., & Wyer, P. C. (2008). “A local habitation and a name”: how narrative evidence-based medicine transforms the translational research paradigm. *Journal of Evaluation in Clinical Practice, 14*(5), 732–741. <http://doi.org/10.1111/j.1365-2753.2008.01077.x>
- Gray, J. B. (2011). From “directing them” to “it’s up to them”: The physician’s perceived professional role in the physician–patient relationship. *Journal of Communication In Healthcare, 4*(4), 280–287. <http://doi.org/10.1179/1753807611Y.0000000013>
- Greer, S. (2003). Healing the mind/body split: Bringing the patient back into oncology. *Integrative Cancer Therapies, 2*(1), 5–12. <http://doi.org/10.1177/1534735403251264>
- Gross-Cohn, E., Jia, H., Chapman-Smith, W., Erwin, K., & Larson, E., L. (2011). Measuring the

- Process and Quality of Informed Consent for Clinical Research: Development and Testing. *Oncology Nursing Forum*, 38(4), 417–422. <http://doi.org/10.1188/11.ONF.417-422>
- Hanna, M., & Fins, J. J. (2006). Viewpoint: power and communication: why simulation training ought to be complemented by experiential and humanist learning. *Academic Medicine*, 81(3), 265–270.
- Harter, L. M., & Kirby, E. L. (2004). Socializing medical students in an era of managed care: The ideological significance of standardized and virtual patients. *Communication Studies*, 55(1), 48–67.
- Hassell, A. (2012). Patient instructors in rheumatology. *Medical Teacher*, 34(7), 539–542. <http://doi.org/10.3109/0142159X.2012.678425>
- Hewa, S. (2002). Rockefeller philanthropy and the “Flexner Report” on medical education in the United States. *The International Journal of Sociology and Social Policy*, 22(11/12), 1–47.
- Hiatt, M. D., & Stockton, C. G. (2003). The impact of the Flexner report on the fate of medical schools in North America after 1909. *Journal of American Physicians and Surgeons*, 8(2), 37–40.
- Hodges, B. (2003). OSCE! Variations on a theme by Harden. *Medical Education*, 37(12), 1134–1140. <http://doi.org/14984124>
- Ishikawa, H., Hashimoto, H., & Kiuchi, T. (2013). The evolving concept of “patient-centeredness” in patient–physician communication research. *Social Science & Medicine*, 96(0), 147–153. <http://doi.org/10.1016/j.socscimed.2013.07.026>
- Joyce, B. L., Steenbergh, T., & Scher, E. (2010). Use of the Kalamazoo essential elements communication checklist (adapted) in an institutional interpersonal and communication

- skills curriculum. *Journal of Graduate Medical Education*, 2(2), 165–169.
<http://doi.org/10.4300/JGME-D-10-00024.1>
- Kalet, A., Pugnaire, M. P., Cole-Kelly, K., Janicik, R., Ferrara, E., Schwartz, M. D., ... Lazare, A. (2004). Teaching communication in clinical clerkships: Models from the Macy initiative in health communications. *Academic Medicine*, 79(6), 511–520.
- Keller, V. F., & Carroll, J. G. (1994). A new model for physician - patient communication. *Patient Education and Counseling*, 23(2), 131–140.
- Klamen, D. L., & Yudkowsky, R. (2002). Using standardized patients for formative feedback in an introduction to psychotherapy course. *Academic Psychiatry*, 26(3), 168–172.
<http://doi.org/12824134>
- Koch-Weser, S., Bradshaw, Y. S., Gualtieri, L., & Gallagher, S. S. (2010). The Internet as a Health Information Source: Findings from the 2007 Health Information National Trends Survey and Implications for Health Communication. *Journal of Health Communication*, 15(sup3), 279–293. <http://doi.org/10.1080/10810730.2010.522700>
- Kontos, N. (2011). Perspective: Biomedicine—menace or straw man? Reexamining the biopsychosocial argument. *Academic Medicine*, 86(4), 509–515.
<http://doi.org/10.1097/ACM.0b013e31820e0d16>
- Krippendorff, K. (2004). *Content analysis: an introduction to its methodology* (2nd ed). Thousand Oaks, Calif: Sage.
- Lane, C., & Rollnick, S. (2007). The use of simulated patients and role-play in communication skills training: A review of the literature to August 2005. *Patient Education and Counseling*, 67(1-2), 13–20. <http://doi.org/10.1016/j.pec.2007.02.011>
- Lee, A. V., Moriarty, J. P., Borgstrom, C., & Horwitz, L. I. (2010). What can we learn from

- patient dissatisfaction? An analysis of dissatisfying events at an academic medical center. *Journal of Hospital Medicine*, 5(9), 514–520. <http://doi.org/10.1002/jhm.861>
- Liaison Committee on Medical Education. (2012). *Functions and structure of a medical school - LCME*.
- Limón, A. (n.d.). What It Looks Like To Us and the Words We Use by Ada Limón : The Poetry Foundation. Retrieved November 2, 2015, from <http://www.poetryfoundation.org/poem/246256>
- Lombard, M., Snyder-Duch, J., & Bracken, C. C. (2002). Content analysis in mass communication: Assessment and reporting of intercoder reliability. *Human Communication Research*, 28(4), 587–604.
- Lurie, S. J. (2003). Raising the passing grade for studies of medical education. *The Journal of the American Medical Association*, 290(9), 1210. <http://doi.org/10.1001/jama.290.9.1210>
- Magnus, S. A., & Mick, S. S. (2000). Medical school, affirmative action, and the neglected role of social class. *American Journal of Public Health*, 90(8), 1197–1201.
- Makoul, G. (2001). Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Academic Medicine*, 76(4), 390–393. <http://doi.org/10.11299158>
- Makoul, G. (2003). The interplay between education and research about patient–provider communication. *Patient Education and Counseling*, 50(1), 79–84. [http://doi.org/10.1016/S0738-3991\(03\)00085-5](http://doi.org/10.1016/S0738-3991(03)00085-5)
- Makoul, G. (2006). Commentary: Communication skills: How simulation training supplements experiential and humanist learning. *Academic Medicine*, 81(3), 271–274. <http://doi.org/10.1097/00001888-200603000-00018>
- Makoul, G., & Clayman, M. L. (2006). An integrative model of shared decision making in

- medical encounters. *Patient Education and Counseling*, 60(3), 301–312.
<http://doi.org/10.1016/j.pec.2005.06.010>
- Makoul, G., & Curry, R. H. (2007). The value of assessing and addressing communication skills. *The Journal of the American Medical Association*, 298(9), 1057–1059.
<http://doi.org/17785653>
- Makoul, G., & Schofield, T. (1999). Communication teaching and assessment in medical education: an international consensus statement. *Patient Education and Counseling*, 37(2), 191–195.
- McCormack, L. A., Treiman, K., Rupert, D., Williams-Piehot, P., Nadler, E., Arora, N. K., ... Street, R. L. (2011). Measuring patient-centered communication in cancer care: A literature review and the development of a systematic approach. *Social Science & Medicine*, 72(7), 1085–1095. <http://doi.org/10.1016/j.socscimed.2011.01.020>
- Meyer, K. (2009). Pedagogy in medical school: Rethinking the narrative nature of standardized patient programs. *Ohio Communication Journal*, 47, 193–214.
- Mishler, E. G. (1984). *The Discourse of Medicine: Dialectics of Medical Interviews*. Greenwood Publishing Group.
- Mishler, E. G. (2005). Patient stories, narratives of resistance and the ethics of humane care: a la recherche du temps perdu. *Health*, 9(4), 431–451.
<http://doi.org/10.1177/1363459305056412>
- Neuendorf, K. A. (2002). *The content analysis guidebook*. Thousand Oaks, Calif: Sage Publications.
- Park, J. H., Son, J. Y., Kim, S., & May, W. (2011). Effect of feedback from standardized patients on medical students' performance and perceptions of the neurological examination.

- Medical Teacher*, 33(12), 1005–1010. <http://doi.org/10.3109/0142159X.2011.588735>
- Peck, B. M. (2011). Age-Related Differences in Doctor-Patient Interaction and Patient Satisfaction. *Current Gerontology and Geriatrics Research*, 2011, 1–10. <http://doi.org/10.1155/2011/137492>
- Porcerelli, J. H., Brennan, S., Carty, J., Ziadni, M., & Markova, T. (2015). Resident Ratings of Communication Skills Using the Kalamazoo Adapted Checklist. *Journal of Graduate Medical Education*, 7(3), 458–461. <http://doi.org/10.4300/JGME-D-14-00422.1>
- Quill, T. E., & Brody, H. (1996). Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Annals of Internal Medicine*, 125(9), 763–769.
- Rabow, M. W., & McPhee, S. J. (1999). Beyond breaking bad news: how to help patients who suffer. *West J Med*, 171(4), 260–263.
- Ragan, S. L., Wittenberg-Lyles, E. M., Goldsmith, J., & Sanchez-Reilly, S. (2008). *Communication as comfort: Multiple voices in palliative care*. New York, NY: Routledge.
- Rau, J. (2011, November 7). Test for hospital budgets: Are the patients pleased? *New York Times*, p. D1. New York, NY.
- Razack, S., Meterissian, S., Morin, L., Snell, L., Steinert, Y., Tabatabai, D., & Maclellan, A. (2007). Coming of age as communicators: Differences in the implementation of common communications skills training in four residency programmes. *Medical Education*, 41(5), 441–449.
- Richardson, L. (2000). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 923–943). Thousand Oaks, CA: Sage.

- Richardson, L., & St. Pierre, E. (2005). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 959–978). Thousand Oaks, CA: Sage.
- Rider, E. A., Hinrichs, M. M., & Lown, B. A. (2006). A model for communication skills assessment across the undergraduate curriculum. *Medical Teacher*, 28(5), e127–e134. <http://doi.org/10.1080/01421590600726540>
- Riggs, G. (2010). Commentary: Are we ready to embrace the rest of the Flexner report?: *Academic Medicine*, 85(11), 1669–1671. <http://doi.org/10.1097/ACM.0b013e3181f5ced4>
- Robertson, K. (2005). Active listening: more than just paying attention. *Australian Family Physician*, 34(12), 1053–1055.
- Rose, M., & Wilkerson, L. (2001). Widening the lens on standardized patient assessment: What the encounter can reveal about the development of clinical competence. *Academic Medicine*, 76(8), 856–859.
- Rosenbaum, M. E., & Axelson, R. (2013). Curricular disconnects in learning communication skills: What and how students learn about communication during clinical clerkships. *Patient Education and Counseling*, 91(1), 85–90. <http://doi.org/10.1016/j.pec.2012.10.011>
- Rubin, N. J., & Philp, E. (1998). Health care perceptions of the standardized patient. *Medical Education*, 32, 538–542.
- Salmon, J. W., & Berliner, H. S. (1980). Health policy implications of the holistic health movement. *Journal of Health Politics, Policy and Law*, 5(3), 535–553.
- Salmon, P., & Young, B. (2005). Core assumptions and research opportunities in clinical communication. *Patient Education and Counseling*, 58(3), 225–234.

<http://doi.org/10.1016/j.pec.2005.05.018>

- Schirmer, J. M., Mauksch, L., Lang, F., Marvel, M. K., Zoppi, K., Epstein, R. M., ... Pryzbylski, M. (2005). Assessing communication competence: a review of current tools. *Family Medicine*, 37(3), 184–192. <http://doi.org/15739134>
- Schwartz, V. S., Rothpletz-Puglia, P., Denmark, R., & Byham-Gray, L. (2015). Comparison of standardized patients and real patients as an experiential teaching strategy in a nutrition counseling course for dietetic students. *Patient Education and Counseling*, 98(2), 168–173. <http://doi.org/10.1016/j.pec.2014.11.009>
- Sharf, B. F., & Vanderford, M. L. (2003). Illness narratives and the social construction of health. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of health communication* (pp. 9–34). Mahwah, N.J: Lawrence Erlbaum Associates.
- Shotter, J., & Gergen, K. J. (1999). Social construction: Knowledge, self, others, and continuing the conversation. In S. Deetz (Ed.), *Communication Yearbook*. Thousand Oaks, CA: Sage Publications.
- Shue, C. K. (2010). Accrediting and licensing standards as evidence of impact. *Health Communication*, 25(6/7), 563–564. <http://doi.org/20845142>
- Silverman, J. (2009). Teaching clinical communication: A mainstream activity or just a minority sport? *Patient Education and Counseling*, 76(3), 361–367. <http://doi.org/10.1016/j.pec.2009.06.011>
- Smith, R., Marshall-Dorsey, A., Osborn, G., Shebroe, V., Lyles, J., Stoffelmayr, B., ... Gardiner, J. (2000). Evidence-based guidelines for teaching patient-centered interviewing. *Patient Education & Counseling*, 39(1), 27–36.
- Sparks, L., Villagran, M. M., Parker-Raley, J., & Cunningham, C. B. (2007). A patient-centered

- approach to breaking bad news: Communication guidelines for health care providers. *Journal of Applied Communication Research*, 35(2), 177–196.
<http://doi.org/10.1080/00909880701262997>
- Stewart, M., Brown, J. B., Weston, W. W., McWhinney, J. R., McWilliam, C. L., & Freeman, T. R. (2003). *Patient-centered medicine : Transforming the clinical method*. Abingdon, U.K.: Radcliffe Medical Press.
- Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research : techniques and procedures for developing grounded theory*. Thousand Oaks: Sage Publications.
- Suchman, A. L. (2005). The current state of the biopsychosocial approach. *Families, Systems, & Health*, 23(4), 450–452.
- Suri, H. (2011). Purposeful Sampling in Qualitative Research Synthesis. *Qualitative Research Journal*, 11(2), 63–75. <http://doi.org/10.3316/QRJ1102063>
- Taylor, J. S. (2003). Confronting“ culture” in medicine’s “culture of no culture.” *Academic Medicine*, 78(6), 555.
- The RSA. (2013). *Brené Brown on Empathy*. Retrieved from <https://www.youtube.com/watch?v=1Evwgu369Jw>
- Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837–851.
<http://doi.org/10.1177/1077800410383121>
- Tracy, S. J. (2013). *Qualitative research methods: collecting evidence, crafting analysis, communicating impact*. Chichester, West Sussex, UK: Wiley-Blackwell.
- Tresolini, C. P., & Pew Fetzer Task Force. (1994). *Health professions education: Relationship-centered care*. San Francisco: Pew Health Professions Commission. Retrieved from

<http://rccswmi.org/uploads/PewFetzerRCCreport.pdf>

van Zanten, M., Boulet, J. R., & McKinley, D. (2007). Using standardized patients to assess the interpersonal skills of physicians: Six years' experience with a high-stakes certification examination. *Health Communication, 22*(3), 195–205.

<http://doi.org/10.1080/10410230701626562>

Vegni, E., Visioli, S., & Moja, E. A. (2005). When talking to the patient is difficult: The physician's perspective. *Communication & Medicine, 2*(1), 69–76.

Wallach, P. M., Elnick, M., Bogner, B., Kovach, R., Papadakis, M., Zucker, S., & Speer, A.

(2001). Standardized patients' perceptions about their own health care. *Teaching and*

Learning in Medicine, 13(4), 227–231. http://doi.org/10.1207/S15328015TLM1304_03

Wear, D. (2003). Insurgent multiculturalism: rethinking how and why we teach culture in medical education. *Academic Medicine, 78*(6), 549.

Wear, D. (2008). On outcomes and humility. *Academic Medicine, 83*(7), 625.

Wear, D., Kumagai, A. K., Varley, J., & Zarconi, J. (2012). Cultural Competency 2.0. *Academic Medicine, 87*(6), 752–758. <http://doi.org/10.1097/ACM.0b013e318253cef8>

Wear, D., & Varley, J. D. (2007). Rituals of verification: The role of simulation in developing and evaluating empathic communication. *Patient Education and Counseling, 71*(2), 153–

156. <http://doi.org/10.1016/j.pec.2008.01.005>

Weissmann, P. F., Haidet, P., Branch Jr, W. T., Gracey, C., & Frankel, R. (2010). Teaching

humanism on the wards: What patients value in outstanding attending physicians. *Journal of Communication in Healthcare, 3*(3-4), 291–299.

Whelan, G. P., Boulet, J. R., McKinley, D. W., Norcini, J. J., van Zanten, M., Hambleton, R. K., ... Peitzman, S. J. (2005). Scoring standardized patient examinations: lessons learned

- from the development and administration of the ECFMG Clinical Skills Assessment (CSA®). *Medical Teacher*, 27(3), 200–206. <http://doi.org/10.1080/01421590500126296>
- Williams, G., Frankel, R., Campbell, T., & Deci, E. (2000). Research on relationship-centered care and healthcare outcomes from the Rochester biopsychosocial program: A self-determination theory integration. *Families, Systems & Health: The Journal of Collaborative Family HealthCare*, 18(1), 79–79.
- Windish, D. M., Price, E. G., Clever, S. L., Magaziner, J. L., & Thomas, P. A. (2005). Teaching medical students the important connection between communication and clinical reasoning. *Journal of General Internal Medicine*, 20(12), 1108–1113. <http://doi.org/10.1111/j.1525-1497.2005.0244.x>
- Wiseman, T. (2007). Toward a holistic conceptualization of empathy for nursing practice. *Advances in Nursing Science*, 30(3), E61–E72.
- Young, A. J., & Rodriguez, K. L. (2006). The role of narrative in discussing end-of-life care: Eliciting values and goals from text, context, and subtext. *Health Communication*, 19(1), 49–59.
- Zayyan, M. (2011). Objective Structured Clinical Examination: The Assessment of Choice. *Oman Medical Journal*, 26(4), 219–222. <http://doi.org/10.5001/omj.2011.55>
- Zoppi, K. A., & Epstein, R. M. (2002). Interviewing in medical settings. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of Interview Research : Context & Method* (pp. 355–383). Thousand Oaks, Calif.: Sage Publications.

ABSTRACT**ASSESSING PATIENT-CENTERED COMMUNICATION IN MEDICAL EDUCATION:
A CRYSTALLIZED APPROACH TO UNDERSTANDING THE THE QUALITY,
NATURE, AND FORM OF FEEDBACK BY STANDARDIZED PATIENTS**

by

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Patient-centered Communication (PCC) is the gold standard in effective clinical communication. Feedback from Standardized Patients (SPs) provides one strategy to teach PCC. SP feedback is highly valued, but little is understood about its quality, nature, and the form in which it is actually delivered. *Methods:* Using the meta-method of crystallization (Ellingson, 2009), I conducted three unique studies, content analysis, iterative thematic analysis, and narrative analysis of SP feedback. These analyses were conducted using transcribed SP feedback from a multi-station, residency-based Objective Structured Clinical Exam (OSCE). SPs in this OSCE were trained using the adapted version of the Kalamazoo Essential Elements of Communication Checklist (KEECC-A). *Findings:* In the content analysis, I identified that most SP feedback was positive, in nature. Additionally, the KEECC-A communication competencies and sub-competencies most referenced by SPs, related to building a deeper, more meaningful relationship with the resident, particularly with regard to achieving a mutual understanding of a treatment plan. In the thematic analysis, I identified five emergent themes: (a) Active Listening; (b) Enhanced Autonomy; (c) Culture; (d) Empathy; and (e) Communication as Comfort. In the

final study, I found through narrative analysis, that the form of SP feedback is a storied process, adhering to five inherent elements of narrative, as defined by Charon (2006). *Discussion:* Looking at these findings through the meta-method of Crystallization (Ellingson, 2009) reveals that analyzing complex phenomena through one methodology inherently limits the depth of knowledge gained; specific to this research, whereas the content analysis provided me with a descriptive understanding of ‘what’ elements of the KEECC-A were being used, the thematic analysis provided a deeper context of meaning – the ‘why’ the elements were used, and the narrative analysis provided the ‘how’ feedback was being delivered (i.e., narratively). Furthermore this research extends current understandings of those elements in the KEECC-A that are most salient, as well as opportunities for enhancing or extending the KEECC-A to be more reflective of ‘lifeworld’ voices (Mishler, 1984). *Future Research:* Future research should continue to explore SP feedback with more diverse groups of SPs, enhanced versions of the KEECC-A and/or, new communication assessment tools, more reflective of lifeworld voices could be piloted. This is the first known study to extend the boundaries of crystallization beyond the qualitative spectrum into the post-positive realm; communication scholars and others committed to interpretive, multiple means for exploring phenomena should continue to embrace and challenge crystallization, seeking out new and dynamic methods for robust and meaningful scholarship.

AUTOBIOGRAPHICAL STATEMENT

I received my Bachelor of Arts in Speech / Theater as well as my Master of Arts in Communication from Wayne State University. For the past 25+ years, the Wayne State University community has also served as my professional ‘home’, allowing me opportunities to work with health education initiatives, volunteer and staff development & medical education training programs, as well as project management over a number of clinical and population-based research endeavors.

I am a health communication scholar, currently working at the Kado Clinical Skills Center at the Wayne State University School of Medicine. Here, I am committed to exploring best practices in teaching and assessing effective patient communication strategies for learners across the continuum (undergraduate – graduate – continuing) of medical education. Working in the Clinical Skills Center, I see tremendous potential in SP methodology as informing elements of the patient perspective, particularly the degree to which SPs can serve in a formative capacity, providing learners with a safe environment for practicing patient-centered communication strategies.

I am the proud mother of Sam and Chris Brennan, happily married to David Brennan. I am extremely proud to have been raised and educated in Detroit Public Schools, alongside my beautiful and talented sister, Emily Norton, by two of the best parents in the entire world, Kae Halonen and Sam Stark.