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Communication Skills in Medical Education: A Discourse Analysis of Simulated Patient Practices

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A Discourse Analysis of Simulated Patient Practices

by

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DEDICATION
To my sons–
John Ezra and Daniel Everett.

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ABSTRACT

Communication is regarded as one of the most important skills physicians develop. The most common approach for training medical students to be skilled communicators is by way of simulated patients, who are persons hired by a medical school to perform the role of patient for medical students in simulated consultations and assess those students on their communication skills. In this project, I examine how communication skills are conceptualized by looking at how they occur as a practice. My analysis focuses on the Communication Skills Learning Center, an organization designed to train medical students to be skilled communicators through consultations with simulated patients. Specifically, I examine the Communication Skills Practice Exam that is designed to prepare third-year medical students for the United States Medical Licensing Step 2 Clinical Skills Exam. Like the licensing exam, the practice exam requires students to perform physician in twelve simulated consultations to demonstrate their communication skills.

I use discourse analytic approaches to examine the three simulated patient practices that constitute the Communication Skills Practice Exam–(1) the twelve Scripts issued to simulated patients by the Communication Skills Learning Center to prepare them for their Simulated Consultation; (2) ninety-seven Simulated Consultations between simulated patients and third-year medical students; (3) and the multiple-choice and open-ended Assessment Form that simulated patients complete after Simulated Consultations to evaluate medical student's communication skills. I investigate the metadiscourse that participants use to constitute communication in these three practices and consider the implications of such conceptualizations.

Through my analysis, I demonstrate how the Communication Skills Learning Center conceptualizes communication in Scripts and multiple-choice Assessment Form items by way of a container paradigm, in which medical students extract patients' concerns by questioning patients. Communication functions as a transparent exchange of relevant medical information about a patient and effective communication occurs when medical students retrieve the information needed to diagnose and treat patients. Yet in Simulated Consultations and open-ended Assessment Form responses, communication is a dynamic and communication skills are negotiated amongst participants. I conclude this project by initiating a metatheoretical dialogue, considering the affordances and constraints of these different conceptualizations of communication, and offering suggestions for ways to enrich simulated patient practices in communication skills education.

CHAPTER ONE:

INVESTIGATING COMMUNICATION AS A PRACTICE

"Don't think, but look"

Ludwig Wittgenstein, *Philosophical Investigations,* 1953

Communication is regarded as one of the most important skills that physicians develop (Boissy et al., 2016). Physicians who practice skilled communication are said to experience lower burnout rates and fewer incidents of medical malpractice, while their patients are more likely to adhere to treatment recommendations, proactively manage their own health, and report a greater satisfaction with their physicians (Brown, Boles, Mullooly & Levinson, 1999; Brown, Stewart & Ryan, 2003; Levinson, Lesser & Epstein, 2010; Levinson, Roter, Mullooly, Dull & Frankel, 1997; Stewart, 1995). Communication skills are recognized by the Health and Medicine Division (previously the Institute of Medicine), the Liaison Committee for Medical Education, and the Association of American Medical Colleges as key to medical practice.

But what is "communication"? What constitutes skilled or unskilled communication? How are these notions enacted? And what are the implications of communication skills? This project examines how communication is conceptualized by looking at it as a practice–specifically communication skills training for medical students (MSs). In this introductory chapter, I describe how I arrived at my questions about communication skills in medical education, explain my approach for investigating communication as a practice, as well as pose my research questions and outline the data I use to answer those questions.

Background

Five years ago, I studied how couples talk about experiences of miscarriage. In interviews, I asked couples to tell me the story of their pregnancy loss. I noticed the most important part of their narrative(s) was the moment a healthcare provider "broke the news" (Maynard, 2003). Whether in an ultrasound room with a sonographer who said, "there's no heartbeat," or over the phone with a midwife who said, "just let your body go through the process," or a physician who said, "you've had a spontaneous abortion," the words of a medical provider featured as "the most tellable moment of the narrative" (Labov & Waletzky, 1967; Peters, 2017). Along with quoting what the speaker said (also called direct reported speech), came evaluations of how the news was delivered. As one participant said, "she was good, and she helped me to calm down." The emphasis on the words a medical provider said and subsequent assessment of what they said as "good" or "bad" taught me that what healthcare providers say to patients is important, and moreover, that patients are invested in claiming and evaluating what counts as "good" communication. My observations along with the common occurrence of early pregnancy loss led me to ask, is breaking the news of miscarriage formally taught in medical school?

To answer this question, I developed a relationship with the Communication Skills Learning Center (CSLC), a pseudonymous organization at a large medical school in the Southern United States that is dedicated to ensuring MSs develop communication skills. My relationship with the CSLC began when they hired me as a simulated patient (SP)[1], which involves (1) performing patient for MSs (MS) in simulated medical consultations and (2) assessing MS on their communication skills by completing computerized assessment forms and offering verbal

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[1] The term simulated patient is used interchangeably with the term, standardized patient.

evaluations. While working as a SP, I asked the CSLC staff whether MS were taught to break the news of miscarriage. I soon learned that although they are not taught to specifically break the news of pregnancy loss, there is an elective activity for third-year MSs called "Breaking Bad News" where students are put in simulated consultations with the goal of informing SPs of potentially life changing health information that would dramatically alter a patient's view of the future (Buckman, 1984). The staff members gave me the email of the oncologist who taught the elective and I reached out to ask to observe the activity. During my observation, I suggested the implementation of a pregnancy loss case, which was soon-after put in place. For the activity, a third-year MS had to go in and inform the patient of the loss. Although the case was about a late pregnancy loss (stillbirth), I felt a sense of satisfaction that the complexity of pregnancy loss was now drawn to student's attention. The CSLC is built on two premises: (1) communication matters to medical practice and (2) SP practices, like the Breaking Bad News elective, are how communication skills are taught.

However, what I did as a SP stood in contrast to my experiences as a patient and what I was learning as a doctoral student studying communication. The Scripts that told me how to play certain patients came as a list of answers to questions that MS should ask and rarely told me anything about the patient outside of what a physician might ask. During my time as a SP, my grandmother experienced a major health crisis that kept her in the hospital or rehab centers for months. I adore my grandmother. She is one of the most influential people in my life. But this in terms of the medical questions that were asked in Scripts, what I love about her would be lost entirely. After long days spent working as a SP, I would feel drained from playing the same case with up to eight different students. I considered the challenge of being in the student's shoes, required to meet with eight different patients and having to put on the "communication skills

show," again and again. And the Assessment Form I completed after each simulated consultation was exhaustive. Admittedly, most of the time, I could not remember whether the student I just met with actually accomplished the tasks the form listed. I wondered if the dozens of communication skills were actually relevant. These disconnects also led me to this project. I wanted to know more about how communication is conceptualized at the CSLC and the tools I was learning as a student of communication gave me an approach for unpacking the complexities at hand.

Investigating Communication

The value of communication extends beyond medical practice. Everyday comments like, "they're a really great communicator," or "there is a communication problem," show that concerns about communication are commonplace. Cameron (2000) suggests we live in "a communication culture," which holds the fundamental view that communication is important, "good" communication is productive for all areas of life, and most problems can be solved through talking it out (p. viii). As a communication scholar, I am particularly invested in the cultural value of communication as it supports my own livelihood (I am glad that others value communication, I do too!). I often make and receive statements like, "this is a B+ speech," and, "Revise and Resubmit," both of which are evaluations of communication. We all claim what counts as "good" or "bad" communication (Katriel & Philipsen, 1981). However, what often goes unexamined, even in my own activities, are the implications of the ways we talk about talk. To consider the implications of communication, I heed philosopher Ludwig Wittgenstein's aphorism with which I opened this chapter, and I look to how notions of communication skills occur in a situated practice–at the CSLC. In the following, I explain how we can understand

communication skills as a practice, specifically a practice of metadiscourse, that allows us to consider the implications of communication skills in medical education.

Practice

Wittgenstein's suggestion to look rather than think informs the fundamental premise of this project– communication is an observable practice (Sacks, 1995). By observable, I refer to the premise that communication is not to be sought in mental states, nor does it indicate cognition, but it is essentially visible in social interaction (Edwards, 1995). Practice scholars acknowledge how "arrays of human activity [are] centrally organized around shared practical understanding" and advocate examining human activity to unpack that shared practice understanding (Schatzki, 2001, p. 11). Sacks (1995) similarly appeals to the importance of observability in interaction for doing research that is transparent; that, "others could look at what I had studied and make of it what they could, if, for example, they wanted to be able to disagree with me" (p. 26). Essentially, by attending to the observable interactions amongst embodied humans and the material world (i.e., drapes, computers, etc.), I reconstruct a practice and attend to what is the shared practical understandings involved, as well as the implications of that practice.

Discourse analysts are practice scholars who study language in use as consequential social action (Bhatia, Flowerdew & Jones, 2008). SP practices at the CSLC constitute, shape, and create meanings of communication skills as well as draw on forms, structures, or orders of established communication practice that impact future practices. Gee (2015) uses the distinction "little d" and "big D" to explain the relationship between situated practices and dislocated institutional and social contexts. Situated practices are the immediate and local interactions at hand, while the dislocated, or "dis-local" is how we import entities (i.e., previous experiences,

values, ideas, institutions, etc.) to make them present (Bartesaghi, Cooren, & Matte, 2020). For instance, a MS may ask a SP, "what brings you in today?" and that situated activity ("little d" discourse) is a uniquely impactful to the interaction. Yet by asking "what brings you in today," the MS draws on institutionally and socially embedded forms of know-how, like this is what physicians do when they greet patients, or this is what worked with (simulated) patients in the past ("Big D" Discourse).

As a discourse analyst, I am interested in the relationship between the situated (what happens in moment by moment interaction) and dislocated (how it calls in or invokes previous ways of doing things) to understand how talk in context reshapes the possibilities of future practice. This reshaping is the consequentiality of discourse, in that what we do impacts the possibilities of what we can do. As Schatzki (2001) explains "practice is the becoming from which discourses result and to which they eventually succumb" (p. 53). What occurs at the CSLC is "the becoming" of communication skills, which draw on previous notions of communication skills, both at the CSLC and in communication skills discourse broadly, both of which shape notions of communication skills in the moment and in a particular location. The mutually constitutive relationship between practice and discourse emphasizes the importance of looking closely at practices to understand them as observable and consequential.

Metadiscourse

Metadiscourse is essentially talk about talk (Craig, 2008). Metadiscourse differs from Reusch and Bateson's (1951/1968) notion of metacommunication in that it encompasses both the metalinguistic and metacommunicative. The difference between these two concepts can best be explained through Bateson's (1972/1999) observation of two monkeys whose play looks a lot like fighting. However, there is some signal between the monkeys that suggests "this is play."

The "metalinguistic" (communication about language) implies this bite is playful and the "metacommunicative" (communication about communicators) implies we are playing. As per Craig (2016), metadiscourse is concerned with the strategies or techniques we use to talk about talk (metalinguistic) and how talk about talk points to our relationships (metacommunicative).

Metadiscourse about communication is implicitly and explicitly observable – from shifts in tone of voice to metaphors of communication in textbooks on communication skills. Implicit metadiscourse involves a momentary "frame shift," where some sort of cue designates that was is being said is about what is taking place (Goffman, 1981). Metadiscursive shifts can occur through one's tone of voice or the use of air quotes, which indicate something about what is being said (i.e., I am being sarcastic). Gumperz (1982) refers to such linguistic, paralinguistic, and embodied actions as "contextualization cues" because they "contribute[s] to the signaling of contextual presuppositions" (p. 131). These signals to context are first-order practices that refer to second-order notions, like who we are or what we are doing.

Other forms of metadiscourse are more explicit. Craig (2008) offers the example of the word "first," which frames everything after it as being the first in a list of points. Shiffrin's (1987) notion of discourse markers (i.e., "because" or "I mean") indicates ways of performing metadiscourse. Additional examples include textbooks or self-help guides that talk about how to talk. Cameron (2000) examines the strategies "communication experts" use to create authoritative communication recommendations. Generalizations, statistics, anecdotes, the use of technical categories, and technical distinctions are all metadiscursive techniques for shaping how we perform and make sense of communication.

Implicit and explicit metadiscourse are both practical metadiscourse or, "our ordinary, everyday practice of talking about what we say and do with language" (Taylor, 1992, p. 10).

Metadiscourse evidences the cultural importance of communication, emphasizes the various strategies for talking about talk, and plays a key role how we understand and live in communication. By analyzing metadiscourse as an observable practice, I unpack how communication is practically conceptualized and consider the entailments of its conceptualization.

The Constitutive Metamodel of Communication

In his reconstruction of communication theory as a field, Craig (1999) advocates for attending to communication as metadiscursive practice in order to address real world problems. In developing the constitutive metamodel of communication, Craig suggests four premises: (1) conceptualizations of communication evolve over time and occur with a broader intellectual history (see Peters, 1999); (2) conceptualizations of communication both draw on and influence ordinary ways of talking about talk (metadiscourse); (3) conceptualizations of communication have implications for how we live and move through the world; (4) communication is only a distinct discipline when scholars foreground communication as *the* social process that implicates all other phenomenon.

Rather than position the premise that communication is constitutive against other ways of conceptualizing communication (i.e., the transmission model), Craig (1999) argues that a practice approach takes a step up, or "goes meta" to "open up conceptual space in which many theoretical models of communication can interact" (p. 126-127). Essentially, the constitutive metamodel of communication foregrounds practical metadiscourse to identify everyday ways of conceptualizing communication. The goal is to facilitate a dialogue amongst different ways of doing communication, not to state that any one is better, but to discuss the implications, merits, and limitations of certain conceptualizations. By taking a metaposition to study communication

as a situated practice, I do not aim to simply deconstruct conceptualizations of communication, but to consider their implications, offer approaches for engaging with practical metadiscourse and the real-world problems that come with them in order to contribute to communication skills training in medical education.

Reflexivity

I am myself part of the discourse of communication skills. Both in my work as a SP and as a communication scholar, I am uniquely shaped by and shaping this practice; as Krippendorff (1997) offers, "we live in communication while theorizing it" (p. 48). Dance's (1967) Helical Model of Communication visually demonstrates the reflexive nature of communication, in that each interaction is building on a previous interaction and offering future possibilities (Figure 1.1). My actions matter and there are consequences to how I participate in the metadiscourse of communication skills (Sigman, 1995). I must be willing to live with the implications of my actions as well as the meanings they draw upon and conjure. Moreover, as Kuhn, Ashcraft, and Cooren (2017) emphasize, reflexivity is not just about an awareness of my own positionality to the work I am doing in this project, but also how "a body of research mingles with (not necessarily human) bodies in practice" (p. 88). This dissertation project is an involves a constant awareness and repositioning to consider the implications of communication skills, both in medical education and broadly.
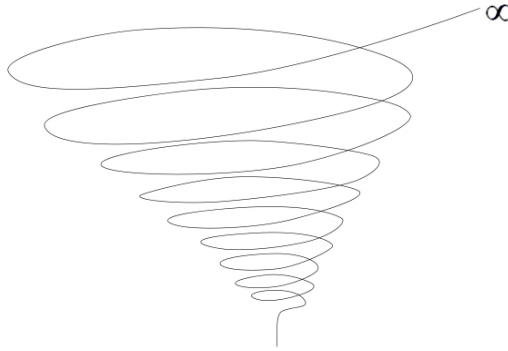
Figure 1. 1 Dance's Helical Model of Communication

Investigating Communication in Medical Education

Lipkin (2010) reflects on the longstanding humanistic and empirical traditions that support and inform the practice of communication skills training in medical education to the extent that, "we know what ought to be done, we can teach it to MSs, residents, and practitioners, and doing so improves important outcomes of care, as well as patient and practitioner satisfaction in their mutual and important work" (p. 10). The notion of skill itself involves an understanding that communication is not an everyday accomplishment, but a medical skill that can be taught and learned. In the following, I explain how communication is thoroughly institutionalized and technologized as a skill in medical education.

Institutionalization

By institutionalization, I refer to the robust integration of communication skills training in the institution of medical education. This is perhaps most evident in the United States Medical Licensing Step 2 CS Exam (USMLE; often called "Step 2"), which is required for any physician or student to practice medicine in the United States. The exam guide centralizes communication skills as the object of assessment and emphasizes the importance of communication to medical practice. For instance the 2017 Exam Guide states:

The ability to engage in patient-centered communication is essential to safe and

effective patient care. Step 2 CS is intended to determine whether physicians

seeking an initial license to practice medicine in the United States, regardless of

country of origin, can communicate effectively with patients (Federation of State

Medical Boards of the United States, Inc., 2017, p. 10).

The Step 2 is a gatekeeping mechanism for medical practice that is built on the premise

that communication is an important skill that can be observed, measured, and assessed. That the

USMLE requires anyone wanting to practice medicine in the United States to demonstrate

communication skills competency exhibits the dynamic of institutionalization at play in the

CSLC. In essence, the Step 2 supports SP practices and SP practices support the Step 2.

Technologization

Communication exists in the realm of experts, who Fairclough (2010) refers to as

"technologists." Peters (1999) elaborates, "[communication] has become the property of

politicians and bureaucrats, technologists and therapists, all eager to demonstrate their rectitude

as good communicators, [and in doing so] its popularity has exceeded its clarity" (p. 24). The

conceptualization of communication as a skill is a "technology," or a tool, used by experts to

designate, regulate, and authorize communication practices (Fairclough, 1989/2013; 2010). The

technologization of communication attempts to ensure and uphold conventions of who should

communicate, how they should communicate, and when communication should occur (Jones,

2016). Fairclough (2010) explains this is accomplished by "redesigning existing discursive

practices and training institutional personnel in those redesigned practices, on the basis of

research into the existing discursive practices of the institution and their effectivity" (p. 137).

Communication skills, as we shall see in the case of the CSLC, are defined on the basis that by performing selected and objective variables, one can become a skilled communicator.

Research Questions

In this project, I attend to communication as a practice, putting together a picture of communication skills from the bottom up. By observing the dynamics of metadiscourse, including my role in it, I argue that communication skills are not a trait that MSs do or do not possess, nor a variable that SPs measure, nor an idea that the CSLC governs. Communication skills are distributed and negotiated by multiple stakeholders, including myself. It is by looking closely at the practices of the CSLC and its members that I am able to consider the implications of communication skills to advance theory and practice.

My analysis centers around the Communication Skills Practice Exam (CSPX)–a day-long activity at the CSLC designed to prepare third-year MSs for their Step 2 CS Exam. I take a synthetic approach to doing discourse analysis to investigate three SP practices: (1) the Scripts issued to SPs prior to Simulated Consultations with MSs; (2) the actual Simulated Consultations between SPs and MSs and; (3) the Computerized Assessment Form that SPs complete to evaluate MS's communication skills. The data come from a single day of the CSPX activity in the Spring of 2018. Over the course of the day, 9 MSs and 21 SPs playing 12 different patient Scripts generated 97 Simulated Consultations (about 24 hours of video data) and 97 Assessment Forms. The following research questions systematically break down these practices to examine communication skills at the CSLC:

1.0   How are communication skills conceptualized in Scripts?

      1.1.   What strategies does the Communication Skills Learning Center use to constitute communication skills in Scripts?

1.2.   What are the implications of communication skills in Scripts?

2.0   How are communication skills conceptualized in Simulated Consultations?

2.1.   What strategies do the Communication Skills Learning Center, Simulated Patients, and Medical Students use to constitute communication skills in Simulated Consultations?

2.2.   What are the implications of communication skills in Simulated Consultations?

3.0   How are communication skills conceptualized in the Assessment Form?

3.1.   What strategies does the Communication Skills Learning Center use to conceptualize communication skills in Multiple-Choice and Open-Ended items?

3.2   What strategies do Simulated Patients use to complete Open-Ended items?

3.3.   What are the implications of communication skills in the Assessment Form?

Outline of the Project

The purpose of this chapter was to introduce my approach to studying communication skills in medical education. Chapter II overviews the background of communication skills in medical education and current research on SP practices, specifically from a discourse analytic approach. In Chapter III, I describe the CSLC and explain how I use discourse analysis to answer my research questions. My research questions frame my analysis of SP practices (Chapters III, IV, and V). In Chapter IV, I examine the how communication is conceptualized in the 12 Scripts of the CSPX by using corpus-based genre analysis. Chapter V unpacks the metadiscursive strategies that the CSLC, SPs, and MSs use to constitute communication skills in Simulated Consultations. In Chapter VI, I analyze how the Assessment Form conceptualizes communication in Multiple-Choice items, as well as how SPs complete Open-Ended items. In the final chapter, Chapter VII, I consider the implications of SP practices as they occur at the

CSLC and suggest ways of moving forward with communication skills training in medical

education.

CHAPTER TWO:

LITERATURE REVIEW

The notion of skilled communication is rooted in the professionalization of medical practice. Professionalization is "a complex dynamic process with several levels of action'" (Abbott, 1991, p. 380). Moreover, professionalization is communicative in that professionals are created through and ratified in communication practices (Benoit-Barné & Cooren, 2009). We speak professionals into existence through speech-acts ("I present to you, Dr. So and So!"), perform material and embodied actions that mark transitions to professional status (i.e., the movement of a tassel on a graduation cap), and create organizations that identify standards of practice (i.e., passing the USMLE Step 2 CS exam) (Austin, 1962). Each of these dimensions of professionalization demonstrates the performative nature of communication, in that communication is social action that impacts how we experience the world. The process of professionalization, often through years of formal education, equips people with the language, techniques, and activities that show persons as knowledgeable, competent, and capable. These performative acts also show others how to treat professionals, not because of any inherent positionality, but through moment by moment performances.

The practices of communication skills training in medical education shape how future physicians present themselves in interactions with patients. Scripts, Simulated Consultations, and Assessment Forms all highlight the importance of communication in medical practice, as well as suggest the approaches that medical students (MSs) should take to show themselves as

competent. In this chapter, I synthesize the history of professionalization in medical education, describe the institutionalization of communication as a medical skill, review approaches to communication skills training with simulated patients (SPs), as well as consider the affordances and limitations of communication skills training in medical education from a discourse analytic approach, which where I situate this project.

The History of Medical Professionalization

Medicine garnered cultural fortitude in the early 20th century through the process of professionalization. Ashcraft, Muhr, Rennstam, and Sullivan (2012) explain that professionalization is ultimately defining the criteria for inclusion and exclusion. A key figure in the process of including and excluding who counts as a medical doctor is Abraham Flexner. Under the funding of the Carnegie Foundation in 1910, Flexner conducts a strategic evaluation of medical education programs across the United States. In the final report, the Flexner Report (1910), he descriptively compounds the failures of proprietary (for-profit) programs and the unreliability of apprenticeships (working with another physician), instead promoting scientific and professional standards observable in university medical education (Porter, 1999).

Through his report, Flexner (2010) argues that all medical schools should adopt a Johns Hopkins "scientist physician" Model. The Johns Hopkins Model is attributed to two prominent figures at Johns Hopkins Medical School–Dr. William Welch and Dr. William Osler–who built a systematic approach that revolutionized medical education: (1) The school recruited professors and students from outside the local area to offer a science and research based education; (2) students spent their first two years learning basic sciences and their last two years of clinical rotations with practicing physicians in hospital wards; (3) students could "specialize" and attend an extended internship known as a "residency" (Starr, 1982/2017). The Johns Hopkins Model

offered a concrete approach to professionalization, which was now backed by an authoritative report. The findings of the report further informed accreditation and licensing practices, in effect eliminating programs that used "alternative" pedagogical approaches, which often enrolled women and persons of color.

Flexner's (1910) curricular demand for medical school to be a place of scientific research made physician character, or bedside manner an addendum to scientific treatment. Only fifteen years after the Flexner Report, Dr. Francis W. Peabody in a 1927 issue of the *Journal of the American Medical Association* wrote of upcoming physicians, "they are too 'scientific' and do not know how to take care of patients" (p. 877). Peabody (1927) argues the importance of combining medical knowledge with "ethical reasoning," in other words, proper communicative conduct. In the early 20th century, "proper ethics" or "bedside manner" could not be taught or shaped but are instead conceptualized as static traits that physicians either do or do not have (Frankel, 2004). The joint philosophy of science and character developed throughout the 20th century in various psychological and behavioral models that shifted communication to something that could be taught, no less through a philosophy of scientific reasoning (Irby & Hamstra, 2016).

Communication as Medical Skill

Over the past hundred years, the discourse of medicine has changed, and in today's modern era of customer service and healthcare reform, communication is more important than ever. The first mention of communication as a medical skill occurred in the mid 1980s. In 1984, the Association of American Medical Colleges (AAMC) created the General Profession Education of the Physician and College Preparation for Medicine, suggesting medical schools teach common "knowledge, skills, values, and attitudes" to all students, regardless of

specialization (AAMC, 1998, p. 2). Only one year later, the United States Medical Licensing

Examination (USMLE) required medical schools to define their objectives, and the term

"communication" caught on.

During the late 20th century, the AAMC, Institute of Medicine (IOM)[2], and the USMLE

identified the need for medical schools to specifically develop "communication skills" training.

In 1998, the AAMC published *Learning Objectives for Medical Student Education: Guidelines*

for Medical Schools, which defined a list of 30 curricular objectives to design medical

curriculum. In Phase II, the AAMC issued a series of reports written by a panel of experts on

special topics in medicine, including, *Communication in Medicine,* detailing the need for

students to become competent communicators as well as what that entails. The AAMC (1999)

states, "interpersonal communication remains the linchpin of medical practice" (p. 4) and

"should be assessed by direct observation" (p. 12). The AAMC argues communication skills are

visible and proposes a series of protocols that medical schools should put in place to capture

communication skills competency.

Like the AAMC's specification of communication as a key aspect of medical care, the

IOM's 2001 report, *Crossing the Quality Chasm,* explains how the healthcare system, broadly,

can foster innovation and improve the delivery of patient care. By instituting six aims—that

healthcare be safe, effective, patient-centered, timely, efficient, and equitable—the IOM put forth

a plan to "[restructure] clinical education to be consistent with the principles of a 21st century

health system throughout the continuum of undergraduate, graduate, and continuing education

for medical, nursing, and other professional training programs" (Committee on Quality of Health

Care in America, 2001, p. 208). The same document offers a list of professional skills, many

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[2] The Institute of Medicine was rebranded as the National Academy of Medicine in 2015.

referring to "communication" as the ability to "synthesize the evidence base and communicate it with patients," "communicate with patients in a shared and fully open manner," and "work collaboratively with teams with shared responsibility" (p. 209). The IOM compounds their skill-based protocol by stating, "teaching these skills will likely require changes in the curriculum," which leaves medical schools to institute communication skills training as they see fit.

Finally, the USMLE's addition of the Step 2 Clinical Skills (CS) Exam in 2004 compounded the institutionalized importance of "communication" in medical education. Following the National Board of Medical Examiner's (NBME) evaluation of the USMLE, the institution saw a need to "assess communication skills, clinical problem-solving skills, and spoken English proficiency" (Hoppe et al., 2013, p. 1670). Examiners determine "communication skills" should be patient-centered, or maintain "a consideration of patient's needs, perspectives, and individual experiences; provision of opportunities to patients to participate in their care; and enhancement of the patient-clinician relationship" (Epstein & Street, 2007, p. 1). The exam's assessment of "Communication and Interpersonal Skills (CIS)" further describes patient-centered communication through a series of activities like, "fostering the relationship, gathering information, providing information, helping the patient make decisions about next steps and supporting emotions" (Federation of State Medical Boards of the United States, Inc., 2017, p. 10).

Models of Communication Skills for Medical Practice

There are multiple models and approaches for conceptualizing communication skills in medical practice. Cegala and Lenzmeier Broz (2002) chart the skills identified in 26 studies from 1990 to 2002, which are by no means limited to asking open questions, establishing eye contact, checking and clarifying comments, acknowledging patient symptoms, making empathic

statements, building rapport, exploring health beliefs, exploring family and social factors, talking less, allowing the patient to tell story without interruption, asking about feelings, relationship-building skills, etc.. The lists of communication skills offered in most studies synthesize physician's actions or describe abstract relational goals in such a manner.

Two of the most notable communication skills models are the Calgary-Cambridge Referenced Observation Guide (Kurtz & Silverman, 1997; Kurtz, Silverman, Benson & Draper, 2003) and the Kalamazoo Essential Elements Communication Checklist- Adapted (Makoul, 2001). Both models align communicative actions with the goals of national organizations like, the AAMC. The Calgary-Cambridge Model is organized around the typical order of a medical consultation– initiating the session, gathering information, physical examination, explanation and planning, and closing the session. Throughout the consultation, practitioners should provide an organizational structure and build the relationship through a series of skills, like making the organizational structure of the consultation overt or using appropriate non-verbal behavior. The Calgary-Cambridge Model identifies 71 skills to use throughout medical consultations, although not all skills are to be exercised in all situations. Furthermore, as various schools and organizations implement the model, they do not include all the skills (Englar, 2017).

A team of researchers, physicians, and prominent figures in medical education wrote *The Kalamazoo Consensus Statement (KECCA-A)* in 1999-2000. The team defines communication as, "specific tasks and observable behavior that include interviewing to obtain a medical history, explaining a diagnosis and prognosis, giving therapeutic instructions and information needed for informed consent to undergo diagnostic and therapeutic procedures, and providing counseling to motivate participation in therapy or to relive symptoms" (Duffy et al., 2004, p. 497). The Kalamazoo II focuses on developing skills physicians should use in patient consultations and

defines practicing the skills as 7 elements, which can be rated by faculty, students, and SPs on a 5-point Likert scale: (1) Builds relationships; (2) Opens the discussion; (3) Gathers information; (4) Understands the patient's perspective; (5) Shares information; (6) Reaches agreement; and (7) Provides closure. The observation and adequate completion of these tasks marks the KEECC-A as "a psychometrically sound, user-friendly communication tool, linked to an expert consensus statement, that can be quickly and accurately completed by multiple raters across diverse specialties" (Joyce, Steenbergh, & Scher, 2010, p. 165).

King and Hoppe (2013) synthesize communication skills models and identify six communicative functions as key to successful medical consultations: (1) Fostering the Relationship; (2) Gathering Information; (3) Providing Information; (4) Decision Making; (5) Enabling Disease and Treatment-Related Behavior; (6) Responding to Emotions. Each of these functions is constituted by lists of skills. For instance, a physician can foster the relationships by greeting the patient appropriately, maintaining eye contact, listening actively, etc. Each of these skills is supposedly linked to positive clinical outcomes and can be captured through assessment forms, which are completed by third party observers.

Supporting the development of communication skills frameworks are two major shifts in medical practice for how patients are conceptualized: the patient-centered approach and the relationship-centered approach. Epstein and Street's (2011) patient-centered approach views patients "as persons in the context of their own social worlds, listened to, informed, respected, and involved in their care– and their wishes are honored (but not mindlessly enacted) during their healthcare journey" (p.100). In essence, the shift towards recognizing and engaging a patient's unique positionality supports skills like, "empathetic listening" or "shared decision making." The relationship-centered approach takes it one step further, acknowledging both the

patients and the physician's subjectivities, as well as how their uniqueness is emergent in that relationship (Suchman, 2005). This manifests in how different skills may be easier for some physicians or how unique patients report satisfaction as a result of some skills rather than others. The paradigm shifts of patient-centered and relationship-centered care emphasize the humanity of patients and physicians while communication skills training becomes the extension of those paradigms, equipping physicians with the tools to improve patient satisfaction and care.

Simulation-Based Education

SPs are the gold-standard of communication skills training in medical education. The use of SPs in medical education is attributed to American physician, Dr. Howard S. Barrows (Barrows, 1993). After two instances in the late 1960s, Barrows conceptualized the possibility of using specially trained people to enact medical scenarios for medical school students. First, Barrows observed the practices of Dr. David Seegal of the Columbia-Presbyterian Research Unit, who closely observed his students carrying out history taking and physical exams for two to three hours at a time. Following the observations, Seegal showed students their errors, then offered feedback for how to better perform clinical tasks. Barrows (1993) notes that students were enthusiastic about receiving such feedback and he continued the practice in his own teaching. Additionally, Barrows served as the chief resident responsible for bringing in neurological patients for board examinations in psychiatry and neurology. One of the patients Barrows brought in craftily played a different patient-role than initially requested, leading him to realize the nuances of performance choices.

These two experiences influenced Barrows' teaching during his first academic post at the University of Southern California. During this time, Barrows coached a female model from the art department to repeatedly portray specific neurological symptoms for students in training.

Barrows (1993) reflects, "this worked extremely well…I learned about students' interpersonal skills, clinical skills and thinking skills" (p. 446). Barrows eventually called this pedagogical device a "standardized patient[3]," which offered students the opportunity to experience actual clinical problems, practice formative skills, receive feedback, and participate in active learning processes in a standardizable and repeatable activity (Barrows, 1993, p. 451). Barrows continued to develop SP practices over the next thirty years, advocating for their integration in medical education for communication skills practices and assessment, which today forms the baseline of simulation-based education.

SPs are routinely used to teach and assess communication skills to MSs (Lane & Rollnick, 2005; Kaplonyi et al., 2017). By using SPs in communication skills training, medical educators are able to create "life-like" cases with a variety of patient persona and pertinent diagnoses for MSs to repeatedly practice communication skills and receive feedback from "a patient perspective." In general, SPs are considered to offer MSs the opportunity to practice communicating with a proxy of patients in a "safe" context, where neither the MS or patient are at risk and where the student can receive feedback to improve communication skills.

SPs are designed to measure clinical competence broadly, which includes "the purposive integration of basic science, technical skill, empathy communication, professional role and personal history," (Feeley et al., 2010; Rose & Wilkerson, 2001, p. 856). The experiential method is said to actively simulate clinical practices and enhances student learning of communication skills (Kurtz, Silverman, & Draper, 1997). Research on simulation-based education mentions student's improved confidence and improved performance scores from SPs and medical educators (Pilnick et al., 2018). Finally, MSs are said to prefer this method of

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[3] Again, the terms standardized patient and simulated patient are used interchangeably.

communication skills training as opposed to listening to lectures, meeting with actual patients, or watching video-taped interviews (Eagles et al., 2001). In a narrative-analysis of MS reflections on simulation-based education, students claim that simulation improves their communication abilities because it allows them to fail in a safe way (Bearman, Greenhill, & Nestel, 2019).

SPs are also integral to Objective Structured Clinical Examinations (OSCEs, "ah-skis"), which are designed to assess MSs on their communication and diagnostic competencies. Medical educators establish the criteria for assessment in Assessment Forms, create Simulated Consultations for MSs to demonstrate their competency, and develop Scripts to prepare simulated patients to perform. Simulated Consultations are conducted in a specified time frame where the MS enters the room and performs physician by interacting with a SP– a person hired by the medical school to portray a patient and assess communicative competency. After the consultation, MSs are assessed by a team of clinical examiners which can include practicing physicians, senior students (preceptors), and SPs, along the pre-determined criteria (Zayyan, 2011). Scores from multiple encounters determine whether students pass or fail official exams (Whelan et al., 2005). Although the emphasis of the evaluation can differ from activity to activity, communication skills are the most common item of assessment. Even the CIS portion of the Step 2 uses SPs in simulated consultations to assess communication competency. Twenty years ago, the AAMC and IOM encouraged medical schools to incorporate communication skills training in medical education, which are carried out in SP practices, implemented in routine OSCEs, and substantiated by the USMLE Step 2.

Despite the thorough integration of SPs into medical education, there are limitations to their use. First, SPs are expensive– each SP is paid anywhere from $15 to $50 per hour. Additionally, MSs say that the knowledge that an SP is not a real patient makes it difficult to

figure out how to interact with them and nearly impossible to empathize with them (Nestel &

Tierny, 2007). SPs may also perform patients or assess students differently from consultation to

consultation, which limits their ability to be truly standardizable. Finally, according to post-

intervention measures, SPs do not prove to offer an objectively better approach to

communication skills training than role playing or watching video-footage (Kaployni et al.,

2017).

Moreover, there remains the question of whether communication skills can be objectively

measured. Bearman and Ajjawi (2018; 2019) offer that checklists are not neutral tools, but

particular ways of seeing. A lead author of the KECCA-A even acknowledges the basis of

effective communication itself has no standard of metric for assessment (Makoul, 2001, p. 169).

Frankel (2004) draws on the mutual subjectivity that the relationship-centered approach proposes

and asks, "effective for whom?" acknowledging how "patients and physicians appear to define

satisfaction using different relationship qualities" (p. 1164).

Researchers also indicate concerns of whether communication skills are actually related

to whether one is "a good doctor." For instance, Hulsman and Visser (2013) challenge the idea

that medical communication can be isolated to particular skills and suggest "when

communication is reduced to skills only, this may not fully cover the subjective meaning

communication has for the interlocutors" (p. 145). Continuing along the idea that communication

is more than skills, Platt et al. (2001) argue the "two most useful physician qualities may be

curiosity and patience—curiosity to ask questions such as 'tell me about yourself,' and the

patience to wait for the answer" (p. 1083). The unmeasurable qualities of communication are

further claimed to be "both a skill and a way of being, that is both innate and teachable, but that

it must be cultivated by integrated methods of teaching and research" (Zoppi & Epstein, 2002, p. 319).

The notion of communication skills that SP practices claim to develop and assess, is muddled by a lack of definition, standard of measurement, and a multiplicity of perspectives on what constitutes a "good" communicator. Yet limitations are not only focused on the *je ne sais quoi* nature of a "good doctor," but also the interactionally imprecise nature of a skills-based framework, which often involves coding student's utterances as "building a relationship," rather than focusing on the actual utterances MS perform.

Interaction-Based Approaches to Communication Skills

Interaction scholars often argue that communication skills frameworks are interactionally imprecise and simulated consultations are an inauthentic proxy for communication skills training. Conversation analysts engage in microanalytic studies of talk in interaction–including medical consultations– to describe and analyze typical features of interaction, like turn-taking (how speakers manage who talks when), sequence organization (how speakers organize their utterances together), and repair (how speakers 'fix' interactional trouble with others) (Heath, 1981; 1986; Heritage & Maynard, 2006; Sacks, Schegloff & Jefferson, 1974; Stivers, 2005).

Conversation analytic findings demonstrate the systematic and nuanced nature of talk and for medical education, conversation analytic findings substantiate the need to specify not only *what* physicians should do but *how* they should do so on an empirical basis. For instance, Robinson (2006) examines the subtleties of how physicians solicit a patient's concerns. The way a question is constructed, or what is known as a question's design, makes explicit physician's understandings of why a patient is visiting the clinic– for a new issue, follow-up visit, or routine care. When physician and patient understandings are misaligned, it can cause a great deal of

interactional trouble, stagnating a consultation's progress, and destabilizing the relational

solidarity required to achieve medical goals. In the following extract of a doctor-patient

interaction, the physician (DOC) begins in line 5 with a question that is designed to solicit a

patient's new concern, which the patient (PAT) expresses trouble with:

Extract 10: DIZZINESS (From Robinson, 2006, p. 41)

>5 DOC: So what can I do for you today.

6   (0.2)

7   PAT: Uh:m- (0.2)

8   DOC: Oh yes. yes.

9   (0.2)

>10 DOC: .hhh How's the dizziness.=hhh

11 PAT: Well I went to a therapi:st . . .

After the physician's initial question, the patient briefly pauses (0.2 being the amount of

time paused; See Appendix C) and delays her answer (Uh:m-), which indicates trouble with the

initial question. The physician tries again in line 10 with a different type of question construction

that requests an update on a previous concern rather than a new concern. Robinson's (2006)

extract demonstrates that it is not enough for physicians to simply "solicit a patient's concerns,"

but that *how* a physician solicits that concern matters.

Furthermore, Heritage and Robinson (2011) consider the implications of how

communication skills are taught in medical textbooks versus what works in actual practice. The

team compares how textbooks suggest soliciting patient's additional concerns ("is there anything

else we need to take care of today?") with what they argue is a more conversationally sound way

of asking ("do you have some additional concerns?"). The team argues the word "any," is

"negatively formulated," or geared towards answers of "no," so they test the different way of asking by implementing an intervention for primary care physicians. Their results demonstrate "do you have some additional concerns," at the start of the consultation rather than "is there anything else we need to take care of today," reduces patient's unmet concerns by up to 75%. Based on this finding, the team recommends that communication skills training should be geared towards the more effective question design.

Stivers (2002) also considers the tensions of the communication skills taught in textbooks and actual medical practice by looking at the issue of antibiotic treatment in pediatric encounters. While there is a consensus that parental pressure is the reason for over-prescription of antibiotics, the techniques that parents use to bring up the issue are in tension with the communication skill of "shared decision making." Stivers states, "physicians must work to encourage and maintain parent participation while simultaneously not giving into pressure to prescribe inappropriate treatment" (p. 1127). Of course, this is easier said than done and Stivers leaves room for future studies to consider the tension between the communication skill and actual practice.

Comparing Simulated and Actual Interactions

Not only are there contradictions between communication skills frameworks and actual medical practices, there are differences in how SPs communicate from how actual patients communicate. One additional criticism of simulation-based education as a means of communication skills training is that SPs do weird things and are "inauthentic" (Stokoe, 2013). Stokoe (2011) compares actual and simulated police interviews of suspects to demonstrate the inauthentic nature of simulation-based education. In simulations, institutional requirements are more exaggerated, "being made interactionally visible and 'assessable'" (p. 165). For instance, the institution requires police officers to state the interview is being recorded, but participants in

simulated interviews include others as part of the recoding process ("everything *we* say is now being recorded") versus how in actual interviews, the officers simply announce the recording without including the interviewee as a participant ("This interview is being tape recorded"). Stokoe (2011) argues the use of "we" versus the announcement of the recording invites participant's understanding that they are part of the recording, which increases rapport for the sake of an observer. Stokoe (2013) urges the need for similar studies comparing "training and actual interactions" to understand the differences and consider their implications (p. 183).

Interaction-based scholars compare actual and simulated medical encounters across a variety of contexts, from general practice to surgery. In a discourse analytic study of simulated consultations between SPs and third year MSs, de la Croix and Skeleton (2013) observe that in comparison to other studies of doctor-patient communication, simulated interactions contain more patient interruptions (versus in other studies that evidence more doctor interruptions), more patient topic selection utterances (versus other studies that demonstrate physicians directing topics of conversation), and initiating closing sequences (versus how physicians typically close interactions). De la Croix and Skeleton (2013) conclude that SPs communicate differently than actual patients and indeed, prepare MSs to interact in an inauthentic manner.

Atkins (2019) compares actual and simulated general practice consultations and demonstrates that MSs in simulated consultations use the phrase "tell me more about" more often than physicians in actual consultations. Atkins proposes that one of the possible reasons for this phrase is that SPs do not provide opening narratives in the same way that actual patients do (Heritage & Maynard, 2006). Because of the shorter openings, MSs offer longer receipt tokens ("I'm sorry to hear that" rather than short continuers, mid-narrative, like "mhm"), and follow up with statements like, "tell me more about" to solicit more elaborate accounts.

In comparing actual and simulated surgical consultations, White and Casey (2016) attend to the differences in problem presentation, transitions, and justifications for visiting the doctor. For instance, SPs present their problems as strange symptoms and unrecognizable problems, although surgical consultations require referrals from general practitioners, which in actual consultations is evident in how patients explain their referral, offer potential diagnoses, and cite medical tests regarding symptoms (i.e., a colonoscopy). Additionally, the transition to the history taking section of the consultation is not as clear in simulated encounters as it is in actual consultations, where patients bring their complaints to the present moment and explain the reason for their visit. Finally, in justifying their reason for the visit, SPs provide accounts similar to primary care consultations, like why their symptoms merit doctorability (i.e., patients showing they are reasonable persons with reasonable reasons to visit the doctor), whereas typical surgical consultations are justified by simple referrals (i.e., "I've got a letter from Dr. Stevens"). Each of these differences provides support for the claim that simulated consultations are different from actual medical consultations.

Discursive Hybridity in Simulation

Though simulated consultations are interactionally different from actual consultations, to consider them inauthentic is an oversimplification of what is actually a theoretically and interactionally complex activity. Roberts & Sarangi (1999) suggest that simulation is a sort of hybridizes discourse that involves moving between multiple modes of talk, from the everyday to the professional and back again. Levinson (1979) explains the concept of an activity type, as "any culturally recognized activity" like, "teaching, a job interview, a jury interrogation, a football game, a task in a workshop, a dinner party" (p. 368). Hybridization involves participants strategically navigating multiple activities and roles. For instance, Linell and Thunqvist (2002)

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analyze simulated job interviews and observe how participants move in an out of the interview activity, and "as a result, the activity comes out as a job interview plus metacommunicative activities (assessing, reviewing, advising, education)" (p. 429). For instance, a teacher performs both interviewer and teacher, shifting away from performing interviewer to teaching how to interview in the moment. Simulation involves a sort of meta-shift to comment on an activity type as participants are both performing and commenting on the situation at hand. Simulated medical consultations are also hybrid activity types, where the ways speakers present themselves and comment on the activity provides a site of practical metadiscourse.

Seale et al., (2007) adopt Goffman's (1974) notion of "framing" to get at the hybrid nature of simulated medical consultations. In simulated medical consultations for communication skills training, there is the activity of medical consultation and the activity of educational assessment. The medical consultation is "the front stage as students perform as doctors" (Monrouxe, Rees & Bradley, 2009, p. 920). However, there are multiple framings available to participants—performing scripted patient, performing physician, evaluating the MS's communication, and reacting to the patient's performances. Atkins, Roberts Hawthorne, and Greenhalgh (2016) offer that, "candidates who can handle the social and linguistic complexity of this somewhat artificial, simulated situation score highly – yet what is being assessed is not real communication but the ability to voice a credible appearance of such communication" (p. 7).

While the medical school or the impending assessment are not explicitly discussed, they are still within the context of the interaction, as something drawn on and emphasized by speakers. Atkins and Roberts (2018) demonstrate how MSs make aspects of empathy interactionally visible in simulated consultations for the purpose of the assessment. They note that empathy in the context of simulation is complex, since it is an "inner" state that must be

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made interactionally visible to what is known as a fake patient. Successful students manage the tension between "trained empathy," or sounding formulaic, with slight modulations of their voice or phrasing that require them to do extra interactional work. These small differences matter in the context of assessment and can unfairly harm non-native English-speaking students.

In part, this project is concerned with how MSs and SPs engage in framing activities in simulated consultations and how those activities comment on communication skills, which are embedded in the metadiscourse of communication. Previous studies either compare simulated and actual consultations or look at how speakers manage the hybrid activity type. While I look at how speakers manage the hybrid activity type and what such metadiscursive performances indicate about communication skills, I also contextualize my analysis of simulated consultations within two other activities: (1) the SP Scripts that form the basis of the consultation and (2) the Computerized Assessment Form that accounts for performances in Simulated Consultations. I look at chains of spoken and written discourse to understand communication skills as part of a larger practice, including institutional documents (Bazerman, 1997; Berkenkotter, 2001).

Institutional Documents and Communication Skills

SP practices are inextricably related in talk and text. Scripts and Assessment Forms are part of Simulated Consultations and vice versa. Murtagh (2015) identifies two problems with scripts: they are written by physicians about actual patients and are thus re-interpretations of a medical experience, from a medical perspective, and the SP has a mental map of how the consultation will or should occur, which students do not have. In actual consultations the physician draws on knowledge of how the consultation should unfold, which patients are not fluent in. That SPs know how a simulated consultation should unfold entails a critical imbalance of institutional knowledge. Bearman and Ajjawi (2018) take a socio-material approach to the

OSCE and add that it is "a holistic combination of peoples and objects," which includes the texts that SPs use (p. 1037).

The most comprehensive study of simulated communication skills is by Roberts, Atkins, and Hawthorne (2014) who analyze the U.K.'s Royal College of General Practitioners Exam by looking at the structure of SP cases and lexical content of simulated talk. The team notes, "interpersonal skills are the most culturally-specific and linguistically demanding aspect of the exam for this group and the skills most based on examiner instinct" (p. xiv). As an intervention, the team suggests a continued use of video recording techniques and creating a new analytic language in Assessment Forms to increase MS's self-awareness of performance and awareness of cultural specificity in interactionally complex cases.

Improving Simulated Patient Practices

Considering issues of authenticity in simulated consultations, the institutional knowledge of, and the weight placed on assessments for the purpose of professionalization, what should be done? Should SP practices be considered an obsolete form of communication skills training? Could other approaches address the issues at play? And what is the role of assessment and reflection in simulated-based learning?

Stokoe (2011) rejects the assumption that simulated-based trainings allow trainees to practice conversational moves in a "good enough" context and suggests the Conversation Analytic Role Play Method (CARM) as an alternative to simulation-based education. Through the method, researchers assemble video recordings and transcripts of actual interactions in a relevant context, for instance, mediation, police interviews, etc... Rather than base standards of effectiveness on *ex-post facto* models, Stokoe (2011) uses the "next turn proof procedure," or how a speaker does or does not respond to the other speaker's utterance, to constitute effective

communication. For instance, if the physician asks a question using a successful design, the patient answers what was asks, rather than seeking clarification or answering about another topic. Then the facilitator presents actual video footage along with a transcript to the workshop audience. At critical points, the facilitator stops the video, asks participants to discuss in small groups what they would do next and why, and then play the actual response to identify effective practice. Through the practice, trainees learn to attend to the nuances of interaction and consider the implications of pauses, word choice, etc...

However, several scholars insist that while simulation is not perfect, it is nonetheless beneficial. Simulation-based education offers MSs the opportunity to practice talking with a proxy of patients in real-time, as well as reflect on and receive feedback about an interaction. Murtagh (2015) suggests applying conversation analytic findings to how roles and scripts are designed, for instance by asking SPs to "construct scenarios based on transcribed material and play the role of the patient based on authentic communication evidenced by patients in actual encounters" (p. 51). Similarly, in a study of hostage and crisis negotiation simulations, Van Hasselt and colleagues (2008) propose, "providing greater detail in scenario descriptions" as a solution for improving authenticity. White and Casey (2016) also recommend incorporating more elements of "the patient experience" into preparation for actors so they can more "authentically" present problems. Additional researchers suggest inviting real patients to talk with SPs so they can be more genuine in simulated consultations (Kruijver et al., 2001; Netstel & Bearman, 2015). Pilnick and colleagues (2018) suggest applying CA findings to SP training around a number of medical conditions, which has shown to be successful for cases on aphasia of speech, epilepsy, and psychosis (Beeke, Maxim & Wilkinson, 2007; Jenkins et al., 2015; Thompson & McCabe, 2016;). This approach seeks to balance the issues of inauthenticity with

the affordances of simulated consultations, which offer "an opportunity to develop confidence and expertise in a safe and supportive environment with no repercussions for actual patients" (Pilnick et al., 2019, p. 8).

Other scholars suggest keeping simulation as an activity but changing how students are taught to reflect on their own communication practices. For instance, Roberts and Sarangi (2002) examine simulated consultations to determine "what makes for (un)successful medical interviews" (p. 99). Overall, students receiving high grades "achieved 'tunefulness' and managed to integrate authority and solidarity," while students receiving low grades "did not take the patient with them" and used means of canned statements and trained empathy (p. 113). Then they describe empathic and retractive styles to offer medical educators interactional evidence and descriptions of what are deemed "effective communication" as well as provide future practitioners with "tools for self-analysis in real patient-health care professional communication" (p. 114). In a follow-up study, Roberts et al. (2003) argue the need for "a new taxonomy to accommodate" their interactional findings of what makes a "good" and "poor" communicator in OSCEs. By creating "interactional maps" easily comparing communicative styles, the team evidences what "works" and what does not, but the institutional limitations of assessment may keep MSs from drawing on the stylistic examples to reflectively evaluate their own performances.

Finally, what role should assessments play in medical education? In the words of White and Casey (2016), "if the simulation is not authentic, what are we assessing? What should MSs be learning about communication and is simulation the best way to learn and assess it?" (p. 271). Ajjawai, Bearman, and Boud (2019) analyze three discourses of assessment– standards as written knowledge, standards as expert consensus, and standards "as a concrete artefact[s] that can

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mobilize or constrain human action" (p. 7). The third, socio-material approach, is embedded in a

performative ontology, where "standards are dynamic and ephemeral but coordinated across time

and space" (p. 8). Moreover, this approach to assessment suggests "the learning outcome is less

about setting a fixed point than it is about providing an invitation to 'productive space'" (p. 9).

However, how the productive space unfolds is key. de la Croix and Veen (2018) problematize

the panacea of reflection by asking questions like: What is reflection? How can we know it (and

in the context of medical education, measure or assess it)? And most importantly, can we even

know it? The authors suggest a deep irony in reflection– that by externalizing an internal process,

it changes it, and moreover, with an audience of educators, perhaps in a "zombie-like" and

unreflective manner. They suggest the antidote to this "zombie apocalypse" is accepting

reflections outside of conventional templates and checklists, considering how reflection is a

performance, and shifting the focus of reflective research to description, rather than prescription.

 Before making a statement on how to improve communication skills training and whether

SP practices are useful, I believe it is important to ask, "what occurs in SP practices?" This

project examines what SP practices actually entail– in Scripts, Simulated Consultations, and

Assessment Forms. Like the discourse scholars reviewed in the second half of this chapter, I see

the spoken and written interactions of the CSLC as institutional hybrid discourse. Agar (1985)

explains that institutional discourse occurs in any conversation when a person comes into contact

with another, who is "a representative of one of its institutions" (p. 147). In simulated

consultations, MSs interact with SPs, who represent the institution of medical education on

behalf of patients and are hired to carry out the mission of communication skills practices.

Furthermore, Agar (1985) identifies three features of institutional discourse: the interaction,

directive given by the institutional representative to either the client or institution, and a report

based on those directives. These features map onto SPs practices in the Simulated Consultation (the interaction), the Scripts that direct the Simulated Consultation, and the Computerized Assessment Form that SPs complete to report on student's communication skills. The hybrid nature of simulation occurs on the metadiscursive level, where participants engage in and comment on the nature of talk. By taking a hybrid stance on written and spoken SP practices, I situate this project within an ongoing thread of discourse research and look for practical findings to contribute to simulation-based education. In the next chapter, I describe the setting and practices of the CSLC as well as explain how I will examine these practices from a discourse analytic approach.

CHAPTER THREE:

STUDYING SIMULATED PATIENT PRACTICES

In August of 2015, I began working with the Communication Skills Learning Center

(CSLC). To begin this relationship, I emailed the Director, Assistant Director, and Professor of

Pediatrics at CSLC:

Hi,

My name is Grace Peters and I'm a doctoral student in the Department of

Communication. I received your contact information from Elisha Rose, who has previously

mentioned to you my interest in the Simulated Patient Program.

I'm interested in participating in the program as a simulated patient, but also am very

interested in the program as a site for my dissertation research. I'd love to talk to each of you,

either together or separately (whatever is most convenient for you, of course) about getting

involved. Would it be possible to schedule a meeting for sometime next week?

I look forward to hearing from you.

Kindly,

Grace Peters

Two days later, I received a response from the teaching doctor, Dr. Bravely, who was

enthusiastic about my interest. I was excited that they were open to my interest as a research site.

Over the next weeks, I heard back from the Director, Phoebe, and her Assistant Director, Liesel.

Phoebe introduced me over email to the Simulated Patient (SP) Coordinators, Doug and

Rebekah. Rebekah reached out to schedule a phone interview and shortly after I was invited to the CSLC for the first time for a tour and face-to-face interview.

To prepare for the face-to-face interview, I received my very first Script via email. I was to portray a patient named Heidi Mangrove, a store associate who injured her left knee while lifting a heavy box. The Script listed an extensive series of diagnostic questions and answers, which I was expected to memorize and perform for the interview. I remember being overwhelmed by the thought of remembering all the diagnostic information, especially how I was supposed to show pain when a MS performed certain physical exam maneuvers. But I spent time with my Script, highlighting the important details and writing how I would say this information in Heidi's words.

I arrived at the CSLC and met with Rebekah, a small young woman with a kind face, in the conference room. Her friendliness immediately put me at ease and her presence during my time at the CSLC was always comforting. She seemed interested in my background as a communication scholar and my minimal acting experience in college. Rebekah explained the bulk of my interview would be centered on the simulated consultation. She asked if I had any questions before we moved from the conference room to a simulated clinic room. The room looked just like a doctor's office, with institutional off-white walls, a paper-covered exam table, medical equipment, and a large computer. On one wall was a two-way mirror and above there was a video camera. Rebekah told me another SP would be playing the "medical student" (MS) and once they entered, we should play the case out. Rebekah said I could call a time-out at any point to consult the Script or ask for clarification on how to perform. Once the "MS" knocked on the door, I invited her in and played along. I answered the questions correctly. I showed the location of the pain in my left knee when she moved it in a certain way. I told the "MS" the pain

ranked a 7 out of 10. I called no-time outs. And then Rebekah called a "time-out." I froze, questioning what I thought was just a flawless performance. But rather than issue criticism, she asked me to offer the "MS" some feedback using the formulation, "As a patient, when you did this, I felt that." I cannot recall what I said to the "MS" that day, but I do remember the anxiety I felt for "getting it right."

After my feedback, Rebekah invited me to sit at the computer to complete my first Assessment Form. She and the "MS" left the room and I did my best to recall how the "MS" introduced themselves, what questions were asked, and how they made me feel. The exercise was challenging, as my focus to state all the right information kept me from paying attention to what questions were asked and how they were asked, but I did my best. And apparently, I did well, as I played my first official Script at the end of the fall semester.

My relationship with the CSLC is what Sarangi (2006) calls, "thick participation," which entails a form of socialization that is necessary for understanding the cultural practices of a professional organization. Moreover, someone who engages in "thick participation" aims to provide feedback to an organization for the potential uptake of research findings. Over three years, I worked to align my own interpretive practices with that of institutional participants and developed a relationship with Rebekah, Liesel, and many of the other CSLC staff members in hopes of sharing my findings. Although between 2018 and the time of completing this project in 2020, I do not feel I have maintained these relationships to the best of my abilities (between teaching courses, completing this project, and having two children, there was little time to work as a SP, which is how we maintained our relationship), I hope that what I offer in this project is of interest to the CSLC and will impact the field of simulation-based education and communication skills training.

During my time as a SP (2015 to 2018) I played over twenty different Scripts, from a college student with cystic fibrosis to a breastfeeding mother. I participated in hours of training, from Patient Portrayal to Musculoskeletal Lower Extremities Exam Skills. I spent four hours observing the Gynecological Teaching Associate Training, although I never worked up the courage to teach medical students how to perform pelvic exams using my own body. In early 2017, I worked with the oncologist who teaches the third year Breaking Bad News Elective to introduce a pregnancy loss case, which answered my initial question about whether medical students learn about pregnancy loss, "now they teach it (kind of)."

In this chapter, I offer a brief ethnography of the CSLC and describe my discourse analytic approach to studying communication skills practices at the CSLC, including the Institutional Review Board processes I maintained. I recount my experiences working as a SP at the CSLC, moving through the space and the people I worked with. Then, I describe my approach to doing discourse analysis, drawing on diverse methods from conversation analysis to corpus-based linguistics to make sense of the spoken and written practices among medical educators, SPs, and MSs that constitute communication skills discourse.

The Communication Skills Learning Center

About two years into my fieldwork at the CSLC, the organization moved from the main university campus where I interviewed with Rebekah to a large continuing education building in the downtown metropolitan area. The CSLC's move was part of a larger restructuring of the medical school, which employs approximately a dozen staff members and 100 SPs, and enrolls over 700 MSs and residents. After the move, everyone was required to drive to the downtown campus from the main university campus, about a twenty-minute drive, sometimes multiple times a day.

When I worked as a SP, I would receive regular emails from Matt, the other SP coordinator, consulting my schedule for the month ahead. When the CSLC was on the main university campus, I quickly responded to these emails with a broad availability. As they moved downtown, I became more limited by the times I could work. I would choose to work longer shifts, sometimes up to eight hours a day. These shifts typically started early in the morning, around 8:00 AM, so I would roll out of bed around 5:30 AM, grab my SP bag and drive almost an hour from my home to the CSLC to make the 7:00 AM arrival time. The following is an example of what a day working at the CSLC looks like.

I arrive downtown in the early hours of dawn, park several blocks from the building, and place my printed parking permit on the dash of my car. Some mornings I would forget to print the parking permit and have to swing by the CSLC lobby, grab an extra permit, run back to my car, and drive around the block of one-way streets to the gravel parking lot. My SP bag is light–a canvas tote with my patient gown, sweatshirt, sports bra, elastic-band shorts, and a pair of traction socks I snagged from the CSLC. In late 2017 and early 2018, I was pregnant and chose not to work as an SP. During this season I conducted between five and twenty hours of fieldwork a week. Once the CSPX activity began in late Spring, I brought my laptop and a lunch box so I could stay from the 7:00 AM arrival time to the 4:30 PM end time. I walk three blocks east in the dusk of morning towards the large building that houses the CSLC, hyper-aware of the cars rushing off the interstate beside me. I walk through the grand front entrance, to the elevator, and press a button that brings me to the third floor. I typically ride the elevator with medical educators or physicians completing trainings in other parts of the building. I walk down a narrow-carpeted hallway lined with abstract artwork and colorful lockers before turning right

towards a non-suspect glass door. The door has a sheet of white paper taped to it from the inside, showing four letters in a large black Helvetica– CSLC.

I enter through the door and gaze down a hallway littered with computer monitors and tall rolling chairs. I can see into the dark simulated clinic rooms beyond the monitors as the doors are often left open. Rebekah and Doug greet me as they tape Door Notes to the simulated clinic doors. They let me know they will be in the break room shortly. To the left of the entrance is a green desk with a time-stamp sheet on a clipboard. I find a pen in my tote bag, check my watch, and write my name and the time of my arrival on the sheet. Nobody sits at the downtown desk of the CSLC, which is strange because on main campus there was a bubbly receptionist, Jenn, who greeted each of the SPs and MSs. I miss Jenn, but I am always glad to see the familiar faces of the other CSLC staff members.

Figure 3.1 Opening Hallway of the CSLC

To the right of the entrance is a small room with a long desk facing two fifty-inch-flat-screen televisions that monitor, from two different angles, each of the twelve clinic rooms. Alexander rushes in and out of the room, ensuring the video monitors to each room are playing on the monitors. I wonder whose voice I will hear from this room later in the day, whether Midge or J.D., the CSLC employees who make the announcements that maintain the orderliness of the practice–when sessions start, end, when feedback tasks and write-ups should begin and end, as well as when students should rotate to their next room. This room is the most common place for CLSC staff to hangout while rounds of simulated consultations are running. I like to hangout in this room and talk with the staff members about what we see on the monitors or even what we last watched on TV during my field work

Figure 3.2 The Video Monitor Room

Continuing out the right of the Video Monitor Room toward the ajar and dark clinic rooms, I walk down the hallways towards the SP Break Room. SPs are asked to arrive before

students, so the narrow hallways are mostly empty. During activities the hallways are a buzz with MSs typing their reports or talking with their colleagues about the consultation that just happened. Sometimes the preceptors, or teaching doctors, join the MSs in the hallways, but most often they stay in the Observation Area– a make-shift space with moveable walls and tangled computers. During my fieldwork, I joined the preceptors in this space. I felt cramped, hunched over an old PC with cheap over ear headphones, trying to focus on the video feed playing in front of me. Between the number of preceptors, low quality gear, and paper-thin walls between the simulated clinic rooms it can be a very loud space.
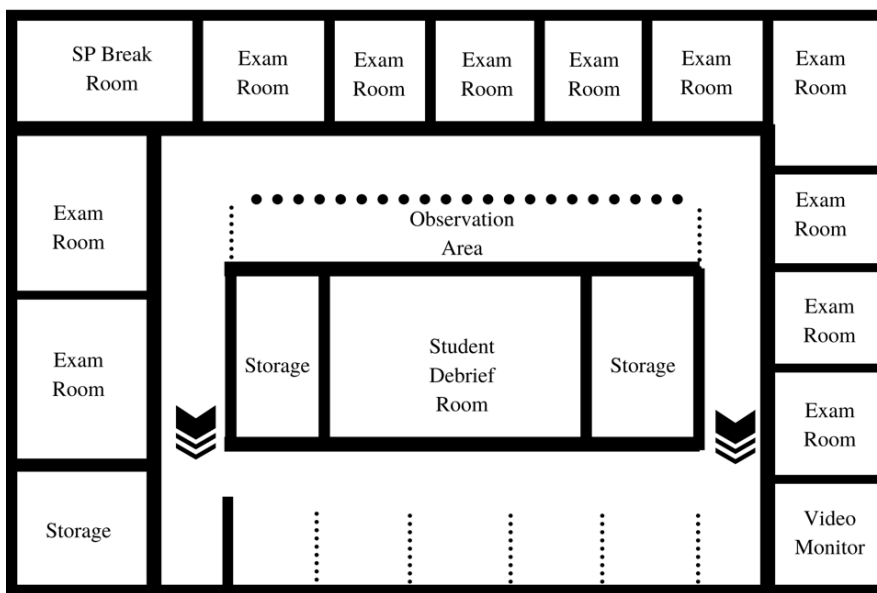
Figure 3.3 Author's Map of the CSLC

At the far end of the back hallway is the "SP Break Room," a window-lined corner-room littered with small tables on wheels that are pushed together to create a conference-like table with a dozen rolling chairs. The furniture is new, but never orderly. Along the wall with the door is a microwave, mini-fridge, and coffee maker. SPs are asked to arrive an hour before their activity starts, which means I spent a lot of time in here with my fellow SPs. While CSLC

officially employs about 100 SPs, about 40 work on a consistent basis, making for a tight knit group of college students, retirees, and local actors. We would talk about our lives, the cases we were playing, current events, and sometimes certain students. In between conversations I would look at my Script, and on the days I forgot to print, I would ask to borrow someone else's. During our waiting period Rebekah and Doug would come in, ask if we had any questions about the Scripts, and then send us to our rooms where we would stay while we met with back to back students.

Figure 3.4 Back Hall of the CSLC

The front hallway is lined with cubicles opposite a wall with two doors to the Student Briefing Room to the left. The Student Briefing Room contains a large flat screen television and five rolling tables, similar to the ones in the "SP Break Room," which are arranged in a U-Shape. Chair line the outer edges of the tables to face the television. On the back wall of the room are more cabinets with medical supplies. Back around to the cubicles, each had a computer for a

CSLC staff member. The office maintained a sort of "open principle," where nobody had their own desk; anybody could use any desk. This meant the cubicles were left without any sort of decoration– no pictures or personal objects. Open cubicles were also occupied by medical educators like Dr. Bravely grading, SPs making Skype calls for phone consultations, or even me, where I wrote field notes or worked on this project's IRB Protocol.

The Clinic Room is the main site of SP practice. Once the MS enters the consultation room with a SP, it is time to perform communication skills. Each Clinic Room contains a remote controlled, navy blue patient table, which can be manipulated to lay back or sit up forward. The table is covered with a thin layer of paper, which extends from a roll, and a paper covered plastic lined pillow. Next to the bed is a metal surgical tray. Along one wall is a built-in cabinet with top and bottom cupboards containing medical supplies, such as gauze, paper gowns, gloves, and paper rolls for the patient tables. Atop the counter is a dispenser of hand sanitizer, a box of hospital-grade tissues, and a plastic bin with smaller medical supplies.

Figure 3.5 A Simulated Clinic Room

During student's first through third years, they are enrolled in general education "Doctoring" courses (Doctoring I, II & III, respectively), taught by practicing physicians and assisted by fourth-year students and residents who volunteer as preceptors. Throughout the Doctoring courses, students participate in formative and evaluative activities with SPs, who offer written and spoken evaluations (See Below). In Doctoring courses, students also complete Objective Structured Clinical Examinations (OSCEs) that apply what students are learning in their courses (For instance, Family Medicine or Cardiology) in systematic and structured evaluations, evaluating diagnostic and communication skills. Elective course directors may also consult CSLC's services, namely their facilities, simulated medical technology, and SP pool to include more performance-based pedagogies. For instance, Dr. Bravely regularly consults the CSLC for two SPs to teach infant growth charts and feeding practices in Pediatric and Maternal Medicine. Additional sessions occur in classes like Surgery, Adult Medicine, and other elective courses. Additionally, in student's first and second years they participate in DCEs (Doctoring Communication Consultations), which are formative activities with two students, a SP and a fourth-year preceptor. These required activities are created and maintained by CSLC staff and aim to further develop students clinical and communication skills.

The Communication Skills Practice Exam

Towards the end of the school year, third year MSs prepare for their Step 2 CS Licensing Exam, and at CSLC that means they participate in the Communication Skills Practice Exam (CSPX). The Step 2 CS involves 12 simulated consultations where students demonstrate their diagnostic and communication skills competency. While initially, I hoped to examine Dotoring I and II as well as CSPX, the need to specify my data required me to make decisions. I selected the CSPX activity because of its direct relationship to the Step 2 CS Exam. To paraphrase the words

of the Center's director, Phoebe, "the CSPX is a gestalt of the exam," since the USMLE issues

only a short guide (the one I quoted in Chapter I). The relationship between the exam and the SP

practices used to prepare students for it provides a unique site to examine the larger discourse of

communication skills. At this point in their medical education, students have spent dozens of

hours with SPs and are well-versed in the communication curriculum. In the following, I explain

the three SP practices I examine as well as provide my research questions as a framework for

moving forward.

Scripts

SPs receive Scripts two to three days prior to simulated consultations. Scripts vary in

structure, but generally are a 3-6-page document detailing the patient's chief complaint, medical

history in a question/answer format, and the differential diagnosis a student is expected to obtain.

CSPX scripts are written by CSLC staff for simulated patients. CSPX Scripts are approximately

6-pages long and contain question and answer sequences for history taking questions. There are

12 CSPX Scripts. I use the 2018 Scripts, which are identifiable by patient name, age, and a chief

complaint (See Table 3.1).

Simulated Consultations

The primary practice at CSLC is the Simulated Consultation where a SP performs patient

for a MS. In typical SP Consultations, MSs enter clinical rooms as if they are a practicing

physician and the SP is already waiting. The CSPX is 15-minutes long. During this time the MS

should solicit a chief complaint, conduct a medical history, perform a physical exam, and offer a

differential diagnosis.

Table 3.1: 2018 CSPX Scripts

Case Name	Patient Age and Sex	Chief Complaint
Holly Adams	60 / Female	Horseness
Caleb/ Cali Daniels	50 /Either	Abdominal Pain
Alexis Fields	24/ Female	Abdominal Pain
Jason Hartman	20/ Either	Sore Throat
Travis/ Taylor Langley	70/ Either	Fatigue
Sebastian Mateese	3 month/ Plays mother, Alana	Fever
Liam O'Conner	53/ Male	Dizziness
Felix Parker	60/ Male	Back Pain
Dominic Romano	67/ Male	Blood in Urine
Bonnie Shuster	60/ Female	Drinking Problem
Isaac Wheeler	25/ Male	Night Sweats
Paul Wright	65/ Male	Chest Pain

The Assessment Form

Following Simulated Consultations, SPs complete an Assessment Form, also called "Checklists," and MSs complete a "Write-up." Both participants have about ten-minutes to do so. For the purposes of this project, I only examine the Assessment Form the SP completes. CSPX checklists contain 39 questions. Questions are organized by the following categories: *(1) Building the Doctor/ Patient Relationship,(2) Reflective Listening, (3) Connecting with the patient, (4) Communications Reflection, (5) History, (6) Physical, (7) Closure and Conclusion to encounter, and (8) Follow up and Wrap up.* Each question section contains differently structured

questions, all of which are multiple choice except the Communication Reflection and the final General Comments section.

Communication Skills Practice Exam Data

The data selected for this project are based on a single day of the CSPX activity. The sessions occurred in the Spring of 2018 and began at approximately 8 AM and concluded around 4 PM. The activity involved 24 SPs who played 12 scripts in two rotations along with 9 MSs. All but three SPs consented to the research (21 SPs) to create 97 unique Simulated Consultations and Assessment Forms. The data encapsulates the before, during, and after of SP practices:

- 12 CSPX Scripts

- 97 Simulated Consultations, each approximately 15-minutes in length to create over 24 hours of audio-visual data

- 97 CSPX Assessment Forms, a 39-question multiple choice and short answer computerized assessment form completed by the SP after the simulated consultation

Institutional Review Board Protocol

This project received IRB Approval by the University of South Florida (USF) in December of 2017[4]. All elements of the project considered "human subjects research," including the audio-visual recordings of SP and MS interaction and the completed Assessment Forms, are used with permission by the Program Director, MSs, and SPs. Participants consented to this research after a conversation with me in either the SP Break Room or the Student Briefing Room. Participants were told their face would be blurred and their names would be changed,

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[4] USF IRB Protocol # 00032331

which I have done. The CSLC Assessment Forms and Scripts are not considered "human subjects research," and were obtained via email with permission of the CSLC Program Director.

The CSLC records nearly all SP practices as part of their normal pedagogical process. During Simulated Consultations the CSLC staff members often observe the interactions through two giant flat screen monitors in the Observation Room, which is also the room where time is kept. Additionally, preceptors and faculty instructors observe and evaluate from their individual monitors along the back hallway or in other locations at CSLC. All of the audio-video files are saved to an online database. Every student, preceptor, instructor, staff member and SP can access the database to watch their previous consultations. Audiovisual data is stored alongside relevant forms, although access varies from person to person. In watching a recorded activity, any observer can flip between tabs to see what the student wrote up after the encounter and how the preceptors and SPs evaluated the student.

Once I received IRB Approval for the project (See Appendix A) and gained informed consent from each participant (See Appendix B), I was granted access to all of the audiovisual recordings and assessment forms of consenting SPs and MSs. I was also able to download video files and Assessment Forms for ease of analysis. In the Spring of 2019, I downloaded the written and spoken data to a password protected cloud database. The file names are coded and anonymized to protect participants identities. Once the data was downloaded, I began my analysis.

Discourse Analysis

Discourse analysis is an "umbrella term" referring to both a metatheoretical position and empirical toolkit (Tracy, 2001). Taking "discourse" to mean language in use and as social action discourse analysts engage the metaposition that communication is constitutive. To paraphrase

J.L. Austin, words *do* things, and by paying attention to how we go about doing what we do we can get a sense of how through discourse, we create the world and the world creates us (Bartesaghi & Castor, 2009). Discourse works through us in particular matrices of social practice, conventions of social order, registers, enabled and constrained by what Fairclough (1989) calls "orders of discourse."

Discourse analysts are interdisciplinary scholars from diverse fields including communication studies, linguistics, sociology, psychology, and education. Each discipline brings its own academic history and toolkit to the study of discourse. For instance, in a multi-disciplinary analysis of a workplace interaction, Stubbe et al. (2003) demonstrate the similarities and differences of tools including conversation analysis (based in sociology), interactional sociolinguistics (linguistics), politeness theory (linguistic anthropology), critical discourse analysis (sociolinguistics), and discursive psychology (psychology). While each of these approaches identifies the strategies participants use to accomplish certain goals, they make varying degrees of connection between interaction and pervasive discourses. Critical discourse analysis and conversation analysis are at opposite ends of the spectrum, with conversation analysts focused on the particularities of turn by turn interaction (context is only relevant as the speakers make it so) and critical discourse analysts attending to societal notions of power and inequality. I strive to see the benefits and limitations of each approach and reconcile metatheoretical tensions between the approaches in my own work (See Schegloff, 1998, 1999; Wetherell, 1998; Billig, 1999). Above all, I agree with Stubbe's final assessment, "the value of analysing one text from a range of perspectives, and the insights to be gained by applying a range of different theoretical and methodological approaches to the same piece of discourse" (p. 380).

Discourse is not limited to what humans do. The practice turn in discourse studies attends to the mutually constitutive relationships between many things—language, paralinguistic expression, materiality, affect, unexplainable feelings, somatic processes, bodies, socio-historical processes, institutional and organizational practices, etc... because all things, human and non-human, "do," or "act" in the constitution of the world (Cooren, Kuhn, Cornellisen & Clark, 2011). Discourse, thus, manifests in the "entanglements" of ontological relational process and the analyst may attend to varied explanations of linguistic and non-linguistic activity (Iedema, 2011, p. 1167). By attending to language, materiality, and embodied practice as consequential activities, there is a shift away from what is hidden, like inner states or abstract ideas, in favor of observable action.

At its most basic, discourse analysis involves recording, transcribing, and analyzing communication (Tracy & Mirivel, 2009). While much of my data are recorded and maintained by the CSLC, I compile and analyze it in a systematic and thorough manner. By doing so, I am able to make actual instances of interaction the focus of my study and include excerpts of data throughout to build my argument (Tracy, 2001). I also heed Tracy's (1995) advice on what makes for a good interpretation: "bring clarity to confusion, make visible what is hidden or inappropriately ignored, and generate a sense of insight and deepened understanding" (p. 209). In examining my data, I do not want to get too "bogged down in the weeds" nor stay "in the clouds." Scollon and Scollon (2004) elaborate on Burke's (1969) notion of circumferencing, which best captures the balance I hope to achieve in this project, "simply making sure the study does not become obsessively narrowed to single moments, speech acts, or events, or participants without seeing how these connect to other moments, acts, events, and participants within the full nexus" (p. 9).

I conduct this analysis to demonstrate "the possibility that things could be or could have been different" (Iedema, 2011, p. 1172). I see discourse analysis as an approach to make transparent what has occurred, a resource for questioning the implications of practices, and a way forward that addresses the tensions I experienced as a SP as well as the constraints of communication skills discourse. Thus, I use a discourse analytic approaches for pragmatic ends (Tracy, 1995; 2005; Tracy & Craig, 2010). I closely analyze spoken and written data to reconstruct an ontology of practice and through this project share my findings and suggestions with the institution I work with (Smith, 2005).

I also draw on the applied principles of Tracy's (1995) Action-Implicative Discourse Analysis. Per Tracy, applied research should "reconstruct the web of actor problems, conversational techniques to address problems, and participants situated ideals" (p. 208). For the CSLC, this means analyzing how SPs, MSs, and CSLC staff designate, assess, and enact communication skills. I account for the spoken and written strategies used in talk and texts. Through my observation and analysis, I aim to recognize communication disfluencies and contribute to the practice's ongoing critique and improvement in creating lines of conceptual agreement and pedagogical consistency (Tracy, 1995). As in the work of Craig & Tracy (2014), I am "especially interested in practices in which the role of communication is not only important but presents complex problems that engage reflection on norms and values as well as technical means" (p. 230).

Finally, the way communication is often described as a skill and evaluated as a behavior-based task incarnates notions that it is an individualistic event and an objective to master, rather than a social process bound in cultural and individual subjectivities. What gets left out of or neglected in communication skills training impacts future medical practice. In the following, I

describe my approaches for studying SP practices, which I organize by explaining how I will

analyze "talk" (the Simulated Consultation) and "texts" (the Scripts and Assessment Form).

Talk

Talk is the taken-for-granted modality of communication. Discourse analysts typically

prefer "naturally occurring talk" in everyday or institutional settings like the dinner table or the

doctor's office. The preference for "naturally occurring data" versus interviews or surveys is

based on the metatheoretical position that communication is joint social action, and the above

modes of data are removed from actual interaction and involve the researcher co-constructing the

data, often unreflexively. In essence, interviews or surveys do not "get at" something that is not

already observable in conversation.

Sociologist, Harvey Sacks was interested in how people go about doing what it is they do

in interaction. Sacks (1995) endeavored to ensure "the reader has as much information as the

author and can reproduce the analysis" (p. 27). That "information" is the audible (or visible)

material of linguistic practice– an audio (or video) recording of some segment of talk and a

finely marked transcript. The transcription method was developed by then student and later

colleague, Gail Jefferson, who aimed to capture the nuances of talk in detail, including the "ums"

and "ahs" of what people say, overlapping talk, and changes in tone and pitch (See Appendix C).

The "information" or data are presented alongside interpretations offering a transparent approach

to doing interactional research, which could be disagreed with on the basis of the actual data

available.

Over time, the availability of video recordings shifted the focus of analysis from simply

"talk in interaction" to the role that materiality plays in interaction. For instance, Streeck and

Mehus' (2005) microethnographic research attempts to demonstrate the relationship between

talk, bodies, and spaces in fine-grained analysis. Taking the approach to institutional contexts, Mirivel (2008) provides a multi-modal analysis of plastic surgeon's physical exam consultations with potential patients and points to the multiple ways the surgeons make surgery more desirable through talk and gestures.

CA's interest in institutional interaction spans a variety of contexts– from courtrooms to doctor's offices. In each of these settings, analysts are concerned with how people perform institutional identities and how those performance enact context. For instance, Heritage and Maynard (2006) expound on the orderliness of the primary care consultation, including the overall structure of the interview, how doctors and patients complete activities like soliciting chief complaints together, and how people design their utterances for others. They suggest that by understanding how patients and providers manage the consultation through communication, there are distinct ways to improve it.

Discourse analysts, such as I, differ in what they strive to understand about institutional interaction. First, not all institutional conversations are purely "institutional." Sarangi and Roberts (1999) notion of hybridized discourse demonstrates how speakers often move between different registers of talk, like from casual talk to institutional talk. Ainsworth-Vaughn (2015) proposes, "[medical] encounters exist on a continuum between interrogation, as described in Mishler (1984) and friendly conversation with a small amount of time devoted to satisfying medical goals" (p. 458). Additionally, discourse analysts see how patients and providers frame identity and context through their utterances. For instance, "small talk" or "storytelling" are framing activities that use a social frame of interaction and show physicians and patients "outside" of their institutional role as certain types of persons. Gumperz (1982) notion of contextualization cues provides the arm of how to apply Goffman's (1974) frame analysis– by

noting the linguistic, paralinguistic, and embodied actions that contextualize frames and identities in collaborative, complex, and shifting dynamics.

In this project, I use a synthesis of discourse analytic approaches to analyze simulated patient practices. Among these is conversation analysis, although many would see the data of simulated consultations as "inauthentic" because they do not fit the typical features of medical interactions. The choice to use conversation analytic concepts like turn-taking or adjacency pairs is to account for the nuances of interaction in Simulated Consultations. Participants conversational moves show Simulated Consultations to be a unique genre of practice where MSs and SPs draw on multiple genres and orders of discourse to pull the thing off. For instance, MSs are performing physician, moreover a physician with communication skills, while SPs perform both patient and institutional assessor. As a discourse analyst, I hypothesize that these multiple institutional roles are observable in how members step in and out of frame and work together to make multiple activities relevant throughout the encounter. Moreover, these framings comment on the notion of communication skills broadly.

To re-present and analyze data in my dissertation, I include transcripts of spoken discourse and still-images of video footage to examine embodied performances. Transcribing interaction is an interpretive practice (Bucholtz, 2007; Ochs, 1979). What I include in my transcripts is meant to streamline my analysis and is a choice guided by my purposes (Tracy & Mirivel, 2009). I transcribe at an intermediate level of detail in with the goal of sharing my results with scholars from multiple disciplines who may find fine-grained transcription cumbersome to read and unnecessary for the overall analysis. I use a modified Jeffersonian Transcription System (See Appendix C), including relevant pauses, changes in pitch and volume,

overlapping speech, elongated and cut off sounds, as well as descriptions of what is occurring (Tracy, 1995).

Many discourse analyses of simulated interaction simply focus on speech without attending to the multi-modal nature of communication. I also include still images to analyze how speakers use gestures, proxemics, movements, and props to enjoin performances. By doing a multi-modal discourse analysis of Simulated Consultations at the CSLC, I aim to add to discourse analyses of simulation, as well as multi-modal analytic techniques broadly.

Texts

Texts are agentic, meaning they do things, both on their own and with the people who create/ read them. Cooren (2004) describes the distributed nature of human/textual agency through the example of a manager and a Post-It note. The manager not only writes a reminder on the Post-It, but the Post-It reminds the manager what needs to be done. Cooren identifies the multiple actions texts perform– asserting, committing, directing, declaring, and expressing. It is by analyzing the interactional resources visible in texts that one can more robustly analyze the role of nonhuman agency, and for this project practices that explicate communication skills.

Often outliving their original authors, texts take on a uniquely independent form (Smith, 2001). The utterances of authors are a dynamic interplay of voices and values. Intertextuality refers to how texts are embedded with the traces of other texts (Bartesaghi, 2015). When texts are infused with authoritative discourses, like the language of science, psychology, or medicine, they in turn authorize the text and the actions they accomplish.

Analyzing how texts intertextually draw on an authoritative discourse, as well as the pronominal, structural, and punctuation details provides clarity to how they perform in institutional practice as well as the implications of those performances. Forbes (2015)

demonstrates how an ADHD screening device is strategically void of first-person pronouns (ex. 'A prisoner of the moment'), which affords the reader a broad interpretive range ('Do I say I'm a prisoner of the moment? Do others say I'm a prisoner of the moment? Am I a prisoner of this moment? etc.') leading to a more likely diagnosis of a learning disability. Bartesaghi's (2009) analysis of the Beck Depression Inventory attends to how the questionnaire uses conversational, first-person answers (i.e., I feel so sad and unhappy that I can't stand it) that "constrain, if not violate, their conversational rights as persons to self-account" (p. 171). These accounts are consequential for clients and patients as they recontextualize everyday terms problems like attention or sadness as diagnostic categories. However, texts are not unquestionably adopted. Galasiński (2008) argues that participants often reformulate, recontextualize, and challenge assessment items. Similarly, in investigating how 'quality of life' is discussed in psychological interviews, Antaki and Rapley (1996) explain how an interviewer using an institutional interview protocol jointly manages an interaction with a client about their subjective feelings, beyond the institutional text.

I see texts as playing a complex role in simulated patient practices. I examine two types of texts at CSLC: Scripts and Assessment Forms. To do so, I take the metatheoretical positions outlined above as well as synthetize corpus-based approaches to genre analysis and register analysis. Corpus-based approaches use a "corpus," or collection of texts (even transcripts), to generate qualitative and quantitative analyses (Lee, 2010). Flowerdew (2004) explains any corpus over a million words is considered a large corpus, while small corpora contain less than 250,000 words. A specialized corpus occurs along a number of delineations, including a specific purpose of analysis, a particular subject matter, or a particular setting or genre (Flowerdew, 2004). By assembling collections of texts to create small specialized corpora (see next section), I

examine matters of register and genre as they relate to communication skills in medical education.

Register describes how words and grammatical structures are used in a text, while genre refers to the larger structure of a text (Biber, 2010). To identify the register of a text, I: (1) identify the situational context of how the text is produced (i.e., whether it is spoken or written; does the author make themselves present, what's the purpose of the text, etc.); (2) identify the typical linguistic features (i.e., nouns, pronouns, verbs, etc.); and (3) explain the function of the linguistic characteristics in the situational context. For example, a register analysis helps me to see whether and how SPs refer to themselves in the open-ended assessment items of the Assessment Form.

Genre analysis identifies the typical patterns and structures of texts. For instance, the genre of academic papers facilitates the order of introduction, literature review, methods, analysis, discussion, and conclusion. Therefore, I use the approach to see the typical structures of both Scripts and Assessment Forms. While some genre analysts argue that genre is simply the conventional features of a text that do not have any functional implications, the Sydney School attempts to locate the functions of how particular texts are carried out (Halliday & Martin, 1993; Rose, 2013). In taking a synthetic approach to corpus-based genre and register analyses, I also draw on Tribble's (2002) analytical framework for analyzing context and text because it spans both features of register and genre (See Appendix D). I ask questions like: What is the purpose of how this is written? And, what does this way of saying something accomplish?

For this project, I assembled two small specialized corpora: (a) 12 SP Scripts (14,995 words) and (b) 97 responses to two Open-Ended assessment items (7,538 words). In the Spring of 2018, I received copies of each of the 12 scripts from Liesel, the assistant director of CSLC

via email after Phoebe suggested that I examine the CSPX for my project. Around the time I was soliciting informed consent from participants, I also received access to the online system C-WEB from CSLC's technical developer, Theo. This access allowed me to download the assessment forms as PDFs. The following Spring, when I decided to focus my analysis on a specific day of CSPX, I downloaded 97 assessment forms that were completed by SPs and about MSs, both of whom agreed to participate in the project. To create the corpus of Scripts, I copied and pasted all the text into a Word Document and saved it as a .txt file. Likewise, to create the corpus of open-ended assessment items, I created three Word Documents (then .txt files), one of item 17, one of item 39, and the other of both, so I could also compare how SPs answered each of the questions.

To analyze the data, I used an open-source corpus linguistics software, AntConc. This software allows me to identify the most frequent words, the specifics of words in each grammatical function (i.e., the most frequent verbs), the most common series of 2-5 words (known as n-grams), and what words are co-located with such words or fragments. To conduct the genre portion of the analysis, I consulted the PDF versions of Scripts to maintain stylistic consistency and account for the typical patterns and categories of the texts. To analyze the data for textual and linguistic features, I copied portions of each text into a Microsoft Word Document to create a cross comparison of particular sections of the Script or Assessment Form Response. The goal of describing these approaches is to answer the following research questions, which comprise the analysis in Chapters IV, V, and VI.

Preview of Analysis

This dissertation traces three SP practices as they occur over a single day. I bring clarity to the key features of the practices and consider the functions of how communication is conceptualized. CSPX is not representative of all of SP practices at CSLC, nor of all the

communication curriculum in medical education. But it is an approximation of what the USMLE desires of MSs in terms of communication skills competency, which in turn impacts the design of cases, consultations, and assessment forms. The CSPX is a situated practice that resonates with the discourse of communication skills in medical education. The following chapters of this project will examine the three SP practices in the order participants experience them: Scripts, Simulated Consultation, and Computerized Assessment Form.

CHAPTER FOUR

COMMUNICATION SKILLS IN SCRIPTS

In the opening of *The Empathy Exams* (2014)*,* Leslie Jamison explains her job as a

simulated patient (SP):

> You get a script and a paper gown. You get $13.50 an hour. Our
>
> scripts are ten to twelve pages long. They outline what's wrong
>
> with us—not just what hurts but how to express it. They tell us
>
> how much to give away, and when. We are supposed to unfurl the
>
> answers according to a specific protocol. (p. 2)

Jamison's explanation shows the importance of Scripts to SP practices– the document

describes the patient to be performed, including how they should communicate (i.e., what to say,

when to say it, how to show pain, etc.) with the medical student (MS) in a Simulated

Consultation. The Script forms the basis of patient portrayal and makes observable the discourse

of communication skills. The Scripts at the Communication Skills Learning Center (CSLC)

similarly orient SPs to the patient they will portray and direct them in what and how to

communicate.

In this chapter, I examine Scripts as genres that are constitutive of communication skills.

I show how Scripts are embedded in a container paradigm of communication– where patients are

the site of medical problems, concerns, and complaints and physicians use their communication

skills to extract and solve patient's problems and concerns. In this, communication is a neutral

tool for information exchange and communication skills are observable based on the information

MSs retrieve from SPs through questioning practices. In this is a belief that problems and concerns occur in the realm of medicine and are solvable through physician's effective communication.

To demonstrate my argument, I draw on corpus-based genre analysis to examine how Scripts are produced and used, as well as what their lexical and structural features and functions are. My analysis answers my first research question and its sub-questions:

1.0.   How are communication skills conceptualized in Scripts?

      1.1. What strategies does the Communication Skills Learning Center use to constitute communication skills in Scripts?

      1.2. What are the implications of communication skills in Scripts?

Examining Scripts

Scripts are a genre, or "a class of communicative events, the members of which share some set of communicative purposes... this rationale shapes the schematic structure of the discourse and influences and constrains choice of content and style" (Swales, 1990, p. 58). Essentially, genres use unique conventions that enable certain goals and constrain others. Scripts are designed to orient SPs to who patients are and direct them to perform those patients in simulated consultations. This institutional goal is observable and ensured by the specific patterns and structures of the genre's discourse. Furthermore, because the Simulated Consultation is a complex hybrid activity type, conceptualizations of communication are observable in the conventional features Scripts.

I draw on Tribble's (2002) Contextual Analytic Framework, a series of ten questions that explicate a genre based on a corpus, or collection of texts (See Appendix D). By answering the questions, I account for the contextual, lexical, and structural features of Scripts, which hold

implications for the metadiscourse of communication skills. Furthermore, the questions create "opportunities in which learners can come to a fuller understanding of (a) the processes that are necessary to the completion of a writing task, (b) the institutional and contextual constraints which operate in the target environment and determine what allows an allowable contribution and (c) the linguistic choices which have to be made in order to produce such allowable contributions" (p. 131-2). I show how Scripts function in communication skills training, as well as explicate the genre in order to contribute to and improve it.

My corpus is a "small specialized corpus," less than 250,000 words and is specific to communication skills practices (Flowerdew, 2004). The corpus contains the 12 documents issued to SPs for the Communication Skills Practice Exam (CSPX). While the larger document is the Simulated Consultation Guide, which is about fourteen pages long, I focus my analysis on two sections of the Simulated Consultation Guide– the Case and the Script– because they direct SPs how to perform in simulated consultations and comment on communication skills. The first page of each Script is the half to single-paged titled *Simulated Patient Case* followed by a five to six-paged *Simulated Patient Script*. Each section has multiple and (mostly) consistent subsections (See Appendix D3). To conduct my analysis, I compiled a master document of all twelve instances of the two subsections to create a small specialized corpus of 14,974 words (Flowerdew, 2004). The average length of the Case and Script together is 1,248 words, which equals about six pages.

My analysis is organized as follows: I examine the statistically prominent words and patterns of the text, as well as consider the overall organization of the text, which shows how communication skills are conceptualized as effective questioning practices embedded within the container paradigm of communication. Then, I show how questioning and answering are the key

communication skills activity in Scripts; next, how the container paradigm informs questioning

and answering practices; and lastly, the underlying ethic of medical care, which is that when

patient's (or their families) have concerns and doctors legitimize and solve concerns through

effective communication.

Linguistic Features

The most frequent words in a corpus give an immediate picture of "the aboutness of a

text" (Tribble, 2002, p. 137). The most frequent words in Scripts include common words with a

range of grammatical functions–verbs (have, do), personal pronouns (you, I), determiners (the,

no, any), conjunctions (and, or), and prepositions (to) (Table 4.1). While seeing the most

frequent words can give a sense of the genre, seeing how those words are used with other words

in the context of the document is even more telling of the document's "aboutness."

Table 4.1: The 10 Most Frequent Words in Scripts

Rank	Word	Frequency	%
1	You	606	33.46%
2	Have	460	25.40%
3	The	404	22.30%
4	No	323	17.83%
5	I	305	16.84%
6	And	263	14.52%
7	Do	261	14.41%
8	To	250	13.80%
9	Or	228	12.59%
10	Any	217	11.98%

N-grams are series of two to five consecutive terms (Table 4.2). In Scripts, the most

frequent n-grams are either question stems (i.e., do you, have you, do you have, have you had,

etc.) and claims of state (i.e., you have, you had, etc.). Interestingly, all of the n-grams have *you*,

the most frequent word, as part of them, demonstrating how the document models a method of

the MS questioning the SP.

Table 4.2: The Ten Most Frequent N-Grams in Scripts

Rank	N-gram	Frequency
1	Do you	223
2	You have	182
3	Have you	169
4	Do you have	150
5	you had	120
6	Have you had	119
7	Had any	104
8	Have you had any	99
9	No do you	82
10	No do you have	76

Structural Features

Tribble (2002) next suggests looking at the structure of the text. A majority of the Script is taken up by a two-column table that progresses through the standard order of a primary care consultation (History of Present Illness, Past Medical History, Family History, Social History, Review of Systems, Questions You Can Ask the Learner, Physical Examination, and Props). For instance, the first page of the Hartman Script has a two-column table:

Extract 4.1: Start of Question and Answer Table in Hartman Script[5]

Question	Answer
Chief Complaint What brings you in today?	Sore throat
History of Present Illness When did you first notice the sore throat?	3 days ago
Is it getting worse?	Yes it has slowly been getting worse
Can you rate the pain on a scale of 1 to 10?	When it started it was a 4/10 and now its a 7/10

Questioning and Answering as Communication Skills

The table depicts an interaction between physician and patient, where the physician who asks questions is shown in the left column and the patient who answers the questions is shown in the right column. Again, the physician uses the second-person pronoun *you* as if they are

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[5] All spelling, grammar, and punctuation is preserved in extracts.

speaking directly to the patient, which places them under a direct obligation to respond (i.e., *What brings **you** in today? When did **you** first notice the sore throat? Can **you** rate the pain on a scale of 1 to 10?*). In the following, I examine the types of questions MSs should ask. I compare all the Opening Questions of the corpus, investigate the issue of "conversational authenticity" that as it is relevant to questioning and answering practices in the Script, then look closely at all the questions in a specific case, Jason Hartman.

Types of Opening Questions

Robinson (2006) explains how subtle differences in opening questions change the social actions they perform, and thus what patients understand about the questions and how to answer them. Robinson analyzes opening questions and how variations demonstrate the three typical reasons for visiting the doctor: a new issue, follow-up visit, or chronic care. Question designs also show a physician's understanding of why a patient is there and if their designs do not match up with patient understandings of why they are there can cause interactional trouble. There are four types of opening questions in the Scripts, which I distinguish by question type (i.e., Open Ended or Closed Ended) and how the question refers to the patient: (1) Direct Open-Ended questions; (2) Indirect Open-Ended Questions; (3) Direct Closed-Ended Questions; (4) and Indirect Closed-Ended Questions.

(1) Direct Open-Ended Questions

The first type of opening question is an open-ended question directed to the patient, *What brings you in today?* (6 Scripts; 50%). This question type is most commonly suggested by medical educators of being the "best practice" for soliciting a patient's concerns (Robinson, 2006). The question design suggests there is a *you* who is *in* somewhere, the patient in the clinic with the physician. Furthermore, the question indicates physician does not have knowledge of

the concerns. However, MSs in this activity view a Door Note prior to entering a room, which succinctly provides a patient's Chief Complaint. Yet most Scripts ignore this possibility, the implications of asking a patient for information they have previously given, and instead provide a patient's answer (See Next Section on Patient Answers).

(2) Named Other Open-Ended Questions

The second type of question occurs in only one script (1 Script; 8%) and is an open-ended question that refers to another person, *What's going on with Sebastian?* This question is focused on another subject that is not the speaker and suggests the MS knows the patient's name and requests the concern/issue with the patient be restated. Additionally, neither question type indicates there are other question that perform equivalent functions like, "What can I do for you?" or "How can I help you today?"

(3) Direct Closed-Ended Questions

The third type of opening question occurs in two of scripts (2 Scripts; 16%) and uses the pronoun *you* to refer to the patient, but instead asks a closed ended question (i.e., *When did you first notice the dizziness?* or *When did you first notice this?*). This question design is based on previous information, potentially the Door Note or even a patient's previous statement like a claim to dizziness or the articulation of what "this" is upon the doctor's entering the room. That the patient themselves notices the symptom and brings it up provides a different dynamic for what the physician can ask. However, a patient's statements are not guaranteed or universal. Moreover, the subtleties of what a patient says and what a physician can then ask are overlooked and instead of instructing SPs on how small changes in the question would change the answers provided, communication as universal information exchange is taken for granted.

(4) Indirect Closed-Ended Questions

The fourth type of opening question does not use the pronoun *you* but refer to some other phenomenon in a closed-ended question (i.e., *When did it start; When did this pain begin*). This question design does not directly address the patient as knower of information, but suggests they have access to the knowledge beyond what is already known. The MS is asking a follow-up question in these cases. This question is type is observable in three Scripts (25%). Although the questions are not explicitly directed at the patient (using you) the SP has an obligation to respond to questions, as questions demand answers. For instance, if the SP was to ask a question in return it would demonstrate there is something wrong with the question and stifle the interaction from continuing.

Types of Answers to Opening Questions

In actual acute care medical consultations, the opportunity a patient has to present their concerns is typically initiated by a physician's Solicitation of a Chief Complaint (in the form of a question) and terminated by a patient once they have presented all relevant information (Heritage & Robinson, 2006). Typical problem presentations for previously unknown or new acute problems are formulated as narratives that lists symptoms and accounts for when symptoms were first recognized, often modified through words like, "just." Through presenting their concerns, patients align with the physician's orientation towards medical care as a problem (and solution) driven practice. There are four types of Problems Presentations formats depicted in Scripts: (1) Short Responses; (2) Epistemic Responses; (3) Account Responses; and (4) Extended Account Responses.

(1) Short Responses

The first and most common type (5 Scripts; 43%) of responses are short responses of 2-4 words, like *a fever* or *2 days ago.* In actual consultations most responses are extended accounts that answer many of depicted opening questions, like how long the symptoms have been present, what it feels like, or the severity of symptoms (Gill & Maynard, 2006). Additionally, these answer types do not correspond to particular questions. Even open-ended questions are met with short answers, which require MSs to do ask more follow-up questions than they would otherwise in actual consultations.

(2) Epistemic Responses

The second type (3 Scripts; 25%) of answer hinges on an epistemic stance, or a claim of knowledge, like *I think* or *I feel* or *It was scary,* to describe a patient's experience of their symptoms. Each of these couches the complaints in a patient's first-hand knowledge, which the provider can only access by asking additional questions. Most of these answer types are given in response to the open-ended question, *What brings you in today?* In the Langley case, the patient is shown to answer by stating, *I feel tired and weak I don't feel like I have much energy.* These concerns substantiate the patient's need for medical attention.

(3) Account Responses

The issue of doctorability is consistent for longer answers. The third type of response is an extended account (2 Scripts; 16%), a short narrative of the serious symptoms that have been occurring over time and motivate their reason for seeking medical attention. For instance, *I have been sweating every night, to the point where my clothes and the bed are wet.* Here the patient is making an extreme case for why they need medical attention (Pomerantz, 1986). Both of these responses are given to the open-ended question, *What brings you in today?*

(4) Extended Account Responses

The final type of problem presentation accounts for the duration of an issue and an account for it (2 Scripts; 16%). This answer type combines information for two potential questions, "what brings you in," and "how long as it been going on?" For instance, in the Romano case, the opening question, *When did you first notice this?* Is shown to be answered by *About 1 week ago. I was lifting some heavy boxes at my job.* This answer type responds to the question but also provides additional information beyond the issues of doctorability.

While each of these responses is given in the table where the chief complaint is solicited, two of the cases also have an *Opening Statement* that occurs before the chart. The Romano Script has the same Opening Statement and response to the Chief Complaint, but the Hartman Script has the following Opening Statement, *My throat has been sore for 3 days and it's getting worse! I have a soccer tournament tomorrow, will I be able to play,* which gives considerably more contextual information than the response, *Sore throat,* to the question, *What brings you in today?* In the Hartman Script, the patient is also shown to ask a question. The inconsistency in opening statements once more overshadows the nuances of questioning to the answers patients can give and assumes that questioning universal is an effective approach.

Comparing Opening Questions and Answers

There are multiple inconsistencies in how questions are formulated and answered (See Appendix D4). Open-ended questions, like those suggested in medical textbooks and frequent in actual consultations are typically met with longer responses in typical primary care consultations (Heritage & Maynard, 2006). In Scripts, when MSs are shown to ask open-ended question the patients reply with extremely short responses. This is not only inconsistent with how actual consultations proceed, where patients use this opening to make a case for why they need medical

attention and even offer hypotheses for what is wrong with them, but it places an additional burden on MSs to ask more follow-up questions. The question and answer dynamic positions the MS as accountable to the structure of the consultation and prioritizes their ability to ask follow-up questions rather than listen to longer stretches of patient talk.

Closed-ended and specific questions are shown to be answered by elaborate responses. Though patients may respond to closed-ended questions with more elaborate responses in actual medical practice, a way to demonstrate the insufficiency of a question, they are less likely to do so. Moreover, Scripts create an inconsistency in the question dynamic (See Appendix D4). SPs are not shown that particular questions are more likely to solicit particular answers. Instead, the inconsistencies teach SPs and MSs that how questions are asked and answered does not matter. That questions and answers are not fitted to one another suggest only the information matters, and SPs should offer information regardless of how it is solicited.

Moreover, the questions are seemingly designed as what Labov and Fanshel (1977) call "B-events," or information that only the answerer of the question has primary access and authority over. This knowledge asymmetry implies that the patient has knowledge that the physician does not. But MSs do have access to prior information in the Door Note (like the patient's name, chief complaint, vital signs, etc.), and in some Scripts, MSs are shown to demonstrate prior information in how they ask questions. For instance, in the O'Conner Script, the MS is shown to open the consultation with the question, *when did you first notice the dizziness,* which implies the MS already knows about the dizziness. SPs are not taught that different question designs might receive different types of responses. The disfluency functionally teaches SPs (and MSs) the nuances of how a question is asked or answered does not matter.

Questioning and Answering throughout Scripts

Grice (1975) suggests conversations have goals that require speakers to cooperate in order to manifest the goal. To do so, speakers practice the Cooperative Principle, which Grice summarizes as, "make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged" (p. 45). The Cooperative Principle is further explained by Grice's Maxims:

The Maxim of Quality: Speak what is true

The Maxim of Quantity: Speak no more information than is required

The Maxim of Relation: Speak what is relevant

The Maxim of Manner: Speak briefly and clearly

I want to zoom into a specific Script to show how the dynamic of questioning and answering is shown to occur throughout the medical consultation and how that dynamic impinges on Grice's Maxims. I use the Script, *Jason Hartman*, which is 4 ½ pages and contains a total of 53 questions and answers (See Appendix D5 for Script).

The first question is an open-ended question, an interrogative (*wh*-question) that requires a longer response. Interrogatives make up only 13% of the overall questions asked in the Hartman Script and occur in two sections: History of Present Illness (i.e., *What makes it better? What makes it worse?*) and Social History (i.e., *How old are your father and mother? What kind of work do you do?*). In response, the patient is shown to give more than the information asked for, violating the maxim of quantity. For example, the question *When were you most recently sexually active,* has a response of, *Only oral sex within the last two weeks,* providing the additional information of the type of sex (oral sex) that is not part of the question, but is key information for the differential diagnosis (strep throat or sexually transmitted infection). By

offering more information than is required, the SP is also showing the patient is a certain type of person (who has oral sex) and the MS should ask more about sexually transmitted infections.

The answer also contradicts the only explicit communication guideline offered in three of the twelve Scripts: *Remember to answer only what is asked. If learner asks an open-ended question, answer with 2-3 pieces of information. Then if encouraged to continue talking by the learner answer with 1-2 more pieces of information.* Although the guideline is not offered in every Script, it is frequently violated. As in the above question, *When were you most recently sexually active,* the patient is shown to answer beyond what is asked. Even for closed-ended questions that are best fitted with a yes or no response (30 questions; 58%), the SP is shown to give more information than is asked for. As above, *Is it getting worse* is answered with *Yes it has slowly been getting worse.* The progressive intensity is once again not asked about. This is integral for the question, *Do you use protection,* which could simply be answered *yes,* but also includes the following account, *condoms with intercourse, but unprotected oral sex.* Grice (1975) explains that when the Maxim of Quantity (give only as much information is required) is openly disregarded when the speaker is certain of the information offered and that information makes the case for a particular phenomenon that is being asked about. So for the Hartman Case, if a MS asks whether a patient uses protection, the SP could imply the MS is only asking about intercourse, but they are shown to separate it from oral sex, which is critical information for the cases differential diagnosis of strep throat or a sexually transmitted infection.

The Hartman Script also contains questions that (1) simply list topics (i.e., Living Situation) (19%) and (2) offer alternative answers (i.e., *Are you sexually active with men, women, or both?*) (6%), or (3) a combination of two or more different question types (or even assertions) on a single line (*i.e., Do you smoke? At what age did you start smoking and how*

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much do you smoke?) (3%). These question types occur less frequently and follow similar characteristics as the above question/answer pairs, insofar as the patient typically offers more information than is asked for or only the information requested.

Another feature of patient's answers is the use of epistemic modals like *I think,* or *I feel*, in response to medically oriented questions (i.e., *do you have a fever? I might have a fever. I didn't take my temperature*). The registers of question and answer sequences differ, as the MS is shown to speak in a clinical register (*swollen glands*) and the patient replies in a non-clinical register (*some lumps*). The differences in clinical and non-clinical registers presuppose that MSs can (and should) speak in a more exclusive register and patients use less specialized language. That Scripts present these differences side by side implies that SPs should be proficient in both vocabularies, but MSs need not excel in the art of translation.

In sum, Scripts promote a contradictory stance towards questioning and answering, whether in opening or follow up questions. Though they tell SPs to answer only what is asked, yet the patient is typically shown to offer more information than is asked about. The notion of information exchange is prioritized above the particularities of how a question is asked, even as it relates to registers of talk. The Scripts demonstrate that what matters is information exchange. Communication is the neutral means to information exchange, which places a burden on the SP to determine whether and how to reveal certain information while also allowing for differences in how SPs respond.

Challenge Questions

Scripts mostly show MSs asking and SPs answering, but one section flips this–the *Challenge Question* (also called the *Challenging Question* or described as, *When the student asks for additional concerns*). In my field work this was most often referred to as the *Challenge*

Question, which poses the question, a challenge for whom? The Challenge Question occurs in ten of the twelve cases (83%) and is always included at the end of the Question/Answer Table. Its location implies it is a last item and that patient's additional questions are the last priority. It would seem the Challenge Question is a potential opportunity for the patients to express additional concerns, they are more so tests of whether MSs can exercise their medical expertise and authority, indicating that the question is a challenge for the MS.

Types of Challenge Questions

There are three basic types of Challenge Questions: (1) questions about a specific medical condition (3 Scripts); (2) questions about what should be done next (4 Scripts); and (3) questions that address a patient's quality of life (3 Scripts). The following extract demonstrates each of these question types:

Extract 4.2 Selected Challenge Questions

(1) *Your worse fear/concern is that you may have HIV, and even if the student does not bring this up to you in presenting to you the diagnostic possibilities ask them whether HIV is a possibility* (Wheeler Script).

(2) *I am going to Europe next week for 2 months, can we wait to do this evaluation until I come back* (Langley Script)?

(3) *Doc, am I going to be okay?* (Wright Script).

Challenge Questions are presented as patient utterances or summaries of the patient's experience, like the Wheeler Script, which suggests this is how the SP should state the question. Many of the questions pose issues that a patient finds concerning or challenging and is seeking guidance on, but it is the second-part of the question that points to where the actual challenge is.

Most of the Challenge Questions are paired with a *Student Response* or *Sample Response,* which takes the form of: (1) no indication of what the MS should say (2 Scripts); (2) a summary of what the MS should say (1 Script); (3) an example of what the MS should say (7 Scripts).

Types of Responses to Challenge Questions

Sample responses create an expectation for how MSs should respond to additional questions. But two Scripts do not create this expectation, which is tricky considering the nature of the question. For instance, in the Hartman Script, the patient is asking if they can participate in a soccer tournament despite possibly having mononucleosis and in the Wheeler Script, the patient is concerned if they have HIV, a life-changing condition. The lack of response leaves room for a SP to interpret whether a MS's response is sufficient without any guidance.

Yet even for the O'Conner Script that tells the SP what the response should entail, there is still ambiguity: *The student should demonstrate empathy regarding your concerns. The student needs to present the possible diagnoses, and potentially which is most likely. They also need to outline a diagnostic plan, and that based on the work up they will have a better idea of what is going on* (O'Conner Script). First, empathy is an abstract and cognitive phenomenon. There is no way of knowing whether someone is genuinely experiencing empathy, and for simulated consultations, this requires the MS to do additional interactional work (Atkins & Roberts, 2018). Next, the MS should present potential diagnoses, which the SP has some indication of based on earlier sections in the Script. Lastly, the summary requires a diagnostic plan and suggests the MS should appeal to further testing before making a definitive claim about what a patient is experiencing.

The actions described in the O'Conner Script are illustrated in other Scripts through a student's sample response. For instance, the sample response to the Wright Script:

> *I understand your concerns, and it must be frightening. First step*
> *is to figure out what is going on. The major possibilities at this*
> *time include, a heart attack, and blood clot, and aneurysm. We will*
> *get an ECG right away, cxray, and labs. Depending on these*
> *results we may need further testing*

This shows SPs what an ideal response looks like rather than tells using the same elements as those described in the O'Conner Script: (1) an empathetic statement (i.e., *I understand*); (2) a list of candidate diagnoses; and/or (3) an appeal to further testing. Yet when empathy is shown in sample responses like, *I understand your concerns, and it must be frightening,* or *I understand your concerns, and this would be a possibility.* The claim "I understand" implies a MS has access to this experience, but MS are not experiencing the same situation as the patient and such a statement can easily backfire ("no you don't!"). Moreover, MS's access to patient experience is only the result of the patient sharing the information. The claim of understanding is rather a strategy to legitimize a patient's concerns within the realm of medical practice, which the physician is able to solve.

Candidate diagnoses are most often used in Scripts where a patient's concerns are the main feature of the Challenge Question, as in the Wright Script. For Scripts where patients are making speculations about a diagnosis (like having HIV, gonorrhea, or pancreatic cancer), the MS is instead shown to appeal to additional testing. Almost all of the responses indicate that medical testing is the way to achieve an accurate diagnosis and there are two key features of appeals to tests: the use of modals and the use of *we*.

First, modals like *I would think* create a double hedge through the modal *would* and epistemic downgrade of *think*. For instance, to state, *I think he should be taken to the ED to be examined,* the modals demonstrate a sort of politeness strategy that try not to make a big deal out of something like going to the emergency department. Additionally, *we* is often used to propose

a testing protocol. For instance, *we will do some testing including a pelvic examination,* and *we may also have to do a colonoscopy.* Both of these examples refer to extraordinarily intimate exams and strategically use *we* to request compliance. *We* is inclusive and exclusive, meaning it can be interpreted flexibly to include the MS, the patient, as well as the medical establishment the MS is speaking on behalf of (Bartesaghi, 2009b).

In sum, Challenge Questions are the only part of Scripts where a patient is shown to direct the topic of conversation. Challenge Questions are shown to occur at the end of a simulated consultation and typically focus on a patient's concerns about their diagnosis, next actions, or general well-being. In responding to Challenge Questions, MS are shown to perform empathy in a way that legitimizes the patient's concern as medically relevant while also appealing to the medical establishment's ability to address that concern through the knowledge of what it really means, which can be achieved through additional testing. Therefore, while Challenge Questions appear to be an opportunity for patients to express concerns, they are moreover opportunities for MS to demonstrate their authority as medical providers.

Standardizing Patients

Scripts not only use *you* as a strategy to speak for MSs asking questions in simulated consultations, but also direct SPs in who they are to perform and how they are to perform them. Patients have specific traits and experiences, but what of those experiences and traits is made relevant in Scripts? I show how the patient having particular characteristics informs the container paradigm at play in Scripts.

Presenting Situations

The subheading, *Presenting Situation*, at the start of Scripts recruits SPs to perform patients through the second-person pronoun *you.* An example of this in the sample concordance

(See Above Table 4.4) in line 11: *Presenting Situation: You are a 60 year old female smoker with progressive hoarseness for the past four months.* Through *you* the text asks the reader to take on the position of the patient. I look at how this is done in the first section of Patient Descriptions because each sentence begins with *you are,* which effectively equates the patient with having certain traits and experiences; essentially as static containers of information. There are four primary strategies for recruiting SPs to perform patients that emphasize particular information about patients: (1) You-are-(age-gender-symptom) (6 Scripts ; 50%); (2) you-have-(experience) (3 Scripts; 25%), (3) you-are-relationship (2 Scripts; 16%), and the (4) you-less-descriptive (1 Script; 8%).

(1) You-are-(age-gender-symptom)

The most common strategy to describe a patient is structured as you-are-a-age-gender-symptom (6 Scripts; 50%). For example, *you are a 65 year old male who has come into the doctor's office for evaluation of severe chest pain that occurred 2 days ago.* Through the use of *you*, the Script recruits the SP to portray the patient described. The specifics of this type of patient description emphasize basic information, like a patient's age, gender, location of the consultation, and the chief complaint. The information presented here is similar to the information in the Door Note (although age is not on the Door Note) and both situate information as contextually relevant and a site of problem identification. Characterizing patients via age, gender, situation, and especially chief complaint, renders the SP intelligible to medical practice and categorizes a patient as "in need of a medical solution from a physician," rather than, "a person." Describing SPs through demographic and social categories further typifies types of patients.

(2) You-have-(experience)

        The you-have-(experience) structure emphasizes a patient's experience of their symptoms, rather than demographic information or a relational reason for seeking medical help, like that one's child is sick (3 Scripts; 25%). This type of description most often uses the adjective *concerned* to describe the patient's emotional response, which in this case is due to the details of patient's lifeworld. For instance, being concerned about your difficulty hearing because you are a concert pianist, concerned about blood in your urine because you have a kidney condition, or concerned about your night sweats because you have been learning about HIV in medical school. Once again, through *you* the SP is invited to take an imaginative leap into this patient's medical concern, which is interrupting their life.

(3) You-are-(relationship)

        The next descriptive strategy uses the structure, You-are-relationship (2 Scripts; 16%). Rather than demographic and experiential information, this type of description emphasizes a relational reason for seeking medical assistance. Each of these cases depicts a patient in a familial context: the mother who calls in after hours and a parent with a drinking problem who was brought to the clinic by their adult child. The parent/child relationships are often the grounds for why a patient is seeking a medical doctor. Additionally, emotion terms are often used to justify the need for the visit. For instance, the mother is *very concerned* about her baby with a fever and the child is *concerned* about their parent's drinking. However, the parent brought to the office is described as *reluctant, annoyed, angry,* and *slightly agitated,* in effect creating an emotional and moral contrast: when one visits the doctor when concerned about one's health, it is a possible solution, and when one is not concerned or does not want help they are angry about

it being a waste of time. In this, certain emotions are portrayed as problematic with respect to the medical establishment.

(4) You-less-description

The final type does not use the pronoun *you;* it is a you-less-description (1 Script; 8%). The one case that uses this type of patient description includes medically relevant information like an age, living situation, chief complaint, and brief history– *20 year old college student presents to clinic complaining of sore throat X 3 days*– but does not recruit the SP through the pronoun *you,* requiring the SP to infer they should learn this information to be able to portray this patient. Notably, this description does not include personal history, relationships, and emotional experience, once again emphasizing medical information and directing the SP to an acute care situation and a patient in need of a medical solution, which tilts the scale and demonstrates that most cases prioritize medical information over a patient's experiences, emotions, or relationships.

Describing Patients

I have shown how Scripts describe patients through question and answer pairs, which signals that patients do not have things to say beyond what the MS wants to know. The section, Presenting Situation directly recruits a reader to portray patients, either through their biographical information, previous experience, relationship to the patient or medical condition. The next section provides additional details about a patient including their Chief Complaint, Name, Demographic and Socioeconomic Descriptions. By examining the information provided to SPs about patients, I adduce the institution values the issues and concerns implied in patient descriptions as they relate to illness rather than the patient.

Chief Complaint

Notably, the first detail of the Script is the *Case Chief Complaint*, which suggests a patient's complaint is the most important part of the patient. Even the notion of a complaint suggests there is a problem that is bringing them to the doctor. There are two main forms of a Chief Complaint: a 2-5 word description in a common register (i.e., *sore throat* or *chest pain*) or a short account (i.e., *The patient is a 3 month old whose mother, Alana, is calling after hours due to a fever*). The register of the Short Description stands in contrast to the register of the Differential or Actual Diagnosis. For instance, the Chief Complaint of a *sore throat* is in a lay register, whereas the Differential Diagnosis of *viral pharyngitis, gonococcal pharyngitis,* and *mononucleosis* adopt a specialized medical register. The difference in lay versus medical registers implies a patient often does not have medical knowledge, while the presence of both indicates the SP should learn and become fluent in the art of translation. The use of a narrative-based Chief Complaint only occurs for the two cases that rely on another "character" to support their reason for seeking medical assistance– a mother caring for an infant with a fever and an adult brought to the clinic because of a "drinking problem." Finally, in three Scripts (25% of Scripts), the information for a Chief Complaint is given in the wrong section, Case Name.

Case Names

Case Names are issued second, indicating that personal information is subordinate to medical information and that the illness takes precedence to the person experiencing it (Hunter, 1991). Case Names are first and last names. Four of the twelve cases (33%) provide two possible first names that begin with the same letter, one feminine and one masculine, which means the SP can be either male or female. Importantly, names are signs that suggest social positioning and cultural distinctions (Billig, 1999). The first names provided include William, Jason, or Travis

along with Bonnie, Holly, and Taylor. Last names like Adams, Hartman, O'Conner, and Wheeler are used for patients. As cultural signifiers, the names used in this activity are coded as white American names, implying a sort of invisible standardness to who patients are.

Demographic Descriptions

Patient descriptions are provided alongside demographic categories like gender, age, race, and socioeconomic status to describe patients. In the CSPX, 33% of patients are male, 25% are female, and 42% can be either. The average age of patients is 50 years old (the oldest being 70 and the youngest 20). In three out of twelve (25%) of cases Race is not included at all, while all other cases list Any or N/A, further supporting a sort of standardized and invisible whiteness. SPs are taught that details about a patient, like their race or gender, do not change how a patient communicates or the information relevant to their visit.

Socioeconomic Descriptions

In the script, the category of Socioeconomic status synthesizes class status, marital status, living situation, education, and current job. Two cases (16%) do not include the subsection *Socioeconomic* at all, either by leaving it blank or marking it as N/A, presumably not applicable. Terms like *middle-class* or *upper-middle class* are used to describe four patients (33%) in conjunction with job descriptions like *5th grade teacher, college student,* and *concert pianist/ well-educated*, depicts a relationship between class and education level. Furthermore, the other six (50%) Scripts do not mention class titles, but instead make a suggestion of class through jobs like *bakery manager*, *nail technician*, *construction worker*, *third-year medical student*, or *finance*, implying a patient is in school or does not need a lot of education. There is even an explicit connection in the Parker Script, to be a *construction worker* and *high school graduate*.

Next, marital status is conveyed in terms of *widowed*, *single*, *married*, *lives with long-term, same-sex partner*, and *lives with wife of 35 years*. Each of these terms not only marks a relational status but a living situation, basis of sexual experience, and ultimately moral fortitude. Aside from the two Scripts with no Socioeconomic information, one case does not mention a relationship status, but instead the patient is a *college student; lives in dorms on campus*. The Script contextualizes a patient's experiences and orientation to their illness experience.

Doctorability as Concern

Thus far, I have explained how questioning and answering are the main communicative activities of Scripts. In this, patients are vessels of information with specific qualities and traits that physicians access through questioning practices. Effectiveness is getting all the right information. What substantiates this practice is that patients have concerns and physicians address those concerns through effective communication (questioning). In this final section, I address the issue of doctorability, or why a patient needs medical attention, as it is based in a schema of concern.

Emotion states are characterized through similes like, "sick as a dog," as well as emotion terms like, "frustrated." Scripts often use emotion terms to explain patient's internal states (Table 4.4). The most frequent emotion terms in Scripts have an overwhelmingly negative valence– *concerned*, *distressed*, or *anxious*– further suggesting the patient is unwell. There are also emotion terms like calm and cooperative that occur less frequently and imply compliance. However, examining the terms in their contexts provides a more accurate picture of how emotion terms are deployed in Scripts.

Table 4.3: The 10 Most Frequent Emotion Terms

Word	Rank	Frequency
Concerned	1	16
Distress	2	13
Anxious	3	11
Anxiety	4	11
Discomfort	5	9
Calm	6	7
Cooperative	7	7
Tired	8	7
Depressed	9	5
Worried	10	4

Concerned is the most frequent emotion term used in Scripts. Potter and Hepburn (2003) describe how the statement "I'm a bit concerned" in phone calls to a child protection hotline sets up the reason for the call and presents the caller as reasonable and attuned to the organization's purpose. Moreover, the notion of concern points to the complex knowledge dynamic, where the caller knows the experience and the child protections officer does not, yet the child protection officer knows what child protection entails (i.e., the procedures, policies, appropriate actions, etc.). The use of *concerned* in patient descriptions involves the patient attuning to a similar asymmetry– the patient knows about the illness, but the doctor knows about medical practice. In a sample concordance of *concerned,* the four functions of emotion terms are observable: emotion terms (1) describe the patient's experience (2) describe another's experience, (3) contrast another emotion term, (4) or portrays a MS's speech. I consider each of these functions as they relate to the term, concerned (Table 4.5)

Table 4.4: Selected Concordance Lines of _Concerned_

1	I am	concerned	That you may be anemic
2	You are anxious and	concerned	Keyword Description:
3	You are	concerned	Because you noted blood
4	You are	concerned	But not anxious/panicky
5	You are	concerned	Due to mother having died
6	You are	concerned	That there could be something
7	You are	concerned	That this may be related
8	Calm but	concerned	Over the baby's fever
9	Male in no acute distress;	concerned	About the symptoms he is
10	Casual clothes, but nothing fancy.	concerned	About what is going on
11	My daughter/son is	concerned	About my drinking
12	Doctor, I am most	concerned	About my hearing
13	A concert pianist, you are most	concerned	About that your hearing will
14	Adult in no distress; very	concerned	About what might be causing
15	Out in the waiting room. Are you	concerned	? No i am not.

The term _concerned_ encapsulates the reason why they are at the doctor's office. Concern is the appropriate performance by a patient and therefore by a SP. Like the patient description above, emotion terms often occur alongside _you_, which places the reader in the position of the patient, or _I_, to indicate the SP should speak on behalf of the patient. The Script often gives a reason for the patient's concern–either the symptoms they are experiencing or family's past medical history. For instance, _you are concerned due to having a mother who died from..._ The use of the pronoun makes transparent that the institution is depicting the patient as such, and that the SP should perform concern. However, emotion terms can refer to other's experiences of a condition. Specifically, in the Shuster Script and the Mateese Script, the child or mother is concerned on behalf of the patient. In this is an ethic of concern–that when someone is concerned about someone's health, they should ensure the patient seeks out a physician who can address the concerns.

Next, emotion terms are often paired with contrastive terms. In the Script for Holly Adams, the patient behavior is described as, _you are concerned but not anxious/panicky,_ which creates a gradient of concern performances where concern is still the appropriate response. Other contrastive terms used with concerned include _calm but concerned over baby's fever,_ or _You are_

anxious and concerned. Each of these descriptions indicates how a SP should perform in the consultation and the interpretations of what an *anxious and concerned* patient looks like can dramatically differ from SP to SP.

Finally, concern is used in the context of speaking for MSs. There are two clear examples of this, one of them a question and the other a statement. The question, *Are you concerned,* demonstrates that by questioning a physician can know a patient's internal state, claiming emotional experience as part of the medical purview. Alternatively, the statement, *I am concerned that you may be anemic, and that can be related to blood loss from your GI tract,* speaks on behalf of the MS and relies on the ethic of concern to communicate a patient's diagnosis. Through emotion terms like concerned, distressed, anxious, discomfort, patients are often described as needing care. Furthermore, it implies the need for redress and depicts the physician as able to do so through appropriate questioning and answering practices.

The Implications of Communication Skills in Scripts

There is a typicality to Scripts that allows them to be analyzed as a genre, constitutive of communication skills discourse. Scripts are written for SPs to prepare them for a Simulated Consultation by describing the patient, providing an organized list of questions MSs should ask, demonstrating the logical order of those questions, and providing SPs the candidate answers to history questions and physical exam findings. Scripts form a baseline of institutional knowledge for what constitutes skilled communication. Therefore, what is implicitly and explicitly stated about communication, as well as patients and providers, offers a site to observe and consider the implications of how Scripts conceptualize communication skills.

Per Scripts, skilled communication means physicians ask questions and patients provide answers. Physicians initiate and direct the topics of discussion (except for in final Challenge

Question), provide the logical flow for questioning, typically begin with open-ended questions (i.e., *What brings you in today?*), but ask mostly closed ended questions, and are responsible for extracting patient's health problems and creating solutions. Conversely, patients are shown to answer all the questions a physician asks, provide information about themselves (often beyond what is asked), appeal to a logic of concern, and express a lack of certainty in response to medical questions.

Scripts recruit SPs to perform the patient described through the statement *you are*, which characterizes them as medically intelligible. Patients emotional states are often described around the language of concern, which plays into a knowledge asymmetry where the patient has an experience and a need for medical knowledge and the physician needs to understand that experience to offer their medical knowledge and offer a solution. SPs are shown how to perform patient primarily through the question and answer paradigm, more so than in descriptions, making what is important about patients that which a physician deems medically relevant. Scripts orient SPs to a patient's or family member's concern and establish a logic for visiting a physician based on those concerns. By physicians asking and patients answering, effectiveness is observable as the information that physicians retrieve from patients.

However, questioning and answering are not shown to be a dynamic where how things are asked or stated impact medical practice. The container paradigm promotes a model where patients are containers of information and that information can be transported with contents unchanged. For instance, when answering closed-ended questions patients are shown to offer more than is asked for and only ask their own questions at the end of the consultation with a *Challenge Question*. Furthermore, Scripts provide patients with a great deal of institutional and medical knowledge, but simulated consultations require SPs to perform as if they do not have it,

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requiring them to act as "translators" of information. Communication is a tool to retrieve information, which is more important than the patient's humanity and the nuances of asking questions.

Krippendorff (1993) considers the implications of the prevailing metaphors of communication, including the container metaphor. I refer to this metaphor here as it provides key insights about the container paradigm of communication observable in Scripts, which is not always used metaphorically. He suggests the major limitation is that containers do not allow for differences of interpretation and when differences happen, speakers "(i) look for causal explanations, (ii) consult authorities on the matter, (iii) or fight them out them to (iv) abandon the metaphor for bringing these discrepancies about" (p. 5). For instance, Scripts constitute communication skills in such a way that if a MS and SP have a difference in opinion on whether "it went well," or a different logic by which to are play the game (i.e., whether non-medical information is relevant) leads them to blame one another through abstractions (i.e., "they just don't have the right personality for this" or "they are bad at their job"), appeals to the assessment tool (which proceeds via the same paradigm; See Chapter VI), and leads to a communicative dead-end. Scripts do not show communication as a nuanced or dynamic practice, but instead provide a standardized order of practice that shapes SP's expectations and performances. Any failure in communication can be traced to the Script, either that the MS did not ask questions or that SPs did not provide answers. Effective communication is the receipt of information, which substantiates the need for the CSLC's authoritative guidelines.

Scripts do not constitute communication as a dynamic practice where MSs and SPs work together to shape the consultation. This is most obvious in the lack of "receipt tokens" in Scripts. Mishler (1984) explains that the typical pattern of medical interaction unfolds as follows:

(1) Physician asks question

(2) Patient gives answer

(3) Physician acknowledges answer and asks another question

The same question-answer dynamic constitutes Scripts with one key exception: how a physician (or MS) acknowledges the patient's answer. This third part could take the form of "okay" (which marks the receipt of acceptable information), "oh" (which marks the receipt of previously unknown and "surprising" information), a repetition of the answer ("yes"), an assessment of the answer ("that's good"), or some combination of responses. Third parts do important interactional work. Through them physicians (or MSs) provide evaluations of patient claims, or even demonstrate empathy, contributing to the ongoing dynamic of the consultation. But Scripts do not show the MS to offer the third part and therefore do not prepare SPs to reconcile how different third parts provide for and shape different communicative dynamics.

In Scripts MSs are the ones accountable for skilled communication. With the exception of the Challenge Question, MSs are the initiators of interaction, ordering the consultation, and discovering information by asking questions. Scripts teach SPs to view medical consultations and communication skills as an information-exchange process, which constitutes the measure of effectiveness as the amount of information that MSs retrieve through their practices than how questions are asked. In showing SPs how to perform in consultations, Scripts position SPs to an imbalance of communicative responsibility by suggesting MSs are the ones accountable for retrieving all necessary information. This prepares MSs to interact with patients who do not volunteer any information outside of questioning practices or who offer more information than is asked for, neither of which is based on the questioning practice (Heritage & Maynard, 2006). Additionally, patients are rarely shown to talk in long narratives or accounts for why they are

visiting the doctor and only once are they shown to direct the topic of conversation, which further trains MSs to do the "asking" rather than waiting and listening.

Scripts constitute communication as a neutral means of information gathering. Across Scripts, MSs are shown to use the same questioning pattern and strategies. Even for Social History questions about sex, drugs, and alcohol use, the questions occur in an identical order and are designed using the same words. Even for the Shuster Case that is specifically about alcohol abuse, there is not variation in how the MS is shown to ask about drinking. Patients claims become medical artifacts that support the actions of the physician. This is also visible in how names are coded in a "standard" manner, demographic information is left out, and the register of patient speech is disregarded. Patients are pieces of information that must be put back together to be fixed, which disregards the complexity (and uncertainty) of medical practice and treatment.

So, what happens if SPs and MSs should disagree about the quality of a simulated consultation? Can this disagreement be resolved? The container paradigm separates each party as having their own views and perspectives (much like the relationship-centered approach described in Chapter II where physicians have their experiences and expectations and patients have their own), their differences in opinion may simply be relegated to "one's opinion," where nobody has the authoritative view of what went well. Moreover, because Scripts show success in terms of the quantity of information gathered, the nuances of *how* that information is asked for or how patients offer answers are overlooked.

Communication is conceptualized as ab objective and repeatable tool that cannot be the cause of a "good" or "bad" consultation. What shapes the quality of communication skills and the quality of the consultation is whatever CSLC claims it is, the accomplishment of certain tasks. What is lost in this is that patients are not recognized as participants in their own

healthcare interactions, nor are MSs oriented to ways of practicing communication *with* patients instead of on them. Finally, this paradigm of communication leads to dead ends of "noncompliance" or "personality" issues, not communication issues, preventing both MSs and SPs from finding ways of moving forward.

I opened this chapter with journalist Leslie Jamison's account of her work as a SP, but her memoir is littered with examples that demonstrate the limits of the container paradigm– the tensions of her personal health experiences and the Scripts she receives; the fake small talk she has to make up to show a patient's personality; and the complexity of empathy as it relates to health and medical practice. In the conceptualization of communication that Scripts present, communication offers no possibility for connection, but is just something MSs and patients do to accomplish their institutional roles. The next chapter considers how MSs and SPs perform communication in simulated consultations.

CHAPTER FIVE:

COMMUNICATION SKILLS IN SIMULATED CONSULTATIONS

In his address to the American Sociological Association, Goffman (1983) argues that to understand the social world, one should pay attention to the micropractices of social interaction. This theme has resounded since the beginning of his career. In *The Presentation of Self in Everyday Life,* Goffman (1959) first theorizes how one manages an impression of the self through the metaphor of performance. Roles are not intrinsic to a person but are accomplished through performances, of the voice, body, and space, that are ratified by others. Through performance, we show who we are and what we are doing. Goffman's (1974) notion of "framing" offers that by paying attention to the micropractices of interaction, analysts gain an insight into the relevant identities, principles, and goals of participants. Rather than refer to a "frame" as a static thing, "framing" as a verb implies the fact that managing identity and context are ongoing performances.

In a study of physician and patient interaction, Coupland, Robinson, & Coupland (1994) build on Goffman's notion of framing to demonstrate how greetings, compliments, teases, and apologies "expand the frame of interaction" from simply medical consultation between doctor and patient to a broader social frame. When aspects of a patient's biography or character become salient to the interaction, it shifts the frame of who the doctor and patient are and what they are doing (i.e., being friendly versus doing medical consultation). Similarly, Tannen and Wallat (1987) examine how pediatricians uniquely address patients, parents, and medical students all in

the same room. The framing strategies visible in a physician's words, voice, and body indicate that an utterance is directed at one party and not another, which participants perform an understanding of allowing the goal of the consultation to progress (i.e., for the MS, the learning how to be doctor, for the parent, ensuring the child's medical needs are met, and for the child, to understand what is going on in the moment).

Speakers invoke and ratify social identities in the micropractices of interaction. In simulated consultations, this is a sort of "meta" activity. Bateson (1972/1999) explains the phenomenon of play (like a simulated consultation) can only occur if speakers are able to metacommunicate about what they are doing in a way that says, "this is play" (p. 68). In the moments when participants indicate an awareness of the play, there is in that moment, a metacommentary on who we are and what we are doing. In Simulated Consultations, MSs perform doctor and SPs perform patient. Such micropractices allow the performance of simulated consultation to come off (or not).

In a study of workplace conversations, Koester (2006) combines Goffman's notion of framing with Gumperz's (1982; 1992) "contextualization cues," or that which contributes to any presuppositions about context. Gumperz (1992) describes the range of communication practices speakers use to manage context– from shifts in prosody (i.e., intonation, stress, and pitch) to choices of expressions or opening routines. Such linguistic actions set and negotiate the frame(s) of interaction, as well as the social identities and interactional goals there within. By grounding framing analyses in the micropractices of interaction, we can gain a better sense of "the continuous construction, destruction, and reconstruction of the social realities we live in" (Krippendorff, 2017, p. 7). Moreover, by attending to the linguistic aspects of contextualization

cues, we can understand the discourse of communication skills as it occurs in Simulated Consultations.

Finally, framing extends beyond what humans do alone and includes the use of texts and props in performing social action (Goffman, 1959). Heller (1984/2016) explains how texts play an important role in institutional interactions, like communication skills assessments or medical encounters, because they carry traces of previous interactions (i.e., Scripts, etc.) or regulations that constrain activities (i.e., Computerized Assessment Forms, etc.). Additionally, Goffman (1961) describes how props, including dress, hairstyle, and objects are key features of a speaker's "identity kit," and are essential to how performances do or do not come off. This is also true for simulated consultations. Props, like charts, texts, stethoscopes, and patient gowns, are important resources for SPs and MSs to accomplish a consultation, and they aid in performances of identity. In this chapter, I attend to the linguistic and paralinguistic resources that SPs and MSs use for performing patient and physician, which metadiscursively point to communication skills, as well as the role that props and spaces play in enacting the simulated consultation.

Simulated consultations occupy multiple framings. Medical students (MSs) are performing physicians and simulated patients (SPs) are performing patients. MSs also show themselves to be either skilled communicators or unknowing MSs and SPs show themselves to be institutional knowers and participants in what counts as skilled communication. I draw on Goffman's (1974) notion of framing to analyze simulated consultations, account for the strategies MSs and SPs use to make simulated medical consultations happen and consider how they point to communication skills discourse (See Appendix E for summary of analysis). I present my analyses with the goal of answering my second set of research questions:

2.0.   How are communication skills conceptualized in Simulated Consultations?

    2.1.   What strategies do the Communication Skills Learning Center, SPs, and medical students use to constitute communication skills in Simulated Consultations?

    2.2.   What are the implications of communication skills in Simulated Consultations?

Observing Communication Skills Discourse

I organize my analysis of communication skills discourse in Simulated Consultations, which is based on conventional structure of actual primary care consultations: (1) Pre-Openings, (2) Opening, (3) History Taking, (4) Physical Exam, (5) Diagnosis and Treatment, and (6) Closing (Robinson, 2003). While I examine participant's framing strategies and how those framings implicate communication skills discourse, the strategies are not limited to the sections they are presented in, nor is the structure universally adapted.

Pre-Openings

I classify Pre-Openings as anything that happens prior to the door opening for the Simulated Consultation. For the Communication Skills Practice Exam (CSPX), this includes the design of the simulated clinic room, the objects and persons therein, the objects and persons outside the room, and the institutional announcements that echo throughout the space to signal the beginning, near end, and end of each consultation. Arguably, the Script and Assessment Form are also key to the Pre-Opening, each implicating the Simulated Consultation. Each of these are framing devices that set up the potentialities of what occurs next and implicate the meanings of communication skills.

Spaces

The space of the exam room and the objects therein are framing technologies that set up what should occur. There is a single door to a small room, about six feet by fix feet. Most rooms have a wall of windows or no windows, along institutionally-off white walls, and some white patterned laminate flooring (there are seven rooms that have a wall of windows). Affixed to the corners of the ceiling are two wide-angle cameras, each looking at either end of the room. There is also a speaker that projects an amplified voice at the start, ending, and end of each consultation. The space is set apart, and the door a liminal barrier for entering a new context. Each SP has their own separate room indicating they are isolated sites of examining communication skills. Each of the items in it offer potentialities for communication skills as SPs and/or MSs can invoke the objects in any manner. Yet their very presence suggests their use. Caronia (2019) notes artifacts are sites, "where culture meets local interaction and strange ephemeral entities such as 'meanings' or 'rules' are made visible an operating" (p. 117).

Objects

The objects in the room point to what actions are relevant and expected. There is a navy-blue exam table with a thin layer of white paper flowing from a larger role tucked behind a pillow with a white paper covering. The paper creates a barrier between the table, the pillow, and the person who will presumably lay upon it. It suggests a temporary sanitation, as it is easily disposable and keeps unwanted things from becoming permanent parts of the room. The foot pedals on the ground control the angle and height of the table, allowing the physician to lay the patient down, as the patient on the table could not possibly reach the pedals themselves. Above the table is a mirror, allowing the cameras to see faces and bodies from multiple angles.

To the left of the exam table is an array of medical diagnostic tools fixed to the wall–otoscopes and their disposable tips along with a blood pressure cuff. The devices are attached to their mount on the wall, suggesting their use in the exam room. There is a separate blood pressure cuff, along with a thermometer and disposable covers. On the opposite side of the table are a series of grey cabinets attached to the walls. In the cabinets are more disposable paper pillowcases, paper blankets, and paper gowns. On the top of the countertop are three boxes of disposable gloves, tissues, hand sanitizer, and disinfectant wipes. There is a plastic box with disposable alcohol wipes, tongue depressors, cotton swabs, and band aids. There is a mesh-backed chair with wheels pushed up to the counter, offering a desk like space.

In the far corner of the room is another rolling chair, this one with no back, pushed up to a desktop computer. The computer has a typed label on the monitor that indicates what computer it is. There is also a black keyboard and mouse. To the left of the computer is another chair, this one without wheels, suggesting it is more permanent. Above it, a hand sanitizer dispenser is attached to the wall. Each of these objects is a resource for the participants in the endeavor of performing communication skills that are drawn upon throughout the consultation.

Institutional Framing Devices

CSLC begins recording simulated consultations shortly before students enter the room. The Pre-Opening is a sort of liminal space where MSs and SPs are "betwixt and between" the frame of educational assessment and medical consultation (Turner, 1967). Yet during this time, CSLC agents, MSs, and SPs are working to transition to the context of a medical consultation. In this section, I show how announcements, presenting and reading documents, and waiting set the frame of the consultation.

Overhead Voice

Simulated consultations at CSLC all begin with an announcement from an employee amplified over the speakers in rooms and in the hallway, "Students you may knock and enter." This announcement is a framing strategy for communication skills. It is directed towards students ("students, you"), paired with a modal ("may") and indicates the actions for initiation, knocking and entering. It is a cue, a framing ritual, performed "for another first time," that marks the beginning of the simulated consultation (Garfinkel, 1967, p. 9). The announcement also occurs in the following forms "students you have five minutes remaining" and "students this marks the end of your patient encounter." All announcements are directed towards students and both emphasize the student's accountability to the practice at hand, the Communication Skills Practice Exam (CSPX).

Documents

Students typically heed the conditional "may" in this Pre-Opening announcement and wait between 20 and 40 seconds to knock on the door and enter the room. Although there is no video data capturing what students are doing during this time, based on my field notes, they are reading the Pre-Encounter Summary, or "Door Note" posted outside the clinic room. While reading they repeatedly open the manila flap to read the document and quickly jot down notes on their legal pad attached to a clipboard, which is provided to students by CSLC. The Door Note speaks specifically to MSs by describing the context of the simulated consultation (mostly, patient information), invoking a specialized register in the use of numbers and acronyms, and addressing the students in detailing the assignment and objectives of the activity. Below, is the Door Note for the Hartman case:

Extract 5.1 (Hartman Door Note)

Patient: Jason Hartman

Chief Complaint: Sore Throat

Vital Signs: Temp 103.3F oral; P 90; RR 16; BP 130/70

Setting: Outpatient Clinic

Role: Primary Care Physician

Assignment:

• You will have 15 minutes with the patient to take a history and obtain appropriate

physical findings relative to the patient's chief complaint.

• After 15 minutes you will leave the room and complete a post encounter evaluation.

You will have 10 minutes to complete the post encounter evaluation.

Objectives:

• Perform a thorough history and obtain appropriate physical findings for case.

• Discuss finding and immediate plan of care with patient.

The Door Note demonstrates what MSs at the CSLC should know before entering a room with a SP. The paper is an agent in the upcoming simulated consultation and in the overall practice of communication skills. After the patient's first and last name is the *Chief Complaint*. The qualifier *Chief* Complaint implies the patient has a single problem that they are complaining about. Moreover, a *Complaint* is not necessarily a medical term, but needs to be investigated as such. In the context of a medical consultation, that is a medical problem that needs to be solved by a medical doctor. In this case, the *Chief Complaint* simply states *Sore Throat.* The presence of a *Chief Complaint* directs the MS towards two goals: figuring out what is causing the complaint

and fixing it. The goals are further supported by the details of Setting and Role, suggesting a sort of narrative: this person came to this clinic to see you (a doctor) because of this.

The section after patient information uses a specialized register when addressing MSs. Presented as a series of acronyms and numbers, the section requires the readers to know only what a *P, RR,* or *BP* are, and interpret the meanings of the accompanying numbers. The inclusion of this information supports the institutional view of its necessity. For example, the patient has a temp, or temperature of 103.3, which is considered a high fever.

If the goals of the simulated consultation are not clear through the contextual information provided, the final items Assignment and Objectives make it explicit through the second-person pronoun you to and the verb will, which directs the reader of the Door Note in exactly what to do– perform a thorough history and physical to discuss findings and immediate plan of care. The manner of addressing MSs differs from how the document speaks to other participants. This document is a contextualization cue for the simulated consultation, commenting on context by indicating that when the student enters the room, this is the patient they are encountering, the situational context, and their role in it is to perform physician.

Performing Waiting

Although the Pre-Opening Announcement is directed towards students, SPs hear and heed the announcement. During the period between the announcement and the MS entering the room SP's bodily movements are anticipating the framing of communication skills assessment. After the Pre-Opening Announcement, SPs often shift their bodies and nearby objects to perform waiting. For example, before the pre-encounter announcement Bob is sitting still on the exam table, gazing towards the door. With the announcement he coughs to clear his throat, moves his hands from his lap to his side, raises his shoulders, leans forward, and gazes down. After the

announcement, Becky breathes deeply, sits up, and places her shoes back on her feet before tilting her head back on the elevated exam table and yawning. Both Bob and Becky are preparing their bodies for the interaction to come, which is framed by a knock at the door.

The embodied shifts SPs make during this time prepares them not for the immediate context of interaction but sets a sort of pre-context where patients wait for physicians. Indeed, SPs perform waiting– by adjusting one's gown, browsing on one's cell phone, placing one's phone face down, closing one's eyes, cleaning one's fingernails, touching one's face, swinging one's feet, etc. What is embedded in performances of waiting is the assumptions about the conditions for an appropriate opening– one where the physician initiates the consultation and the patient is ready to respond. Framing is thus an embodied activity.

Performances of waiting are important because interruptions by MSs are treated as troublesome. For instance, a SP named Molly waits an average of 25.8 seconds between the overhead announcement and the door knock. But in a simulated consultation with a MS named, Justine, Molly unscrews the cap of her water bottle 16 seconds after the overhead announcement, which makes Justine's early knock on the door after 20 seconds about five seconds too early.

Figure 5.1 Performing Waiting

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Upon Justine's entrance, Molly looks towards the door with an open bottle of water, her left hand, and the cap in her right. Molly looks at Justine, smiles and quietly says, "hey" before taking a sip of the water. Justine is then silent for her first five seconds in the room during which she sanitizes her hands. Justine, rubbing her hands together, approaches Molly with an extended hand and says, "nice to meet you, my name is Justine Downs" and then softly chuckles. With Justine's hand outstretched, Molly contorts her face and swallows the water in her mouth. She places the cap back on the bottle before grabbing Justine's hand. Together, Molly's gaze at the door and initiating talk ("hey") indicate that the frame of the medical consultation has not yet begun. Molly effectively pressed the pause button because Justine maintains silence, busies herself by sanitizing her hands. After a few moments, the MS proceeds with opening the interaction by introducing herself, yet she laughs at the end of her introduction, acknowledging the strangeness of what just occurred. This is an atypical opening interaction and further suggest the importance of SP's performances of waiting in the Pre-Opening sequence as key to framing the opening of the consultation.

Openings

Participant's Openings in Simulated Medical Consultations are key sites for contextualizing who they are and what they are doing. Openings have a similar function in actual medical consultations, as the doctor and patient establish an interactional relationship for the consultation to come, which often occurs through greetings, identifications of patients, consultation of medical records, and a physical orientation to the examination room (Heritage & Maynard, 2006; Robinson, 2006). The Openings of Simulated Consultations function very similarly, framing the context of the interaction through greetings, identifications of patient and physician, requests for the chief complaint, and accounts of medical problems. Yet in the meta-

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frame of simulation, there is more going on through which participants metacommunicate about notions of communication skills. In this section, I show how Openings are opportunities for MSs to display knowledge of the patient and demonstrate authority/ accountability as medical provider.

Introductions

MSs typically initiate introductions, which indicates they are responsible for the communication skill that is "doing introductions." But MSs not only introduce themselves, but also name and make relevant their patients. In these introductions they present various degrees of knowledge and authority. I want to zoom into two interactions that demonstrate the role of knowledge in introductions. First, an opening between a SP, Molly (SP_11) and a MS, Caleb (MS_07):

Extract 07.11.1 (Caleb and Molly- Opening)

4	MS_07:	Hello
5	SP_11:	Hey
6	MS_07:	Uh Misses Hartman?
7	SP_11:	((nods))
8	MS:_07	Miss Hartman?
9	SP_11:	((nods))

Patient Introductions. The Opening of this Simulated Consultation consists of a greeting that Caleb initiates ("hello") and Molly reciprocates ("hey"). In line 6, Caleb asks a question, "uh Misses Hartman?" That he holds his turn with uh and states a name in a rising tone poses the utterance as a question. Molly nods, answering the implied question that she is indeed Misses Hartman. Implicit in this is the acceptance of the term of address, Misses, as appropriate.

This makes the start to Caleb's next turn interesting, "Miss Hartman?" Caleb changes the term of address from Misses to Miss, even though Molly agreed to Misses. Molly once again nods, accepting both terms of address and allowing Caleb to make the next move. Zooming out, Caleb's repair is interesting because the note on the door indicates the patient's name is *Jason Hartman*, a traditionally masculine name, although Molly presents as feminine. Perhaps the repair in terms of address is a way to seek clarification about the patient's gender. It is also a way the Door Note is acting in Simulated Consultations. As mentioned in Chapter IV, about 42% of cases can be played by either a man or a woman, meaning that MSs are accustomed to SPs performing patients of different genders/ sexes.

Figure 5.2 Introduction in a Simulated Consultation

Caleb's (MS_07) introduction with Fiona (SP_10) provides further insight into the issues

of gendered terms of address in simulated consultations (Figure 5.2):

Extract 07.10.01 (Caleb and Fiona- Opening)

3	MS_07:	Hello::
4	MS_07:	Hey
5	MS_07:	How are you
6	SP_10:	Doing well and you
7		((Shakes hand))
8	MS_07:	Good good good
9		um Mister Fields
10	SP_10:	Um Miss Fields yeah
11	MS_07:	Oh Miss Fields I'm sorry

This interaction opens with Caleb and Fiona greeting one another (lines 3-4), but Caleb's

question in line 5 ("How are you?") performs an ambiguous social action. In medical

consultations, a question like "how are you feeling?" functions to solicit an evaluation of an

ongoing health concern (Robinson, 2006). Even the question, "what brings you in today," is a

medical question that often solicits a medical answer. However, when Caleb asks, "how are

you," a type of question that occurs in a range of social situations (not always medical), Fiona

treats the question as a non-medical question and answers with a non-medical response, "doing

well and you." This answer assumes a "no problem" stance, which is contradictory to the site of

medical practice. If a patient is claiming to be well, why are they visiting the doctor?

Caleb attempts to move past Fiona's response by offering his hand and quickly stating,

"good good good," (line 8) before trying to confirm the patient's name, "um Mister Fields?"

(line 9). Fiona corrects him by stating, "um Miss Fields yeah" (line 10). Fiona restates the patient's name with a differently gendered honorific. The addition of "yeah" after the restatement covers Fiona's repair and instead offers agreement with Caleb's action of introducing the patient. Caleb performs a change of state token, "oh," which shows this information is new to him (Heritage, 1984; Schiffrin, 2001). Caleb corrects himself by repeating the term of address Fiona offers, "Miss Fields," and apologizes, "sorry" for misidentifying the patient. Once again zooming out from this interaction, the name on the Door Note is Alexis Fields, a traditionally feminine name. Could it be Fiona's boy-ish presence (a short haircut, no make-up, and baggy clothes) that cause the trouble? Or is it the routine depersonalization of a patient's gender that creates such complexity?

Regardless of why this trouble occurs, these instances point to key aspects of patient introductions in the openings of consultations. First, SPs do not typically introduce themselves; MSs state patient's formal names with a rising tone, as if they are confirming the patient's name. When MSs initiate patient introductions, they constitute introductions as the student's responsibility, which is ultimately a knowledge responsibility. To confirm a patient's name is a way for the MS to demonstrate their knowledge, show themselves as knower of patient, and therefore interpersonally competent. So, how do MSs introduce themselves?

Medical Student Introductions. How MSs introduce themselves sets the stage of the simulated consultation. Per Goffman, claims of identity are also claims to the rules of interaction (i.e., because I am this type of person, I should be treated in this sort of way). MS's claims to authority occur along a continuum. Whether a MS introduces themselves as "a student in the clinic" or "the doctor," is a performance of professionalization. Let's return to the conversation between Caleb and Molly to see how he introduces himself:

Extract 07.11.02 (Caleb and Molly- Opening)

10   MS_07:   ((extends hand))

11   Sorry I'm Caleb Guzman

12   I'm one of the medical students here (.)

13   in the clinic today (.)

14   and um I'm gonna be taking care of you today

15   (.) how can I help you?

After an apology for the misused term of address (line 9), Caleb introduces himself to Molly in five parts: (1) he gives his first and last name ("Caleb Guzman"), (2) identifies his role ("one of the medical students"), (3) identifies the context ("here"), (4) more specifically identifies the context ("in the clinic today"), and (5) explains his role ("I'm gonna be taking care of you today"). The first two parts occur in succession, without any pause and assert that "I'm Caleb Guzman I'm one of the medical students here." To refer to himself by his first and last name suggests a degree of formality. He does not introduce himself as "Cal" or even "Caleb," but by his first and last name. Notably, Caleb also does not refer to himself as "Dr. Guzman," (there is no rule stating they cannot) but as a MS, which suggests he is not the physician, disclaiming his own status and therefore, authority. By referring to himself as a MS, he is also claiming a student status that holds him less accountable to error than a professional status. The issues of authority and accountability are also clear in Will's (MS_08) introduction to Fiona (SP_10):

Extract 08.10.01 (Will and Fiona- Introduction)

7   MS_08:   Hello my name is William

8   I'm a third-year medical student

9	uh the attending physician will be in
10	in just a little while to clarify the plan
11	in the meantime I wanted to see
12	how you're doing
13	and what brings you in today?
14	((offers hand))

Will introduces himself as "William" and designates himself first by his status ("a third-year medical student"). The specifics of being a "third-year medical student" indicate that he has more experience than perhaps a first- or second-year student. But he still refers to himself as a student and the designation of a year is considered relevant to state. However, Will bolsters his position by claiming a relationship with another doctor, "the attending physician." Through this introduction, Will creates a context that involves someone who has more experience and authority than he and where he has less accountability because he is under this person's authority. Indeed, Will is part of an institution in which he fits in a clear hierarchy. The inclusion of student and student working with another doctor both limits his own credibility, yet shows he is supported by a physician with greater authority.

This final extract of an introduction shows the medical student demonstrating even greater authority as the physician by claiming ownership over a patient. The next extract comes from a phone consultation between a SP, Jennifer (SP_18), who is portraying the mother of a 3-month old imaginary patient, Sebastian, and Barrett (MS_06), a medical student. About a minute into the recording, the following introduction occurs:

Extract 06.18.01 (Barrett and Jennifer- Opening)

0	((Skype Ring Tone))

1	SP_18:	Hello?
2	MS_06:	Hi am I speaking to Miss Mateese?
3	SP_18:	Yes this is she
4	MS_06:	Um and um I'm just returning a call
5		about a patient of mine
6		Uh Sebastian Mateese
7	SP_18:	Uh yes my son
8	MS_06:	And uh okay that's your son so you're mom
9	SP_18:	Yes
10	MS_06:	Can I get your first and last name
11	SP_18:	Alana Mateese

This Opening begins differently than the others because it is a phone consultation. Prior to line 1 there is a summons (the sound of Skype ringing) that is met with an answer in line 1. In line 2, the MS greets the answerer and asks a question that identifies the patient by their last name and a formal term of address ("Miss Mateese?"). Once again, the MS is displaying prior knowledge of who the speaker is. The SP answers the question ("yes this is she"), and the MS proceeds introduce himself via a direct relationship with the patient ("a patient of mine uh Sebastian Mateese"). Claiming that Sebastian is "a patient of mine" is a way of the MS to show themselves as *the physician*, and therefore one with ownership and authority. Jennifer's response to this claim is also about authority via ownership, "*my* son." Barrett restates her claim ("that's your son"), affirming her claim to knowledge about the patient, and confirms her identity ("so you're mom"). Jennifer agrees to this ("yes") and then Barrett has to shift his own positionality

once again by asking, "can I get your first and last name?" demonstrating that he does not have this prior knowledge.

In sum, Openings establish identities, relationships, and goals for a Simulated Consultation. The communication skills dynamics revolve around matters of knowledge, authority, and accountability. Communication skills are a matter of professionalization (Chapter II) and how MSs go about showing their professional knowledge matters. When MSs confirm patient's name, they are displaying their knowledge of interpersonal strategy. Yet depending on how they introduce themselves, they show more or less authority and accountability over the situation. The complexity of this dynamic is most evident in Jennifer and Barrett's opening as after Barrett indicates a strong sense of knowledge and authority over the patient, the SP does the same, and Barrett leans into that asymmetry by seeking information from the parent (their first and last name). However, seeking information from a patient is one of the core activities of the simulated consultation, as the next section demonstrates.

History Taking

History Taking occurs in a dynamic of questioning and answering that is the most common activity of a Simulated Consultation. Mishler (1984) highlights the role of physician questions in medical consultations and suggests that the physician driven dynamic is a means of maintaining interactional control. This is a common pattern in simulated and actual consultations– MS's turns are "predominantly first parts of sequences, in which they launch courses of action and solicit responses, whereas patients' turns are predominantly second parts of sequences, in which they provide responses" (Robinson, 1998, p. 100). However, in Simulated Consultations not all questions and answers function to maintain control, launch courses of action, or solicit information– they are key sites for the metadiscourse of communication skills.

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In this section I break down how MSs and SPs metacommunicate through questioning and answering practices. By attending to the dynamics of questioning and answering I demonstrate the notion that communication skills are not located in MSs or their behaviors but are distributed and negotiated amongst MSs and SPs.

Opening Questions

Questions often function as a transition between the Opening of the consultation to the Presentation of a Chief Complaint (Robinson, 2006). Subtle differences in question design impact the actions that questions accomplish (See example in Chapter II). In the CSPX, MSs typically start with open-ended questions that seek unknown information. However, in zooming out of the consultation, MSs see Chief Complaint on the Door Note, yet they ask for them anyways. I suggest one of the reasons for doing this is that opening questions offer MSs the opportunity to perform communication skills tasks (as stated in the Computerized Assessment Form), such as asking open-ended questions and performing empathy. However, it is in the dynamic of questioning and answering that do or do not allow these activities to occur. To demonstrate this, we will compare how a SP named George responds to two different MSs in two different Simulated Consultations.

The first instance is between George (SP_19), who is playing Dominic Romano, and a MS named Saul (MS_09):

Extract 19.09.02 (Saul and George- Opening)

19	MS_09:	um whats going on
>20	SP_19:	Uh I'm having really bad back- lower back pain
21	MS_09:	Okay I'm sorry about that
22		well (.) right that can be pretty frustrating

23   SP_19:   Yeah it hurts heh

Saul transitions to a new topic by asking George, "what's going on?" This is a common question in medical encounters that is designed to elicit a patient's new concern (Robinson, 2006). Then George does extra interactional work in his answer to emphasize and specify the pain the patient is experiencing– George holds his turn as if he is formulating a response that he has yet to consider ("uh") (Tottie, 2015). George's response is elaborate ("I'm having really bad back- lower back pain") in that he (1) emphasizes that the back pain is "really bad," not just bad and not just back pain and (2) his self-initiated self-repair after "back" to specifies the pain is in his lower back, not just his back. Each of these subtleties anticipates potential follow-up questions Saul could ask like, "how bad is the back pain?" or "where is the pain?"

Yet the work George does in his answer allows Saul to offer an elaborate response. Saul acknowledges George's complaint with a receipt token ("okay") before stating, "I'm sorry about that." While the statement I'm sorry can perform an apology for which the speakers is expressing a regret of personal responsibility, Saul is not personally responsible for this and is instead expressing condolences or sympathy (Robinson, 2004)[6]. Saul prefaces his next statement with "well," which indicates that what is coming next is being something that will prioritize his own desires, knowledge, or experience in the next action (Heritage, 2015). Indeed, Saul aligns himself with George's complaint ("right that can be pretty frustrating"), which could be seen as performing empathetic or concerned physician. The distance Saul creates between his own experiences and George's through the determiner "that" makes his claim one of authority. Saul is

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[6] Robinson (2004) prefers the term condolences (defined in Merriam Webster (1996) as "an *expression* of sympathy with a person who is suffering sorrow, misfortune or grief") over the term sympathy as sympathy is typically associated with an actual psychological or emotional experience rather than an expressive one. I suggest the notion of empathy as relevant as it is part of the communication skills discourse. Particularly item 12 of the Computerized Assessment Form defines empathy as "acknowledged and demonstrated understanding of your feelings (i.e.: that sounds hard,... or, you look upset...)," which is part of what Saul does through this response.

formulating George's experience as frustrating, offering a professional assessment that legitimizes George's interpretation of pain and reason for seeking medical attention (Hak & de Boer, 1994). George agrees with this assessment, ("yeah") and restates "it hurts," and offers a slight chuckle. Perhaps this chuckle is a sort of metacommunicative maneuver that comments on the elaborateness of what just took place. Moreover, this interaction demonstrates how George and Saul collaboratively accomplish the back pain as bad and indeed a cause for medical concern.

Now, contrast George's interaction with Saul to his interaction with Justine (MS_04), where he is also playing Dominic Romano:

Extract 04.19.01 (Justine and George- Opening)

25	MS_04:	=No oh good. What brings you today?
>26	SP_19:	Uh I'm having lower (.) back pain.
27	MS_04:	Okay. When did that start?
28	SP_19:	Uh week ago at work.
29	MS_04:	okay (.) what you do for work
30	SP_19:	Construction.

Like Saul, Justine asks an open-ended question designed to solicit a patient's chief complaint, ("what brings you in today?"). However, George's response moves the interaction in a different direction. Once again George holds his place with "uh," as if he is formulating a response, then he states, "I'm having lower back pain." The key difference between George's response to Saul and his response to Justine is the intensifier "really bad." George does not tell Justine that he is having "really bad" lower back pain, which does not allow Justine to issue the same type of response. Instead, Justine offers a receipt token ("okay") and then asks another

question ("when did that start?"). George's response to Saul allows the MS to perform empathy and provide an assessment regarding his need for medical care, but his response to Justine does not enable her to make the same move, she is only able to move along in the interaction, in this case by continuing to ask questions that George continues to answer.

The differences in how a SP responds to a question demonstrates the notion that communication skills are distributed. It is not only what the MS does, but also what the SP does. Together their interactions allow for or prevent certain possibilities. Although a MS may ask a question, how the SP responds to that question determines the student's next possible move. In this case, George's response allowed Saul to perform an empathetic assessment, something that is considered a key communication skill per the Computerized Assessment Form, while his response to Justine kept her from doing such. Communication skills are not located in individual persons but rely on a dynamic of practice.

Answering

Thus far, I have shown how MSs are not solely responsible for communication skills, as there is a dynamic interplay of accomplishing communication activities. A great deal of attention is given to the notion that physicians and MSs typically direct the conversation around matters of medical information. In this next section, I show how SPs are attuned to this dynamic in how they attempt to offer "correct" answers on behalf of the patient.

Earlier in Justine (MS_04) and George's (SP_19) simulated consultation, Justine asks George:

Extract 04.19.02 (Justine and George- Age Trouble)

14   MS_04:   Okay (.) and how old does that make you?

15   SP_19:   How old does that make me?

16	MS_04:	Yes heheh
17	SP_19:	.hhh that makes me (.) fifty eight?
18	MS_04:	Fifty eight. Okay.
19	SP_19:	That makes actually sixty.
>20	MS_04:	Sixty (.) okay (.) I apologize (.) Heheheh[uum
21	SP_19:	[alright

George responds to Justine's question about his age with another question ("How old does that make me?") which marks the question as troublesome, since questions are typically met with answers (Sacks, Schegloff & Jefferson, 1974). Justine confirms this is the question she has and laughs, a sort of metadiscursive shift that demonstrates an awareness that this is a troublesome interaction, more likely because the patient does not have immediate access to their own age. George indicates the trouble with his answer in three small moves (".hhhh that makes me (.) fifty eight?"): (1) a deep breath in that functions to hold his place; (2) a brief pause before the age is stated; and (3) a rising tone, indicating this as potentially questionable information. Despite the metalinguistic moves that mark this as a potentially unsatisfactory answer, Justine treats it as an acceptable answer by first repeating the number and then offering a receipt token, which signals acceptance of the information ("okay") (Greer et al., 2009). However, Justine does not continue with another question instead George initiates the next sequence by stating "that makes actually sixty." Justine attempts to treat the answer in the same way by repeating the number and stating "okay," but she subsequently apologizes for the trouble she has caused and laughs, acknowledging the trouble that occurred.

However, MSs do not always acknowledge the trouble that occurs as the result of SP utterances but instead move the consultation along as if there was no error. In the following

consultation between Mackenzie (MS_02) and Clarissa (SP_16), who is playing a patient Cali

Daniels, Clarissa's self-repair in lines 181-182 shows the question is not the problem, but that

her recall of the Script is:

Extract 02.16.01- (Mackenzie and Clarissa- Smoking Question)

174	OH_00:	You have five minutes remaining
175		in your patient encounter
176	MS_02:	I forgot- to ask
177		do you (.) um smoke (.) cigarettes
178	SP_16:	Yes
179	MS_02:	About how much
>180	SP_16:	About three packs- heheh
181		I'm sorry (.) about heh a pack heh a day=
182	MS_02:	=one pack a day? okay
183	SP_16:	Heheheh yeah I've been trying to cut down
184	MS_02:	Okay (.) and then any alcohol?
185	SP_16:	(.) uh no
186	MS_02:	Okay (.)

Mackenzie prefaces her question as out of place with the account "I forgot to ask," before

asking whether the patient smokes cigarettes (line 177). Clarissa answers, "yes," and the MS

asks a follow-up question, "about how much," which Clarissa begins to answer, "about three

packs," but then stops herself, apologizes, pauses, and reissues the answer with a laugh

throughout, "about heh a pack heh a day." Mackenzie does not treat this as an issue but restates

the SP's answer and marks the sequence as adequate with "okay." The SP, however, continues to

work to ease the tension of her error by laughing once more and accounting for the error as a matter of the patient trying to cut down on their smoking (line 183).

Whether MSs respond to instances where SPs correct themselves in what they said demonstrates the frame they are operating in, whether the simulation (like Justine's apology and laughter) or communication skills assessment (like how Mackenzie ignored Clarissa's account for error). Both the SP and the MS work together in framing what is going on.

Beyond Questions and Answers

One of the key findings of Chapter IV is that Scripts do not describe what is said after answers are given, or the third part of a question-answer sequence. In the following section, I show how third pair parts shape interaction. Both of these strategies function to extend the framing of the medical consultation to include aspects about the patient's humanity and a metadiscursive value of patient experience. First, look at how a SP, Alfonso (SP_15), playing a patient named Isaac Wheeler, works to extend the framing of the medical consultation through a metacommunicative move outside the question and answer dynamic with Ayaan (MS_05):

Extract 05.15.02 (Ayaan and Alfonso- Lifestyle)

155	MS_05:	And what do you do?
156	SP_15:	I'm in med school
157	MS_05:	In med school
>158	SP_15:	I'm a third-year student ((smiles))
159	MS_05:	Okay (3.0) awesome

Ayaan asks the SP, "what do you do?" which Alfonso responds, "I'm in med school." Ayaan's third-pair part (line 157) is a partial restatement of what Alfonso just said ("in med school"). Rather than awaiting another question, which would have followed the same question

dynamic that occurred before this, Alfonso metacommunicatively provides additional information, "I'm a third-year student ((smiles))" (line 158). In this move, Alfonso adds the detail of being in his third year along with a smile, which extends the framing of the simulated medical consultation where Ayaan is a physician to call attention to the irony of the simulation involving a third-year MS interviewing a third-year MS. However, Ayaan does not take up this metacommunicative framing. He simply offers a receipt token ("okay"), writes something on his paper and plainly assesses the position ("awesome") (line 159). Ayaan stays in the framing of the consultation although Alfonso is metacommunicatively breaking it.

While Ayaan avoids acknowledging the framing of the consultation as a simulation, Caleb (MS_07) makes it obvious in a way that makes humanistic aspects of the patient, Jamie played by Molly (SP_11), more obvious:

Extract 07.11.04 (Caleb and Molly- Accounting)

145	MS_07:	Okay (.) um so what do you do now (.)
146		you go to school?
147	SP_11:	((Nods))
148	MS_07:	Study? Go to school?
149	SP_11:	Yeah
150	MS_07:	Oh and what are you studying?
151	SP_11:	Accounting
152	MS_07:	Accounting! <u>Alright</u> (.)
>153		you must be good with numbers
154	SP_11:	Yeah ((laughs))

Caleb begins by asking the SP, "what do you do now" (line 145) which he subsequently offers a candidate answer ("you go to school?") (line 146). Molly nods in response to this question (line 147), but Caleb does not treat her nonverbal answer as answering his question, so he reformulates it with two more candidate answers ("study? Go to school?") (line 148). Molly agrees in line 149, "yeah." However, Caleb does not leave it there, he offers a change of state token as if he has received new information ("oh") and asks, "What are you studying?" Molly answers ("accounting") which Caleb repeats and accepts ("accounting alright"). He briefly pauses and offers an assessment, "you must be good with numbers." Molly rewards this pursuit of additional information through her laughter in line 154.

These two excerpts demonstrate that the questioning and answering dynamic allows SPs and MSs to "go meta," or indicate an awareness of the simulation. Like communication skills, metacommunication is distributed and hinges on both parties. One party may or may not play into another's metacommunicative shift. Some MSs seem more inclined to stay in the framing of the consultation for the purpose of exhibiting communication skills while others are more attuned to the aspect of the interaction being a simulation. The irony of MSs staying in the framing of the medical consultation is they do not extend the framing into aspects of the patient's humanity. It seems that SPs prefer the lifeworld framing because they metacommunicatively index the simulation by bringing up details of a patient's humanity or reward MSs when they seek details about a patient beyond the typical diagnostic activity. Regardless of how participants incline themselves to the framing of the consultation, it cannot be removed from the practice of Simulated Consultation.

Physical Exam

The Physical Exam is a distinct section of the Simulated Consultation. Not all Scripts indicate the necessity of a physical exam, particularly Bonnie Shuster (the patient whose son/daughter brought them in for a drinking problem) and Sebastian Mateese (the infant whose mom called in after hours). For Bonnie Shuster, the indication occurs through the clothes she is wearing[7] and for Sebastian Mateese it is the physical distance between the SP and MS as well as lack of actual patient that characterize signify them as different. All other SPs are told to wear a fabric patient gown in an email with the Script, which indicates the physical exam should take place. The Physical Exam highlights the role of objects along with linguistic, paralinguistic, and embodied strategies to manage the Simulated Consultation and the performance of communication skills. Specifically, I look at the role of patient's clothing in requesting a physical exam, the exam table as agent, and the coordination and performance of pain in simulated consultations.

Clothing

MSs typically transition to the physical exam by stating what they will do next or asking the patient a question, like Amanda (MS_03) in line 146 or Justine (MS_04) in line 114:

Extract 03.16.01- (Amanda and Clarissa- Transition to Physical Exam)

>146   MS_03:   Okay I'm gonna take a look at you if thats okay

147   SP_16:   Okay

Extract 04.17.01 (Justine and Elizabeth- Transition to Physical Exam)

>114   MS_04:   Okay is it okay if I start (.) the exam then?

115   SP_17:   Sure

---

[7] The Script for Bonnie Shuster says, bold, in all caps, **STUDENTS WILL NOT PERFORM A PHYSICAL EXAM** and subsequently describes the patient's Appearance as "You are unkempt. Clothing disheveled, and old, dirty."

116   MS_04:   Okay

Although MSs make physical exams out to be requests that SPs could say no to, SPs consistently agree to them. Even Lorena who is playing Bonnie Shuster and is not wearing a patient gown consents to physical exams in all three of her consultations of the day (Figure 5.2). Yet there is a distinct difference in the amount of work that goes into requesting a Physical Exam with Lorena. See how Stephanie (MS_01) goes about transitioning to the physical exam in her consultation with Lorena (SP_01):

Extract 01.01.01 (Stephanie and Lorena- Transition to Physical)

200   MS_01:   Um (3.0) do you mind if I (1.6)

201   press on your belly a little bit

202   and see if I feel anything in your liver?

203   SP_01:   ((nods))

204   ((gets up))

205   MS_01:   Have a seat over here.

Figure 5.3 Preparing for the Physical Exam

In line 200, Stephanie pauses for three seconds before transitioning to the physical exam. She holds her place, pauses for three seconds (a significantly long pause), and begins her question with "do you mind if," implying that the patient might mind if they are doing a physical exam. Stephanie pauses again before describing what she will do "press on your belly a little bit and see if I feel anything in your liver" (line 202). The distinction "a little bit" suggests this is a minor physical exam but what is more notable is the justification she gives for doing the physical exam ("see if I feel anything in your liver"). Perhaps the extra work is due to the fact that all other SPs are wearing exam gowns that signal the need for a physical exam while Lorena is in everyday clothing. Stephanie indicates an awareness of the precarity of this exam, but delicately asks as a way to account for her efforts at practicing the communication skill. That all the MSs who met with Lorena that day request a Physical Exam points to the importance of conducting a "thorough" Simulated Consultation over attending to the details of the person in the room (i.e., what they are wearing).

Exam Table

The exam table that most SPs sit on is a key part of the Physical Exam and how SPs and MSs navigate the exam table demonstrates a knowledge asymmetry at play in the examination. For instance, Clarissa (SP_16) shows Mackenzie (MS_02) how to move the exam table before the Physical Exam begins:

Extract 02.16.02 (Mackenzie and Clarissa- The Table)

126	MS_02:	I'm going to have you lay back
127		so we can get a good abdominal exam on you
128		(.) let me see how this
>129	SP_16:	°You'll want to get back over there°

130		((points))
131	MS_02:	Oh okay thank you
132		There we go
133		((pick up remote))
134	SP_16:	((moves up))
135	MS_02:	Okay, I'll have you lay back here
136		and I'll get this for your legs

Figure 5.4 Pointing to the Exam Table

In line 126, Mackenzie requests that Clarissa lay back so she can conduct the physical exam and even offers that she should "lay back" so "we can get a good abdominal exam on you." Similar to Stephanie in her consultation with Bonnie Shuster, Mackenzie offers a reason for requesting the patient to participate in a physical exam (so that it is "good") and also speaks on

behalf of a "we" to encourage her to do so. Mackenzie then pauses and quietly says, "let me see how this," which functions as an account for the issue she is having with the table. However, in line 129 Clarissa, the SP, intervenes in the process by quietly stating and physically pointing to where the pedal to adjust the table is ("you'll want to get back over there"). Mackenzie signals this is new information ("oh okay") and thanks the SP for the directions ("thank you"). In this exchange, both participants jump out of the framing of the consultation. They metacommunicatively demonstrate the value of certain objects, like the exam table, to the simulated consultation going well. Line 132 moves them back in the consultation framing ("there we go") and Mackenzie returns to directing the patient in what she should do next for the physical exam.

Bodies

MSs and SPs often work together to ensure the Simulated Consultation goes well, something that occurs when all relevant information is communicated. This is perhaps most obvious in how SPs perform pain. It is not simply the MS getting information, but through talk, touch, bodies, and objects, the two-co-produce pain as medically intelligible. This interaction between Will (MS_08) and George (SP_19) exhibits this:

Extract 08.19.01 (Will and George- Back Pain)

99	MS_08:	Alright and so you tell me when i- when i
100		get to the (.) level where the pain is okay
101	SP_19:	kay
102	MS_08:	((moves hand down spine))
103	SP_19:	Its low
104	MS_08:	Its low

105	SP_19:	°yeah° (.) it's down it's down in the-
106		like right in here and in here and here
107	MS_08:	Okay
108		(.)
109	SP_19:	Yeah
110	MS_08:	Okay Yeah so does this hurt right here?
111	SP_19:	uh huh
112	MS_08:	mkay now compared to when i touch on
113		either side of it (.) is that worse?
114	SP_19:	That hurts too
115	MS_08:	That hurts too the same? Worse or or just=
116	SP_19:	=Nah it aches all across there
117	MS_08:	all across there [okay
118	SP_19:	[I just feel (it everywhere)
119	MS_08:	Okay so not a huge difference for pushing
120		here versus here
121	SP_19:	Right
>122	MS_08:	okay and not a huge difference in pain pushing
123		here versus ^here
124	SP_19:	right
>125	MS_08:	Okay and you're feeling pain over here?
126	SP_19:	Yeah its (.) not as bad but-
127	MS_08:	Okay not as bad

| 128 | ((touches SP's back)) (6.0) |
| 129 | Kay |

That this extract is longer than most because it demonstrates the amount of time and work that goes into making a patient's pain medically intelligible. First, Will asks George to tell him "when I- when I get to the (.) level where is pain is, okay?" The SP agrees ("kay") as Will begins to slowly move his fingers from the top of the patient's spine towards the bottom of it (Figure 5.4). In line 103, George tells the MS that "it's low," a sort of cue to move faster towards the bottom of the spine. The MS repeats the phrase ("it's low") but continues moving his fingers at the same pace. George speeds him up once more in lines 105-106 by pointing to exactly where the pain is. Will responds to the cue by moving his hands down there and proceeds to ask about pain in different locations (lines 110, 113, 115). In line 116, as Will is asking whether it is worse, George latches on to state "nah it aches all across there," and makes himself clearer in line 118 "I just feel it everywhere." The amount of direction and information George gives Will during the physical exam tells him of the importance of locating the pain. However, Will wants more nuances of the pain (line 122 and line 125). George picks up on this in line 126 with "yeah (.) it's not as bad but," which Will repeats George's statement ("okay not as bad") and George does not attempt to redirect him.

In this interaction, there is a different value orientation for the co-production of pain. Will's physical movements are often interrupted by George's verbalization of the pain. George continues to redirect Will by telling him where the pain is and even pointing to it. However, Will works to demonstrate his competence in conducting a proper examination of the back, something that he continues into the diagnosis and treatment portion of the consultation.

Figure 5.5 Co-Producing Back Pain

Diagnosis and Treatment

Towards the end of the Simulated Consultation MSs diagnose and create a treatment plan for SPs, as well as closing the simulated consultation. MSs metadiscursively transition to this by physically moving themselves away, often to an angle that the SP can observe the next phase. The process of diagnosis is very different from the rest of the simulated consultation because MSs take longer turns at talk and SPs talk less. During diagnosis, MSs show themselves to be "good listeners," often by repeating the symptoms SPs have communicated. MSs rely on what SPs do and do not say, either in the history taking portion or in the physical exam. For instance, when Ayaan (MS_05) transitions from the physical exam to the diagnostic period, he builds his argument on the concerns Alfonso (SP_15) has communicated:

Extract 05.15.03 (Ayaan and Alfonso- Diagnosis)

261   So I think what I'd like to do is

262   run a couple of tests um (.)

263   And if that's okay with you do-

264   would you mind doing an STD panel

265	SP_15:	That's fine
266	MS_05:	Just in case
267		And you know-
268	OH_00:	You have five minutes remaining
269		in your patient encounter
270	MS_05:	You know at the very least-
271		Its negative
		((Lines 272-293 Omitted))
294	SP_15:	okay
295	MS_05:	do- do you have any other thoughts
296		questions concerns
297	SP_15:	do you think its HIV

Ayaan summarizes Alfonso's chief complaint in the lines immediately prior to this). But what happens in line 261 is a key activity in Simulated Consultations– the need for further testing. Instead of claiming he will perform diagnostic test, he asks the SP "and if that's okay with you- do you mind doing an STD panel" (line 264). Ayaan's request for the particular test indicates a recognition that it is a sensitive issue. Even after the SP consents ("that's fine"), the MS accounts for the sensitive nature of test ("just in case").

At this point, J.T. announces overhead that the students have five minutes remaining (line 268), framing the Simulated Consultation as almost over. Rather than speak over the announcement, Ayaan stops, waits, and resumes speaking with the same utterance he left off with in line 270 ("you know"), which continues the same action– explaining how the symptoms he has described justify a potential diagnosis. Then Ayaan asks if the patient has additional

thoughts, questions, or concerns, all things that would merit the MS's additional talk (line 295), to which Alfonso asks, "do you think its HIV?" This is Alfonso's only question in the consultation, which often occurs at the end of the Diagnosis and Treatment session, receiving little attention from MSs.

Closings

During Closings SPs and MSs display a shared understanding of next actions and continue to co-manage the framing of the simulated consultation. The overhead announcement "five-minutes remaining," often occurs in the Diagnostic and Treatment phase of Simulated Consultation. In some instances, the final announcement, "This marks the end of your patient encounter" also plays, which prompts a quick closing. SPs and MSs often work beyond the time limit to complete the simulated consultation. Here's how it happens with George (SP_19) and Saul (MS_09):

Extract 09.19.01- (Saul and George-Closing)

282	MS_09:	Yeah I think it's also prudent to get an MRI to
283		see if there is a bulging disk
284	SP_19:	Okay so strain is muscle
285		Yeah strain is the muscle pain
>286	OH_00:	This marks the end of your patient encounter
287	SP_19:	Okay I understand right thank you doc
288	MS_09:	Yeah no problem take it easy ok
289	SP_19:	No problem
290	MS_19:	Ok don't do any heavy lifting right
291	SP_19:	With the note I wont

| 292 | | ((MS Exits)) |

Saul explains the testing protocols he would suggest and why in lines 282-283 ("it is prudent" and "to see if there is a bulging disk"). The SP clarifies the source of the strain and the overhead announcement echoes, "this marks the end of your patient encounter." The SP then rushes ends the consultation by stating "Okay I understand right thank you doc" (line 287). The combination of these metadiscursively alerts the MS to the need to end the exam and that was has taken place is sufficient. Saul attempts to end it by combining multiple closing actions, "yeah no problem take it easy ok" (line 288). George echoes the "okay" and Saul inserts one final note, "don't do any heavy lifting right," (line 290) and George affirms he won't because of the note Saul claimed he will provide (line 291). Together, the SP and MS are working to conclude the encounter yet emphasize the importance of next actions for the patient and provider. Even after the consultation they are under obligation to one another and both parties demonstrate an awareness of the goal-oriented nature of the activity– to diagnose and treat the patient.

For instance, in Amanda (MS_03) and Clarissa's (SP_16) closing, the overhead announcement alerts the participants that the consultation is over, which both the MS and SP implicitly address:

Extract 03.16.02 (Amanda and Clarissa- Closing)

277	OH_00:	[Students this marks the end of your patient
278		encounter (.) You have ten minutes to complete
279		your patient write up
>280	SP_16:	[Hehehe thank you
>281	MS_03:	[heheh
282		((shakes hand and smiles))

283	SP_16:	Whats your name again?
284	MS_03:	°Amanda°
285	SP_16:	Amanda? Amanda. Thanks.
286	SP_16:	((Rolls to drape and begins to fold up))
287	MS_03:	((Closes door))

The overhead announcement initiates this Closing, which both Amanda and Clarissa laugh at. The laughter is a framing shift, that what was occurring through this announcement is not part of what was previously happening. Together they shake hands and smile, signaling the simulated consultation as over. But Clarissa asks another question (line 283), "what's your name again?" That Amanda quietly gives her first name shows this is a different framing from the opening of the consultation, when she introduced herself ("Hi my name is Amanda Lowry I'm a third medical student" (line 7-8)). This extra bit of SP-initiated conversation shows an awareness of the simulation framing being regulated by the overhead announcements. What Clarissa does outside of those announcements also suggests an interest in the MS, to know her name, which Amanda gives on a more formal register.

The Implications of Communication Skills in Simulated Consultations

In this chapter, I describe how SPs, MSs, and the CSLC constitute communication skills in Simulated Consultations. The linguistic, paralinguistic, embodied, and material resources (i.e., objects, spaces, and props) are metadiscursive tools that strategically comment on the notion of communication skills. Through these multi-modal resources, communication skills are co-constituted, not a trait that only MSs or SPs enact as Scripts and Computerized Assessment Forms suggest. Communication skills are a dynamic of practice, which extend meanings of communication skills beyond the framing of the Simulated Consultation. The

metacommunicative paradox of communication skills as isolated instances or innate traits stands in tension with the dynamic of a situated practice that extends communication from a skill to something we live in and through.

SPs, MSs, and the CSLC use a range of strategies to constitute communication skills as a situated practice. First, the simulated clinic room creates a physical division between "in consultation" and "out of consultation." This division between "real life" and "simulation" is further supported by the overhead announcement that echoes before, during, and after each simulated consultation, bracketing it from everyday experience. SPs wait in what appear to be temporary clinic rooms (with disposable exam table coverings and drapes, indicating their own temporality) for MSs. The announcement before the MS enters cues the SP to prepare themselves for the Simulated Consultation to begin. Furthermore, the Door Note sets an agenda for the fifteen minutes they'll spend together: diagnosing and treating the patient. Though the MS is held accountable to this goal through the Computerized Assessment Form and there is no acknowledgment of the role the SP could play in preventing this from happening. Indeed, SPs work to support MSs in achieving their goals. For instance, when Clarissa shows Amanda how to use move the exam table, she is supporting the idea of what the student needs to do. When George allows Saul an additional attempt at the physical exam, he is supporting him in achieving the goal of diagnosing and treating his back pain using the standards Saul metacommunicatively suggests he wants to use (by conducting an additional physical exam). Communication skills are a collaborative dynamic that extends the notion of communication beyond what MSs do or do not ask.

Communication skills are not a static concept, but a dynamic of practice. As MSs and SPs interact, they index authority and accountability. For instance, the ways MSs introduce the

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patient or themselves points to how much they know about that patient, their medical knowledge and authority, and their relationship to the practice of medicine. MSs account for what they are doing, like when they go back to perform a part of a physical exam and account for it after they have transitioned to another portion of the consultation. Furthermore, what SPs say and do changes what MSs are able to do. When SPs offer more or less information in response to a question, it changes the actions that can occur next, like the differences in George's responses to Saul and Justine. Depending on what the MS and SP do together not only impacts the type of communication skills tasks they are able to perform together, but they also metacommunicate about the general understanding of the consultation. Participants are not limited to the seemingly concrete instance of the simulated consultation, but they move in and out of it with their words, tone of voice, bodies, and objects.

Metacommunication is ever present. Whether interaction is simply accomplishing a social action or commenting more broadly on the practice or relationship is a paradox at play in Simulated Consultations. Communication skills are both an iterative performance in an isolated instance (doing them presently), yet in a simulation there is always the potential of moving out of the simulation framing to comment on the nature of communication skills themselves or participants relationships to one another. However, what are the implications of this ability to "go meta" at any moment?

On one hand, the ability for MSs or SPs to comment on communication skills in the midst of the simulated consultation makes alternative perspective of "good" or "bad" communication visible. SPs hold different values of communication from the CSLC (I know that I did) and they are able to demonstrate those to students in simulated consultations. For instance, there is a SP named Elizabeth, an elderly woman who brings her own cloth drape on the days she

works as a SP. The extra work she goes to bring her own drape and the higher quality of drape point to the fact that she values draping and modesty during a physical exam. These performances allow MSs (or fellow SPs) to consider the strengths or weaknesses of other's positions about communication practices. Furthermore, metadiscourse provides a way for MSs to be more considerate of how actual patients may use the same strategies in consultations to make their views and values relevant. Metadiscourse makes communication a matter to be negotiated.

On the other hand, if communication is something to be negotiated, it challenges CSLC's authoritative account of what constitutes skilled communication. SPs could (and likely do) promote communication practices that contradict institutional standards, creating a sort of double bind for MSs– do the SP wants or do what CSLC wants. Extending this to actual practice– do I perform what I have been taught or what this patient is suggesting?

Metacommunication offers a way to consider the affordances and constraints of simulation beyond whether SPs "authentically" communicate (again, the dominant critique from conversation analysts). Simulated consultations are messy and complex. Participants are playing multiple games at the same time and as Atkins (2019) suggests, students who do well in simulated consultations are demonstrating nuanced skillset that is not the same as interacting with patients. It is by leaning into this complexity and observing what is actually happening in SP practices that we can consider new ways of teaching communication skills, a topic I engage in the conclusion of this project. Before considering what is next for simulation-based communication skills training, I examine the Computerized Assessment Form and the conceptualization(s) of communication it facilitates.

CHAPTER SIX:

COMMUNICATION SKILLS IN THE ASSESSMENT FORM

The following vignette is from a performance I wrote and staged in the Summer of 2018 called, "What it's like to be a Standardized Patient." I performed it for an interdisciplinary audience of physicians, medical educators, and communication scholars at the Narrative Medicine Division of the Association for Communication and Healthcare Conference. In it, I draw on my own experiences of working as a simulated (also called standardized) patient to call attention to the challenges of communication skills training, particularly the tension of standardization and embodiment. Simulated patients are persons in bodies whose work requires them to take on the position of another's body. The work prioritizes the Script, which serves as a basis to perform the patient and complete the form, which is often devoid of what they themselves are experiencing.

I spend a lot of time waiting in fake clinics. Waiting for "doctors." Waiting for answers. Waiting for relief. A voice over an intercom says, "You may knock and enter." I turn over on crinkled paper. They ask me how I'm feeling. They ask me where it hurts. How does it hurt. I read a script that told me:

> *The patient is a 17-year-old female who complains that she began*
>
> *to get "stomach" pain yesterday evening but it was not too bad.*
>
> *She thought he might have eaten a b ad chicken sandwich*
>
> *yesterday for lunch that he got at Wendy's. It tasted funny. Then*

about 4 hours later, just before supper he started to get some

"stomach" pain. She ate very little dinner, and had no appetite.

Then this morning the pain was much worse and hurt to even walk.

So my mom dropped me off here at the clinic to get seen. I felt to

sick to go to school.

The script tells me it hurts 7/10. The script tells me it hurt 3/10 yesterday. But me, actually me, can't remember where it hurts because I have a cold. I do my best to share what I recall. And in between students I refresh my memory and look at the script again.

1.   McBurney's Point: Tenderness to direct palpation in the

right lower quadrant, with rebound tenderness in that area.

2.   Psoas sign: If the student does an iliopsoas test (having the

patient lift up the right leg and then hold it up against resistance or

extending the right leg backwards with patient on there left side)

there is mild tenderness,

3.   Obutror sign: If they do a obturator sign (internal rotation

of the right hip) this does not cause any increase in pain.

4.   Rovsing's sign: There is tenderness over the right lower

quadrant when the student lets go of the pressure on the left.

Now I know. I think. Then after three rounds of abdominal exams and not enough time to leave the room between students. I have to pee. 10/10. Also, I have to blow my nose. Also, I have to answer this questionnaire before the next student comes. I wipe my nose and look up at

the camera overhead, knowing someone's watching me cross-leggedly answer questions with a

tissue up my nose. I answer questions like:

Student presented acceptable appearance.

Student introduced him/herself to me.

I click through 56 questions until I arrive at the last question:

What is your overall impression of the student's performance?

1-   Not able to assess this student's performance

2-   Reasonable impression, could be better

3-   Good impression, on level with peers

4-   Great impression above peers

5-   Outstanding impression

I question choosing one, unable to assess. But I choose a 3, throw off my patient gown

and on a different dress, disregarding the camera to run to the bathroom in the three minutes I

have remaining before the next student comes knocking. Before I go answering.

In this chapter, I examine how communication skills are constituted by the Computerized

Assessment Form that is completed by each SP after the Communication Skills Practice Exam

(CSPX)[8]. The form has two parts– 39 multiple-choice items and 2 open-ended answers– which I

examine as separate takes on communication skills (See Appendix D for the Form). Through the

multiple-choice items of the form, the Communication Skills Learning Center (CSLC)

institutionalizes communication as a medical skill that MSs are held accountable to, yet by

listing, describing, and quantifying communication tasks, the organization claims what MSs *and*

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[8] Portions of this chapter have been previously published in *Qualitative Research in Medicine & Healthcare,* 2019, Vol. 3 Issue 2, and have been reproduced with expressed permission from the Editor-in-Chief.

SPs ought to do in Simulated Consultations. The open-ended items offer SPs an opportunity to evaluate communication skills on the record, which illuminates the complexity of their role. I answer the following research questions:

3.0.   How are communication skills conceptualized in the Assessment Form?

    3.1.   What strategies does the Communication Skills Learning Center use to conceptualize communication skills in Multiple-Choice and Open-Ended items?

    3.2.   What strategies do simulated patients use to complete Open-Ended items?

    3.3.   What are the implications of communication skills in the Assessment Form?

Analyzing the Communication Skills Assessment Form

The computerized assessment form issued for the CSPX, is made up of 39 items– 37 multiple-choice and 2 open-ended. The form is organized into eight sections: *(1) Building the Doctor/ Patient Relationship,(2) Reflective Listening, (3) Connecting with the patient, (4) Communications Reflection, (5) History, (6) Physical, (7) Closure and Conclusion to encounter, and (8) Follow up and Wrap up.* The sections suggest a temporal order of practice, from the beginning to the end of a consultation. The orderliness is evident in time-based verbs like *Building, Connecting, Closure, and Wrap up.*

Ordering Communication Skills

The order presented in the form is comparable to actual primary care consultations– Opening, Presenting Complaint, Examination, Diagnosis, Treatment, and Closing (Heritage & Maynard, 2006). The order also shares terms with popular communication skills models, like the Calgary-Cambridge Model or the Kalamazoo Essential Elements Communication-Checklist Adapted (KEECC-A), which are commonly used to develop SP practices. The KEECC-A (2010) even begins even with "builds relationship," and ends with "provides closure." That the

assessment form uses the language and order of practice observable in actual consultation analyses and communication skills models (like those presented in Chapter II) points to the metadiscourse of communication skills, meaning that the language of the form resonates with the genre of communication skills discourse in medical education and validates its local use.

Each section of the form designates particular communication skill sets. *Building the Doctor/ Patient Relationship*, requires SPs to evaluate how the MS enters the room, introduces themselves (by name and role), and learns and uses the patient's name and reason for being at the clinic. However, item 6– *The student maintained good eye contact and body language with me*– is not bound by when it occurs in the simulated consultation. Although *good eye contact and body language* can occur anywhere in the consultation, the presence of this item in this section suggests eye contact and body language are relationship building activities.

Accountability for Communication Skills

The form not only identifies certain communication tasks as relevant skills but specifies who should complete them. At first look, it seems only MSs are held accountable to communication skills tasks per the form, but the form also implies what SPs should do. This dual specification means the form directs SP actions and creates a record of what MSs have completed.

Thirty-five of the items (92%) follow a similar grammatical structure: beginning with the subject, *The student* and fitted with a verb or series of past-tense verbs (i.e. *The student introduced…The student discussed…. The student asked…The student maintained*). The only exceptions are item 32, which is formulated as, *Did the student....* and the two open-ended items, which state *elaborate your reflections on the student* and *state and additional concerns you would like to share with the student*. That most items begin with *The student* implies success is

built on a skilled performance of *student* action. Notably, a student is not a practitioner, but one who is learning and has the capacity to improve based on the parameters issued in the text. The structure of each item suggests that the capacity for successful communication originates from the student.

However, SP actions are implied in item descriptions, yet they are not held accountable in the same way as MSs. I present a taxonomy of task types based on how agents, including MSs, SPs, and objects, are implicated in task completion (See Appendix F): (1) Medical Student Object-Based Tasks, (2) Medical Student Assertion-Based Tasks, (3) Medical Student Question-Based Tasks, (4) Medical Student and Simulated Patient Body-Based Tasks, (5) Medical Student and Simulated Patient Assertion-Based Tasks, (6) Medical Student and Simulated Patient Question-Based Tasks, and (7) Simulated Patient-Based Tasks. I describe the distinctions between these tasks below, which create a gradient of accountability for the simulated patient.

(1) Medical Student Object-Based Tasks

The first type of task involves the MS and objects: knocking on doors, sanitizing hands, and using a drape. Although the MS does not need the SP to accomplish these tasks, their presence is what makes the task significant. For instance, knocking on a door is given meaning through the context of an exam room and further significance through a patient inside, one who perhaps responds to the knock.

(2) Medical Student Assertion-Based Tasks

Secondly, MSs should initiate utterances that: introduce themselves by name, identify their role, and inquire or explain the purpose of the visit. According to the form, it is the responsibility of the MS to accomplish these actions, they should not require a SP to prompt the statements.

(3) Medical Student Question-Based Tasks

Third, MSs should systematically ask questions about: a chief complaint, a history of smoking, a history of drinking, a history of drugs, what medications the patient takes, if the patient has any allergies, permission to start the physical exam, and if the patient has additional questions or concerns. Again, per the form, these matters should be initiated by the MS.

(4) Medical Student and Simulated Patient Body-Based Tasks.

While 15 of the tasks should be initiated by the MSs without prompting from a SP, 22 of the 39 tasks significantly rely on SP cooperation. For instance, the fourth type of activity identifies the SPs body as a resource for task completion: maintaining good eye contact and body language, refraining from repeating painful maneuvers, listening to the heart, listening to the lungs, examining the abdomen, examining extremities and performing reflexes.

(5) Medical Student and Simulated Patient Assertion-Based Tasks.

The fifth and most common type of activity requires MSs to speak with an understanding of what the simulated patient has stated: correctly using the patient's name, summarizing concerns, working with the patient to identify main concerns, acknowledging and demonstrating an understanding of feelings, taking personal responsibility where appropriate, valuing choices, behaviors, and decisions, validating and showing understanding for feelings and choices, offering support, requesting additional exams, discussing diagnostic options, providing a differential diagnosis, discussing their initial management plans, mentioning specific tests they'd like to do, and answering final questions or concerns.

(6) Medical Student and Simulated Patient Question-Based Tasks.

In discerning between assertions and questions for activities that suggest only MS involvement, I notice two question-based tasks that explicitly involve both MS and SP: asking open ended questions and actively listening to responses, asking patients to list their concerns and listening to their concerns without interrupting them.

(7) Simulated Patient Based Tasks.

The final type of activity the form designates occurs post factum. The form requests that SPs elaborate on reflections of the student (from a patient's perspective) and state any additional comments about the encounter. Though these are the only two items that explicitly request the SPs perspective, the variation between these two items highlights the complexity of the SP role: one who embodies the imagined patient, offers commentary on the simulated interaction, and accounts for how the assessment form is completed.

Based on the taxonomy of task types, the form explicitly directs SP action in approximately half (20 items; 56%) of the designated tasks, either through referencing bodies, assertions they should make, or questions they should respond to. But arguably, SPs are implicated in every one of the items. Even Medical Student and Object-Based Tasks, like *The student knocked on the door before entering*, are significant through the potential presence of a SP on the other side since just knocking on a door can have mean a number of things. For Medical Student Assertion-Based Tasks, a SP should be there to receive an introduction or to offer a chief complaint; and for Medical Student Question-Based Tasks SPs are required to account for whether the question was asked and are indirectly told to answer it. Therefore, while the assessment form appears to direct and regulate MS actions in simulated consultations, it also directs SPs to act as particularly skilled patients. By completing the form, simulated patients act as institutional accountants who create a record of student actions.

Directing Communication Skills Tasks

The Computerized Assessment Form orders the communication skills tasks that ought to occur, assigns who should complete them, and holds participants accountable to either performing the actions or creating a record of those actions. The Form also designates how communication skills should take place, primarily through the following three strategies (Table in Appendix D): extended questions forms, parenthetical sample statements, and qualified answers.

Extended Questions

The first strategy for regulating communication skills competency is through extended questions, or sentences that qualify a communication skills task through further description, either in the sentence or parenthetically. For example, item 27 uses the extended question strategy to direct and regulate the role of the SP in the simulated interaction, which provides implications for MS and their future patients. The item, *The student did not repeat painful maneuvers on you when you said it was painful?,* suggests SPs are responsible for making pain obvious to the MS during the physical exam and therefore, trains MSs to anticipate particular performances of pain. Item 9, *The student summarized my concerns, often using my own words,* qualifies how a summary should occur by often using *my [the SP's] own words*. This item also directs SPs to express concerns (and by proxy assumes future patients will express concerns in a summarizable fashion). The qualifier *in my own words* suggests skilled students "join in" or align speech styles with the patient.

In analyzing conversation dynamics, Stivers (2005) explains how repeating another speaker's utterances in the same or slightly different terms is a "modified repeat," which "work[s] to undermine the first speaker's default ownership and rights over the claim and instead

assert the primacy of the second speaker's rights to make the statement" (p. 131). Similarly, the form trains future physicians to use a reclaiming of hypothetical speech, which strategically removes the patient from their own talk (and concerns), reclaiming them as part of the domain of medical practice.

While several extended question forms use compound sentences to further qualify communicative actions, others add conditions through the use of parentheses. Item 2 requires a MS to introduce themselves by their (*first and last name)*, not simply by their first name or by the role they are playing in the simulated interaction. The most common extended question form that incorporates a parenthetical qualifier occurs for items in the physical exam section of the assessment form through the statement, *(if applicable),* which places analytic responsibility on the SP in determining whether a task is applicable to the case they are portraying. However, what constitutes *applicable* is not obvious in the assessment form and requires the SP to draw on the script or other knowledge, which may or may not be professionally based. In sum, extended provides SPs guidelines for their actions and qualifications for completing the computerized assessment form.

Parenthetical Sample Statements

Rather than provide the SP transparency on the conditions of a task or how to complete the assessment form, parenthetical sample statements offer examples of MS talk that demonstrate task completion. For instance, item 7, *The student asked an open-ended question and actively listened to the response without interrupting me*, parenthetically provides sample statements as a resource for the SP's assessment: *(i.e., "Can you tell me about… I understand that you are saying… or what happens when…I see, so in other words")*. This detail focuses SP attention

towards canned statements, which is a common feature of communication skills models, literature, and exam requirements.

Furthermore, the use of parenthetical sample statements to explain communication skills tasks are only used for abstract or psychological concepts like active listening, partnership, empathy, apologizing, and legitimization, which requiring the SP to report on whether the MS provided the sample statement and assumes its utterance effective. However, SPs and future patients can and often do interpret such statements as insincere or uncaring (Atkins, 2019; Atkins & Roberts, 2018; Atkins, Roberts, Hawthorne & Greenhalagh, 2016). In doing so, the form constructs sample statements as coins MSs can deposit into the conversational black box to achieve particular outcomes, creating an unquestioned "if this then that" communication equation and ignoring interactional findings on simulated medical consultations that suggest such statements can backfire.

In item 7, the parenthetical sample statements are not attached to either *open-ended asking* or *actively listening*, which suggests the SP can accept the statements accomplish both tasks, regardless of whether they experienced feeling "actively listened to." This acceptance is bound by the *Not Done/ Done* answer structure, which constitutes open-ended asking and active listening as two parts of the same activity. The further irony of this item is that the MS must talk for the SP to assess listening, leading to another transactional notion: if students ask like this, patients will answer, active listening will occur, and in the end MSs will be skilled communicators. Per the form, if the student uttered a statement like the ones listed, the SP can mark, *Done*. However, if the utterance does not mirror the sample statements offered or if the actions are not done together, the only other option is *Not Done*.

This item also relies on black box assumptions of communication and overshadows the observability of talk. For instance, when patients provide extended accounts of their illnesses or experiences, physicians often perform "continuers," which are verbalized tokens of acknowledgment like "mhm," "yeah," and "right" (Gill & Maynard, 2006). Such continuers are a form of backchannelling that indicate a patient should continue with what they are saying, because the physician is listening. Instead of favoring observable features of communication, the Form encourages more ambiguous psychological notions.

Qualified Answer Forms

The final strategy for regulating communication skills competency through the assessment form is a qualified answer form. Nearly 70% of all items (27 of 39) have two possible answers: Not Done or Done (See Appendix F). Placing *Done* as the second option insists the importance of student action, taking SP cooperation for granted in both the form and simulated consultations. The other 10 items similarly gloss SP cooperation, but further implicate SPs by requiring them to judge MS performances based on the qualifications described in answer options. These items have three or four options grounded in expectation– with *Not Done (or not applicable to the case), Below Expectations, Meets Expectations*, and *Above Expectations* as candidate responses. Answer items synthesize (simulated) patient experience as universalized expectation and present various degrees of competency. However, the differences between answer options are ambiguous and the numerical assignments disordered.

First, whose expectations does the form account for? The patient portrayed, whose expectations may be written into the script and imagined by the SP? The SP's, whose expectations are based on their training and experience? Or the student's expectations, based on what they're taught? Attending to the pronouns used in the form offer a path for discerning

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whose expectations the form refers to. The pronouns *me*, *you*, and *our*, as well as the noun *patient* are used throughout the document offering contradictory navigational turn-points for form completion. Item 8, *The student asked me to list my concerns and listened to the response without interrupting me*, is the first item requiring SPs to elaborate on degrees of communication competency through qualified answers. Notably, it contains four degrees of accomplishment:

> (*1) Not done;*
>
> (2) Below Expectations: Infrequently: The student kept interrupting me while I was trying to answer and/or the student kept asking me questions without waiting for a response;
>
> (3) Meets expectations: Mostly: In general, the student asked me my concerns and listened to my response without interruptions;
>
> (4) Above Expectations: Consistently: The student always asked me to respond do a prompt and waited for my response before moving on.

In this answer, *The student* and *Me* are the two agents described. The student asks for a list of concerns and does not interrupt the SP as they offer a response. But what if an actual patient has no concerns? A single concern? This item indicates an institutional preference for the SP to offer a list of concerns and assumes future patients can and will do the same. This ambiguity highlights a key concern for the use of SPs in medical education: standardization does not account for the abilities *actual* patients may have in communicating with physicians. The possibility of a patient not having a concern, misunderstanding a physician's question for concerns, or offering an extended account with multiple concerns are unassured. In other words, students are trained by proficient patients whose matters of "expectation" are not based on the patient's expectation but are dependent on the SP's ability to fulfil their institutional role, which is constituted in professional knowledge.

The lack of connection between answer items and patient experience becomes

exceedingly complex for items that claim to measure psychological constructs. For example,

item 11 states:

Empathy: The student acknowledged and demonstrated understanding of your feelings

(i.e.: that sounds hard,...or, you look upset...) with the answer options:

(1) Not done;

(2) Below Expectations: The student did not acknowledge my feelings very often

Infrequently, less than two times;

(3) Meets Expectations: The student consistently acknowledged my feelings and

verbalized this in empathy statements.

The pronouns *your* and *my* are once again used interchangeably. To acknowledge *your*

feelings suggests the MS acknowledges the feelings of the portrayed patient. However, the

answer items use the pronoun *my* when referring to feelings, suggesting the SP should use their

own feelings to assess student communication competence. However, this pronominal switch

does not distinguish the SPs feelings from those of the portrayed patient. Additionally, the

parenthetical statements described (that sounds hard…or, you look upset) suggest the utterances

will appeal to both parties. This ambiguity ignores the possibility that persons may experience

empathy differently.

Furthermore, item 11 implies that statements of empathy are qualitatively and

quantitatively different. The answer options distinguish whether someone meets expectations

based on the frequency of a MS offering such statements (less than two times and consistently).

The items assume that such statements of empathy work universally. The psychological notion is

made visible by how often MSs make such statements. However, MSs, are knowingly in a

simulated interaction. Engaging empathetically with a fake patient requires "more interactional work to inoculate them against sounding formulaic or insincere" (Atkins & Roberts, 2018, p. 26-27). Doing empathy as a communication skill decontextualizes empathy from the everyday experience of SPs and MSs and uses them to create seemingly observable and quantifiably different standards (canned sample statements) that do not translate to actual medical practice. That the quantified answer items of the Computerized Evaluation Form are unequal and inconsistent in their design further demonstrating their limitations in accounting for communication skills and emphasizing their function as directives for MSs and SPs.

Unqualified Items

While the strategies of extended questions, parenthetical sample statements, and qualified answers directs both MS and SP actions in simulated interactions as well as metadiscursively regulates communication skills competency, 14 out of 39 questions (36%) do so without providing additional descriptions. Most of these items are also associated with Done/Not Done answer types (70%). Nonetheless, many of the items are based in professional knowledge using terms like *chief complaint, history, diagnostic impressions*, and *management plans* in the question stems. Such terms only begin to illustrate how professional knowledge is embedded in the discourse of communication skills.

Metacommunicatively, the Communication Skills Assessment Form continually emphasizes the importance of professional knowledge (Sarangi, 2010) in SP practices, regardless of the question and answer strategies invoked. A shining example is item 10, which asks SPs to assess whether *The student asked me questions in a systematic and efficient method, asking questions that were logical to follow*. The item implies ideal student questioning is systematic, efficient, and logical to follow, and infers a SP knows what is unsystematic, inefficient, and

illogical. A response to this item is based in SP's professional knowledge of history-taking. The candidate assessments create a three-point differentiation based on expectations: (a) *scattered and organized (and perhaps "smooth flow),* (b) *inefficient, fairly efficient, or efficient* and (c) *inaccurate, mostly accurate, or consistently accurate.* The differentiation of the answers means students should master the order, efficiency, and logic of questions, and in order for the SP to be an effective institutional accountant, they must be able to distinguish degrees of ability, based on available resources of the form.

By completing the form, SPs (1) create a record of designated student actions performed, which authorizes those actions as facets of communication skills, and (2) assess along the continuum of communication skills offered in the form, and (3) proclaim the professional knowledge of communication skills under the guise of a patient perspective. In this, the assessment form not only regulates what the skilled MSs should do but imposes institutional expectations of SPs, MSs, and by association patient skills and perspectives.

Assessing Communication Skills Competency

At the end of the day, a goal of the Computerized Assessment Form is to evaluate MS's communication skills. Evaluating communication skills assumes (1) communication can be isolated into distinct generalizable variables; (2) communication variables can be accurately measured; and (3) SPs complete the measure reliably. As shown above, most items assess multiple behaviors (variables are not measured distinctly) and the answer options provided offer very little differentiation (especially for items with three or four answer options). In the following, I demonstrate how SPs do not complete the Form in a reliable manner, which means the Computerized Assessment Form is an invalid measure that describes what MSs ought to do

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rather than captures what they actually do in simulated consultations. The form is more a set of

directives that is measuring an illusion of competence rather than a valid assessment device.

Table 6.1: Distribution of Average Scores Given by Simulated Patients

Type of Grader	SP Name	Average Scores
Easy Grader	Andy	47.5
	Lorena	46.75
	George	46.4
Average Grader	Judy	45.75
	Frank	45
	Molly	44.8
	Linda	44.5
	Jerry	44.5
	Jennifer	44
	Melissa	43.25
	Rick	43
	Bob	42.5
	Jonathan	41.8
	Elizabeth	41.6
	Kat	41
	Eric	40.5
Hard Grader	Naomi	39.6
	Alfonso	39.5
	Becky	39.2
	Juan	37.4
	Fiona	33.8

SPs complete the multiple-choice items on the form differently from one another. The

multiple-choice items on the Form add up to a total of 54 points. In order to receive all 54 points,

a SP would mark *Done/ Not Applicable* and *Above Expectations,* on all items. That *Not*

Applicable is combined with *Done* allows MSs who do not perform unnecessary tasks to still be

considered successful. Based on the 97 simulated consultations the dataset, no student receives a

perfect score of 54 and only one student receives a score of 0 (the SP, George, most likely ran

out of time to complete the form or there was a computer error because all items were left blank).

The highest score of the day is 53 points, which was given by George to Justine. The lowest

score of the day–29 points– was given by Fiona to Saul. The average score of the day is 42.4

points, which means the high and low scores of the day are far outside the range of normal. Fiona

and George score differently than many of their other colleagues. Fiona's average score she gives is 29 points, and despite George's lack of completing a form, the average score he gives is 46.4 (Table 6.1).

Table 6.2: Distribution of Average Scores per Medical Student

Medical Student	Average Score
Saul Hateem	39.45
Will Pineda	41.1
Caleb Guzman	41.2
Barrett Harris	42
Mackenzie Jones	42.4
Ayaan Benyamina	42.5
Justine Downs	42.6
Amanda Lowry	43.1
Stephanie Hammond	44.6

SPs tend to score in a more consistent manner than students receive. Saul was the lowest scoring student of the day, receiving 39.45 points and Stephanie was the highest scoring student with 44.6 points (Table 6.2). These two students have about a 5-point difference, which is far less than the approximately 17-point difference of the average SP score. Essentially, the difference in Saul and Stephanie's performance are more likely the result of the SPs they met with that day rather than their actual skill level.

The CSLC addressed the inconsistency of how SPs complete the form through a two-hour workshop held in the Spring of 2018 before the CSPX began. However, based on this dataset, it does not seem their intervention worked. I do not know if students are aware of the unreliability of the Form, but it jeopardizes the CSLC's claim over communication skills and leaves room for the work of SPs to be dismissed entirely. Whether students are even interested in the quantitative scores is also unclear from my time at the CSLC. Rather than measure student's communication skills, the Form constitutes the notion of skill by providing an elaborate and seemingly objective account of what students ought to do.

Open-Ended Items

Open-Ended Items are the only opportunity a SP has to comment on a MS's performance using their own words. During my time at the CSLC, I sat in on a Written Feedback course, in which Rebekah, one of the SP coordinators, encouraged SPs to use the formulation, "As a patient, when you did this, I felt that." Yet SPs have their own strategies for completing the Open-Ended Items on the Computerized Assessment Form. To analyze Open-Ended responses, I use corpus-based approaches to get a big picture of the data and perform a close analysis to see the particular strategies the form requests and SPs use. First, I unpack how the form solicits open-ended responses and then demonstrate how SPs: (1) frame their evaluations using the first person pronoun, "I," or the designation "as a patient," often combined with an *emotion* term; (2) typically speak *about* MSs although some SPs speak directly *to* them; (3) evaluate the exam or the student in a general sense and also mention topics like the physical exam, which they evaluate on an emotional basis; (4) use varying structures for completing open-ended items; (5) and do not answer the two items differently.

Requesting Responses

First, Open-Ended Response solicitations are designed to request a SP's perspectives on a simulated consultation. These are the two different prompts for the two Open-Ended items on the assessment form:

> *17. Communications Reflection: Please elaborate your reflections on the student here, discuss what you would have preferred from the patient's point of view;*
>
> *39. General Comments: Please state any additional comments you would like to share with the student regarding their encounter with you.*

The second person pronoun, *you*, speaks on behalf of CSLC to the SP. The use of *please* appears to be a polite request but is more so an impositive speech act that is designed to get the reader to follow the action requested for the benefit of the speaker (Lee, 1976). The asker is aware of the potential imposition of asking for the following activities:(1) *elaborate reflections on the student,* (2) *discuss what you would have preferred from a patient's point of view, and* (3) *state any additional comments you would like to share with the student.* That SPs are asked to elaborate their reflections suggests the form has already captured the basis of their reflections, which may require further explanation. Reflection is a cognitive activity bound up in an institutional framework of communication skills as described by the form. MSs are the objects of these reflections and this first task suggests that reflections are something that can be accounted for by the person reflecting, the SP. In soliciting an elaborated reflection of the student, the Form requests an evaluative account of what the student should have done, from a patient's point of view.

The request to discuss *what you would have preferred from a patient's point of view,* provides a stipulation that the evaluation should come from a patient. The stipulation suggests the SP is not a patient, however, they can play the role as it is needed for the communication reflection. The Form assumes the SP has epistemic access to a patient's perspective and suggests the patient has a perspective that is valid to medical practice. The *patient's point of view* is offered as a resource for evaluation.

Item 39 asks the SP to *please state any additional comments,* which appears to create a distinction between the patient's point of view and the perspective of a SP. The other facet of this item is that the SP is asked to speak to the MS. Therefore, the item suggests SPs have something to offer MSs and that MSs will be interested in these. The distinctions in these open-ended items,

requesting an account *on* the student and an account shared *with* the student about the encounter suggests two different activities.

In essence, the form requests SPs to take an evaluative and potentially critical stance towards a specific MS through two different frameworks: (1) reflections from a patient's perspective about the MS and (2) comments from a SP that will be shared with a student. The frameworks are a resource for SPs to offer evaluations. Yet, performing an evaluation is complex interactional work. In face-to-face interactions, speakers hedge evaluations through "I think," or "I feel," which carry less epistemic weight than claims of "I know" or even "You are" (Latour & Woolgar, 1976; Pomerantz & Heritage, 2012). Evaluations also vary greatly depending on the context of the evaluation and the relationship between writer/reader (Vásquez, 2014). Moreover, evaluations organize meanings of "good" and "bad" or "skilled" and "unskilled" communication. Whether SPs align with CSLC's framework of evaluation, both in how they write evaluations and what they focus on, is key to the overall practice of communication skills practices.

Examining Responses

To analyze SP's open-ended responses, I compiled three documents: responses to item 17, responses to item 39, and responses to items 17 and 39. Together, this forms a small specialized corpus of 6,609 words (See Chapter IV), which provides a snapshot of the written genre of communication skills evaluations. Item 17 (3,465 words) has a 94% response rate (91/97 responses) and the average response length is 38 words, with the shortest response being 3 words and the longest 151 words. There are comments missing from six sessions across three SPs. Five comments (all from Elizabeth who says, *See comments below*) refer the reader to their other comment. Item 39 (3,153 words) has a 97% response rate (94/97 responses) and each response is an average of 34 words long, with the shortest response being 1 word and the longest

105 words. There are also five comments that refer the reader to the other comment (two from

Naomi, *Please see above*, Andy*, See above*, and two Jennifer, *Please see above*). While more

SPs respond to item 39, the responses to item 17 are slightly longer. There is no correlation

between the average grade a SP gives and the length of their response(s) (harder grades do not

give longer responses, etc.). I organize my analysis around the following questions: (1) How do

SPs position themselves within responses? (2) Who do SPs address in their responses? (3) What

do SPs discuss? (4) How do SPs complete open-ended responses? and (5) Do SPs answer items

17 and 39 differently?

How Simulated Patients Position Themselves

First, SPs typically own their responses through the pronoun *I,* (the most common term

in the corpus) or the phrase, *as a patient* (the fourth most common n-gram) (See Tables 6.3 and

6.4). SPs typically pair *I* with past tense verbs (felt, was, would etc.). Through phrases like *I felt,*

SPs offer access to patient experience as it relates to a particular emotion.

Table 6.3: The 20 Most Frequent Words in Open-Ended Items

Rank	Word	Frequency	Item 17	Item 39
1	I	310	180	130
2	The	308	153	151
3	To	176	81	95
4	Was	174	81	93
5	And	173	75	97
6	A	164	91	72
7	That	140	74	65
8	Student	120	72	46
9	Me	119	61	58
10	My	110	50	60
11	Felt	109	77	32
12	She	109	46	73
13	He	107	59	48
14	As	74	50	24
15	Of	71	29	42
16	With	65	37	28
17	Did	63	28	35
18	Good	62	34	28
19	When	60	38	22
20	In	59	29	30

Table 6.4: The 10 Most Frequent N-grams for Open-Ended Items

Rank	n-gram	Frequency	Item 17	Item 39
1	I felt	97	65	32
2	The student	85	53	32
3	I was	40	25	15
4	As a patient (pt)	36	27	9
5	Did not	27	9	18
6	The encounter	25	15	10
7	I would have	24	20	4
8	Felt that	22	14	8
9	Of the	22	13	9
10	That I	22	10	12

Clarissa's response to item 17 positions her as the knower and experiencer of a patient's emotion:

Extract 17.15 Clarissa and Madison

As a patient I felt that the student was kind and respectful in questioning and exam. She helped me to sit up and put gown back on which made me feel vey comfotable with her care[9].

Clarissa combines *As a patient,* with the phrase, *I felt.* She is situating the "I," not as her own, but as the patient, in effect splitting the two in a way that allows her to differentiate and claim being a patient. This positioning is attached to the evaluation of Madison– that she was *kind and respectful in questioning and exam.* Clarissa promotes two values, kindness, and respect, as well as differentiates two activities of the consultation *questioning* and *exam.* Clarissa then goes on to account for what Madison did (*helped me to sit up and put gown back on*), which once again created a feeling (*very comfortable*). Clarissa argues that when MSs do something, it creates an emotional reaction for patients, for whose behalf she can speak on. Furthermore, Clarissa has access to this emotional experience, *as a patient,* but also as an institutional agent.

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[9] All spelling and punctuation are preserved in excerpts.

When SPs use *I* in their responses, they could be referring to themselves as patients, SPs, as one who completes the form, or even all three. In Juan's response to item 17 he uses *I* to cover many speaking positions with various epistemic rights and obligations of evaluation:

Extract 17.75- Juan and Justine

Justine Downs did very well; she was polite, professional, respectful, & seemed comfrotable/confident in her role. As a patient, I appreciated that she was thorough & took her time. I felt like she did well with the physical, though don't be afraid to ask a patient to unbotton their gown so that you may do a better inspection. Additionally, utilizing empathetic/validating/reassuring statements will help with patient rapport/comfort. I also appreciated her discression/respect regaurding my sexuality; deffiniately non-jugdemental
She did well on her differential, stating a few things that it could be or at least things she'd like to rule out 7 explained in terms easy to understand Otherwise, I feel like Justine has a great clinical foundation that can only be refined from here; keep up the good work! [10]

Juan's response to item 17 is an extremely long response, which is typical for him (on average, he issues the longest responses, 134 words, compared to a 38-word average among all SPs). Juan uses the phrase *as a patient* to preface a general evaluation of Justine as *thorough & took her time.* The position of *as a patient* suggests patient's prefer thoroughness and when practitioners take their time with them. This is an interesting comparison to the next sentence, *I felt like she did well with the physical exam,* because a patient most likely does not have a sense of what constitutes a "good" physical exam. Juan uses *I* in multiple senses that are accomplishing

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[10] All spelling and punctuation are preserved in excerpts.

different tasks which sometimes multiple positionalities bolster. Even Juan's closing phrase, *keep up the good work*, claims the evaluation is presented as a sort of universal. Similar phrases, *like "good job"* bolsters evaluations as universally relevant, through which SPs wield the multi-positionality.

Who Simulated Patients Address

Next, SPs typically speak *about* MSs rather than *to* them, especially in item 39 (which actually asks SPs to directly address MSs). A writer's audience is evident in the terms of address they use and the language they use in their responses. Most SPs use terms like *he, she, the student, First Name, the student, her/his, this student,* or *First and Last Name* in their responses (See Table 6.5). This demonstrates the preference for speaking about students rather than to them.

Table 6.5: The 10 Most Frequent Person-Reference Terms in Open-Ended Items

Rank	Word	Frequency	Item 17	Item 39
1	He	107	59	48
2	She	107	54	53
3	The student	87	53	34
4	First Name	47	25	22
5	Her	31	17	14
6	You	28	24	4
7	His	24	16	8
8	This student	23	9	14
9	First Last	13	9	4
10	Your	5	4	1

Even the word *you* can be used to speak about students and to them. For instance, in her response to item 39 Fiona quotes what Caleb said:

Extract 39.22- Fiona and Caleb

*The student spoke very rushed (replying "good good good" to "how are **you**?") This, in combination with the fact that the student started prescribing antibiotics and saying I had*

a UTI halfway through the encounter, made me feel like the student was not taking as

much care with the case as I would have liked.

Fiona begins her response with *the student,* specifying a student, but not calling them by name. She subsequently offers evidence for what *rushed* means by directly quoting their conversation (*replying "good good good" to "how are you?"*). Through this response, she offers descriptive evidence for the student *not taking as much care with the case as I would have liked,* in a way that the student could go back and check this for himself. In this, Fiona is describing her preference of how the student handled *the case,* as a SP (*I would have liked*).

Only three SPs speak directly to MSs in their responses: Juan, Naomi, and Elizabeth. Juan's response (see above) demonstrates how SPs speak *about* and *to* MSs, as he switches who he is addressing mid-response: first *she* is the object of the evaluation (and presumably not the reader of the response), then she is the recipient of the evaluation (*don't be afraid... you*). Elizabeth also exemplifies a multi-faceted approach to addressing the reader:

Extract 39.40- Elizabeth and Justine

Justine Downs was pleasant anc confident. Student should practice more using

the drape. Ask the patient to open and lower the gown and hold the drape in front

and then put under the arms. Always ask the patient to remove the glasses, open

the gown and push the shorts down. Never reach in and do it yourself. Student

asked if I 'Currently" smoke? My answer was no but I wasn't asked if I had ever

smoked so I couldn't relate my whole smoking history. Good job

Elizabeth uses *yourself* towards the end of her response. She begins the response by listing the student's first and last name and providing a general evaluation of her. Elizabeth then refers to the MS as *Student,* not *the student* or *this student.* Student also entails the context of

learning. Elizabeth then does some teaching, explaining what should or should not take place. Who is this for? It becomes clear towards the end of her lecture about draping and the gown and in the context of an extreme criticism: to *never reach in and do it* (remove glasses, open the gown, and push the shorts down) *yourself*. This comment is similar to Naomi's critique of Saul– as both use *you* to speak directly to the MS about an error.

Extract 17.11 Naomi and Saul

I felt very unconfortable when you pulled down my pants so abruptly during the physical exam, I would have appreciated you letting me know you had to do this rather than just doing it. I felt that there was little connection I believe it was because you came into the room pretty much with a smile on your face and it just did not seem like you were concerned that I was in pain.

Naomi does not refer to Saul as *a student* or *the student* or even by his name but speaks directly to him through *you* (a strategy she uses in each of her comments). Naomi also uses, *I felt* to make a case for Saul's errors. Once again, *I* could refer to a patient perspective, a SP's perspective, an evaluator's perspective, or even all three. This multi-functionality is important because she accuses him of something drastic: making her feel ***very*** *uncomfortable*. The addition of the intensifier *very* makes a case for what he is doing as extremely wrong, and the accusation is attributed to him pulling her pants down ***so*** *abruptly,* a serious offense. Although Naomi uses these very direct strategies to explain Saul's errors, she builds her criticism indirectly, using phrases like *I felt, I would have, I believe, it did not seem.* Each of these terms has a low epistemic modality yet strives for control in how it accesses the multiple positions a SP can claim (Marín-Aresse, 2011). Naomi demonstrates one of the most compelling strategies for completing

open-ended items, speaking directly to MSs using the multi-functionality of I in conjunction with emotional experiences.

How Simulated Patients Evaluate

SPs combine a range of linguistic strategies to advocate for certain communication skills practices. For instance, the pronoun *I,* invokes multiple positionalities– everyday experiences, SP, the evaluator, the patient, etc.– each of which holds various weight in relation to the situation it occurs. SPs typically pair *I* with terms like think, feel, appreciated, etc., each of which involves different degrees of epistemic positionality. In the following section, I unpack the dynamic between claiming a subjective stance in a communication skills evaluation.

Marín-Arrese (2011) explains epistemic stance as a resource for speakers to strategically claim various degrees of knowledge about a topic. For instance, to claim "I know" is a higher epistemic force than "I think," which is a greater force than "I feel." Each of these are subjective claims of evidentiality as opposed to intersubjective claims (i.e., we all know, it seems, supposedly), which creates a distinction between the evaluator and the subject of the evaluation. SPs typically make subjective claims with lower epistemic force, which attaches personal commitment (and accountability) to the claim. SPs most frequently make low epistemic claims like *I felt* to evaluate MS's communication skills (97 hits). No SPs use the phrase *I know* in Open-Ended Responses although the phrases *I think* and *I thought* are used about seven times overall. For instance, Jerry claims *I thought* when evaluating Stephanie's performance on the physical exam:

> **Extract 12.1.39 Jerry and Stephanie**
>
> *I thought that that Stephanie did a pretty good job on my physical exam but wish that she could have been a little more positive about how I was going to be healthwise*

Jerry's use of *I thought* pairs a moderately weighted claim of certainty with a modified evaluation of her performance on the physical exam (*a pretty good job*). These strategies hedge the Stephanie's moral argument in that *she could have been a little more positive about how I was going to be healthwise.* The stance enacted through "could" is indeed morally weighted but is minimized by her claim to subjectivity. This works in a similar way to Jennifer's use of *I think* in her response to Item 39:

Extract 18.4.39 Jennifer and Justine

This student has a very upbeat and kind tone of voice. I think that can be an advantage in most situations. She did change her tone when she expressed concern. I definitely think that was helpful in expressing empathy and understanding since this was a phone case

Jennifer's first use of *I think* is given after a description of Justine's voice as upbeat and kind, which she claims *can be an advantage in most situations.* The use of *most* suggests that such a voice may not be appropriate in all situations. The next sentence describes what did happen (*change her tone when she expressed concern).* To recount this offers a sort of intersubjective evidence for what took place. Jennifer concludes she *definitely thinks* this change in tone of voice is helpful in expressing empathy, which effectively bolsters Jennifer's claim to communication skills. Essentially, Jennifer is strategically arguing that it is better for a student to change their tone of voice from upbeat and kind when expressing concern to a patient, as it shows empathy.

SP's use of *I feel* attaches greater personal commitment to subsequent evaluations. George's evaluation of Justine uses the phrase to make a case for his general experience (*being taken care of*) and her performance (*understanding what I was going thru* (interestingly, this *I* is on behalf of the patient)):

Extract 17.59 George and Justine

I felt very taken care of. I felt she understood my pain and what I was going thru

SPs typically use *I feel* as a strategy to claim various positionalities (whether SP, patient, evaluator, etc.) with a greater deal of personal commitment and therefore, holding the MS more accountable to their actions. To claim a patient felt a certain way is an appeal to an interpersonal dynamic, which is relationally bound more than claims of knowledge. That the CSLC teaches this strategy creates a dynamic where SPs hold MSs accountable to the claims they make in Open-Ended Items, in their evaluations of communication as a feeling stands in contrast to the seemingly objective standards of the Form.

What Simulated Patients Evaluate

SPs are able to strategically work around the limits that statements like *I feel* impose on evaluations of communication through the topics they mention and the language they use in their responses. When looking at the nouns of open-ended responses, *student* and *patient* are some of the highest-ranking terms, which further demonstrates how SPs evaluate MSs (Table 6.6). Other high-ranking terms include *exam*, *encounter*, *gown*, *drape*, *pain*, and *physical*. *Exam*, *encounter*, and *physical* refer to the general experience of the consultation, while *gown*, *drape*, and *pain* refer to specific communication skills practices. However, SPs use each of these to build a case for communication skills, often as a proto-professional (De Swann, 1990; Hak and de Boer, 1994).

Table 6.6: The 25 Most Frequent Nouns in Open-Ended Items

Rank	Word	Frequency	Item 17	Item 39
1	Student	118	72	46
2	Patient	56	40	16
3	Exam	32	12	20
4	Encounter	31	17	14
5	Gown	25	9	16
6	Drape	23	6	17
7	Pain	20	14	6
8	Physical	15	8	7
9	Empathy	13	9	4
10	Tests	13	0	13
11	Care	12	6	6
12	Connection	10	8	2
13	Eye Contact	10	9	1
14	Questions	10	7	3
15	Soccer	10	3	7
16	Cancer	9	3	6
17	Health	9	4	5
18	Heart	9	1	8
19	History	9	5	4
20	Rapport	9	7	2
21	Statements	9	9	0
22	Time	9	5	4
23	Lungs	8	0	8
24	Answer	7	2	5
25	Question	7	0	7

The term *encounter* is found alongside general evaluations of what took place and specific reports of the consultation (See Table 6.7). *Encounter* is collocated with evaluative terms like– good (lines 1 and 5), respectful (line 2), professional (line 3), casual (line 4), smoothly (line 7), efficient and thorough (line 10)– which SPs use to generally describe the encounter. *Encounter* is also used as a basis to report on and evaluate multiple topics.

Table 6.7: Selected Concordance Lines of *Encounter* in Open-Ended Items

1	For the pain to just go away! Good	encounter	FNAME looked very prof	39
2	Was respectful during our	encounter	even when my sexual orient	17
3	FNAME did a professional	encounter	.For the step 2 exam, he	39
4	He was able to keep the	encounter	casual, while also being	17
5	There was a good pace to the	encounter	He chose his words care	17
6	Empathy statements throughout the	encounter	FNAME- I felt like you	17
7	Questioning, but overall I felt the	encounter	Went pretty smoothly	39
8	NONE He began the	encounter	With the statement, "I see	39
9	She built trust during this	encounter	So that I was able to agree	39
10	Efficient and thorough	encounter	(SP). She was very empa	39

For instance, Eric uses the notion of *encounter* to comment on a number of communication skills:

Extract 39.66 Eric and Barrett

He began the encounter with the statement, "I see in the chart that- - - ". (not open ended question) He cover all of the main points of the HPI. The exam was good, really listened to my heart, listened to my lungs under the gown, tapped on my lower back on each side. He gave a good reply to the challenge question. Because of the tenderness on my right lower back, he thinks that I have a kidney stone, b ut could be more serious like cancer. I felt good about the encounter. The pace was good; the exam was gdod.

First, Eric summarizes what Barrett said at the beginning of the encounter (*"I see in the chart that- - - ". (not open ended question)).* In doing so, Eric parenthetically calls back to item 7 in the assessment form (open-ended question). Eric draws on institutional knowledge in using the terms *open-ended question* and *HPI*, and in describing how one would properly do a physical exam. Eric shows himself as a proto-professional, a term introduced by De Swann (1990) to describe someone who "adopt[s] the basic stances and fundamental concepts of the professions as a means of orientation in their everyday life" (p. 14). Proto-professionals are proficient in the logic and language of a professional practice. Hak and de Boer (1994) explain how therapists' formulations of client's experiences (i.e., "you are an introvert") functionally teach clients the professional models of therapy. Not only are the systems of operating proto-professional resources, but so are the particular linguistic repertoires, or registers, for that realm of discourse (Agha, 2006). The assessments (*good reply; the pace was good; the exam was gdod)* are all evidence of proto-professionalization in SP evaluations.

Juan draws on the register of communication skills in his evaluation of Will, is comparable to his evaluation of Justine excerpted above:

Extract 17.76- Juan and Will

Will Pineda did very well. As a patient, I felt like he was polite, kind, professional, & seemed comfortable/confident in his role. This encounter was fairly standard/straightforward. I appreciated the attempt at small talk; to help with rapport empathy, try utilizing more empathetic/validating/reflective statements as well as the patient's name a few times. I did appreciate that you apologized for what's been going on recently(Night Sweats) & that you summarized compnets of the interview to check for accuracy. While he didn't really establish relationship or sexual orientation, he still gave me respect & decency, even when I brought up concerns about potentially having Night Sweats due to HIV. I think that Will has a very good clinical foundation that will only get better with refinement Keep up the good work!

Juan describes the MS (*polite, kind, professional, comfortable/ confident*) and the encounter (*standard/straightforward*) before developing specific comments about *small talk, rapport, empathy, empathetic, validating, reflective, summarized, accuracy, respect, decency, etc.* Many of these terms are found earlier in the Form, which enables proto-professionalization by offering the SP professional formulations. Furthermore, terms like *respect* and *decency,* as a result of the form, are now institutionalized as communication skills and enregistered in the discourse of communication skills.

There is a dynamic between evidentiality (the degree of epistemic certainty; i.e., *I feel*) and professional register (the terms that SPs use; i.e., *empathy*) that enable different degrees of

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commitment to and authority about communication skills. When SPs offer evidence devoid of personal attachment (i.e., describe what took place) and/or adopt the register of the evaluation form, they strategically and authoritatively comment on and evaluate communication skills. This allows SPs to leverage a higher claim to communication skills than when SPs speak in subjective generalities like, *I felt like it was a good encounter.* For instance, Rick identifies uses a specific number on the evaluation form as a resource in his evaluation of Stephanie:

Extract 39.70 Rick and Stephanie

 # 26 - When I showed indifference to the drape Stephanie chose not to use it. Her differential was vague, mentioning several possibilities but not zeroing in on anything pending further testing.

Rick explicitly cites an item on the assessment form (#26) and accounts for what happened as *showed indifference.* He provides an account of what took place, which when looking at the multiple-choice items of the form, allow him to make the claim that the drape does not matter. This form of evidence combined with the communication skills register evidenced in the Form and even the Script (i.e., *differential, pending further testing)* creates a high degree of certainty with a low degree of personal commitment.

How Simulated Patients Structure Evaluations

The final aspect of Open-Ended Items I want to attend to is the function of having two open-ended items on the Computerized Assessment Form. The Form offers SPs two different tasks and frameworks: reflections from a patient's perspective about the MS (item 17) and comments from a SP that will be shared with a student (item 39). However, SPs do not answer these items as they are written and typically favor one or combine both strategies. For instance, Juan only leaves comments in response to item 17 and in item 39 he writes *N/A.* Similarly,

Elizabeth only leaves comments in response to item 39, while in item 17 she writes *See comments below.* SPs follow their own systems for completing open-ended responses and do not differentiate between SP and patient perspectives nor do they speak to MSs in one item rather than the other. The biggest difference occurs in the ways they organize the skills of their response in relation to the items on the form.

First, SPs rely on the pronoun *I* and the phrase *as a patient* in both responses, despite the distinction indicated in the questions. It seems using a patient perspective is a strategy for justifying their evaluations rather than an execution of the conditions of the questions. Furthermore, Naomi, Juan, and Elizabeth are the only SPs who speak directly to MSs in their responses. Although Juan and Elizabeth comment on one item rather than the other (Juan item 17 and Elizabeth item 39), it seems that SPs do not see the distinction between items 17 and 39 (item 17 from a patient perspective and item 39 as comments to the student). SPs who speak directly to students (like Naomi, Juan, and Elizabeth) will continue to speak *to* students and those who do not, will continue to speak *of* them, as objects of assessment (as the 18 other SPs do).

However, there is a difference in what skills are discussed in what items. For instance, *gown* and *drape* occur twice as often for item 39, while *pain* and *empathy* are addressed twice as often in item 17. *Tests, questions,* and *lungs* are only ever discussed in item 39, while *statements* and *eye contact* are discussed in item 17. Interestingly, the words exclusively used in item 17 occur in items 1-16 of the document–eye contact (item 6) and empathy (item 12); as do the topics discussed more often or exclusively in item 39 relate to topics brought up in items 18-38, like the drape (item 26), heart (item 28), tests (item 36), and questions (item 37). SPs organize their responses according to the topics covered in the items immediately prior to the open-ended item.

The Implications of Communication Skills in Computerized Assessment Forms

Responses to items 17 and 39 do not differ along the lines of what they refer to, how they are written, or who they are written to. So, what is the function of having two items? And what are the entailments of how SPs complete them? First, it is important to note that only two of thirty-nine items offer SPs a space to comment on MSs using their own words. The rest of the assessment form enacts standards and evaluations on behalf of a "patient perspective," which is actually the CSLC's view of what constitutes a patient perspective.

Nonetheless, multiple-choice items are ordered, exhaustive, and terminology-based lists that create an authoritative account of right or wrong. Open-ended items contain a perspective. Just a thought or observation. The epistemic weight of the multiple-choice items reinforces the institutionalized version of communication skills over the version of competency described by SPs or the imagined patients they portray. Within the context of multiple-choice, seemingly objective-based items, SP comments might be read as secondary, especially considering their inconsistency and numerous spelling errors. Therefore, offering SPs two spaces to write comments gives SPs a sense that they have a lot to offer, suggests there are multiple things they can comment on, as well as multiple perspectives they can comment from (patient and communication skills expert).

Yet SPs strategically use the open-ended items to create communication skills. SPs use the term *I* to claim a number of positionalities– whether this patient, patients in general, SP, evaluator, experiencer, or any other position. Comments have a low degree of epistemic modality, typically making subjective claims of *feeling* that create a high degree of personal affiliation and accountability. This allows for the CSLC to discount SP's evaluations as "just a feeling" in contrast to the systems they provide. Yet claiming *I feel* is multi-functional as when

combined with descriptions of what occurred, the register of communication skills found in the form, or the logic of the practice, SPs strategically offer their positions in a manner that the CSLC cannot argue with. Furthermore, if SPs offer high certainty and high evidentiality claims, they in turn compete with the CSLC in constituting communication skills.

The Assessment Form designates, authorizes, and regulates MS and SP actions by making recognizable specific communication tasks, who should complete said tasks, and what various degrees of skilled communication are. In practice, the assessment form decontextualizes communication from an everyday activity and technologizes it as an institutional practice, which can be measured, assessed, taught, and learned. Furthermore, when SPs complete open-ended items, they situate their evaluations as subjective experiences, which cannot be argued with, or even intersubjective experiences that serve as evidence for evolving communication skills. SPs can own knowledge about communication beyond what is offered in the form. But SP's subjective claims could also be seen as inconsistent with the form, which makes them seem like "just opinions" in the context of seemingly objective communication skills.

The Communication Skills Assessment Form, like the Script and the Simulated Consultation promotes a limited paradigm of communication. Communication is a wire between boxes– boxes with their own experiences and goals. When participants have contradictory experiences, the only solution is the authority of the institution. And despite the attempts to negotiate different ways of doing communication, unless there is an approach that constitutes communication as a performative, doing, next action, MSs will continue to be learn through strict regimes of competency and SPs will be dummies striving to make a difference. I address these issues in my concluding chapter.

CHAPTER SEVEN:

CONCLUSIONS AND DIRECTIONS FOR COMMUNICATION SKILLS

The popular social media site Reddit offers a variety of forums around a number of

interests, including r/medicalschool. In this subreddit, medical students from across the globe

talk about life as a medical student, including their experiences with simulated patients (SP). In a

2020 thread, a first-year medical student (MS) asks for advice on how to perform empathy better

for their upcoming exam:

> I have my next exam with a standardized patient coming up (where
> the standardized patient does the grading). My last one didn't go
> very well. I lost points for not being empathetic enough, despite
> my best efforts to convey empathy. I did significantly worse than
> most people so now I'm low-key freaking out for the next one (and
> the rest of my career of patient interactions lol I'm fine, it's fine).
> Any advice or tips? I particularly struggle with nonverbal empathy,
> as I am uncomfortable touching people if I don't know whether
> they want to be touched.

One of the most popular responses to this question was from a fourth-year MS who

simply linked to a website called empathysim.com. The site features a simple game where the

player is a medical student in a simulated consultation. Level 1 is a consultation with a "24 y/o

male w/ cough." There is even an overhead voice that says, "you may now enter the exam

room." Once the level begins, a clock begins ticking down from ten to one. The player navigates

the exam room with the arrow keys to find a patient next to a graphic of a space bar. When the

player presses the space bar, a monotone computerized voice says one of the following

statements: "how does that make you feel," "I am sorry that you are going through this," "it is

hard to imagine what you are going through," "it must be hard," "tell me more about how you felt," "wow that is tough," "I understand," or "it sounds like you are upset." No matter how many times the player presses the space bar or where they are located in the room when they press the space bar, the player will fail, an audio clip of a crowd cheering "boo" will play, and a graphic will flash that says, "You did not empathize fast enough." On a random chance, the player may pass and go to Level 2, "4 y/o w/ diarrhea," where if they are ever too close to the patient, the patient will run away leaving a trail of human excrement. Ultimately, the player will fail. The simulation game proves a point about how MSs view communication skills training with simulated patients–there is no formula for success; you will always fail.

Communication skills training in medical education is a complex process. The conceptualizations of communication skills in simulated patient (SP) practices offer competing notions of communication. I examined how communication is conceptualized in the three SP practices– Scripts, Simulated Consultations, and Assessment Forms– of the Communication Skills Learning Center's (CSLC) Communication Skills Practice Exam (CSPX). I began this project because I was interested in how medical schools train future physicians to communicate with patients. My own conversations with couples about pregnancy loss made evident the importance of physicians learning and practicing delicate communication moments, like breaking the news of miscarriage. Medical education offered a natural site of inquiry to study whether and how communication skills training occurs. I asked questions like: What is communication? What are communication skills? And how may we understand the implications of how communication is conceptualized as a skill in medical education?

I took on these questions by developing a relationship with the CSLC. I observed and participated in communication skills training as a SP. I read (and memorized) Scripts. I

performed patient for hundreds of MSs in Simulated Consultations. I completed Assessment Forms. However, my work as a simulated patient felt limited. I questioned whether my work with MSs mattered. Yet it is not whether they mattered, but *how* they matter that is the more important question. To understand how communication skills training makes a difference, I looked closely at the simulated patient practices of the CSLC.

It would be impossible to examine every activity that takes place at CSLC. Students spend hundreds of hours in consultations with SPs throughout their years of medical education. Instead of taking a broad approach, I examined a single day of a critical activity: The Clinical Skills Practice Exam (CSPX). The CSPX exists because communication is so thoroughly institutionalized as a medical skill that it has its own examination in the United States medical licensing process, which the CSLC strives to prepare its third-year students for through the CSPX. The CSPX is not representative of all that CSLC does; nor is it comprehensive of communication skills training. The CSPX is one medical school's approximation of what the United States Medical Licensing Exam Step 2 Clinical Skills requires of candidates, and therefore, what the institution of medical education values.

I use discourse analysis to examine the CSPX because its metatheoretical position allows me to examine ordinary practices of talk (Craig, 1999). I (and other discourse analysts) see communication as constitutive of identities, relationships, activities, institutions, and societies. Rather than assume the truth of these things occurs "inside" something, I take practice approach and examine what we perform through talk, bodies, and objects. Cooren (2018) suggests that close looking allows researchers to "illuminate the hybridity and complexity of our world," (p. 10). Communication is observable and each activity allows for or prevents the next set of actions.

I organized my analysis around three simulated patient practices, in the order that SPs experience them: (1) the Scripts SPs receive that orient them to the simulated consultation they will engage in; (2) the actual Simulated Consultations between SPs and MSs; and (3) the Assessment Form that SPs complete in order to evaluate communication skills competency, which contains both multiple-choice and open-ended responses.

In Chapter IV, I asked: (1.0) How are communication skills conceptualized in Scripts? (1.1) What strategies does the Communication Skills Learning Center use to constitute communication skills in Scripts? (1.2) What are the implications of communication skills in Scripts? I used corpus-based genre analysis to examine the twelve Scripts issued to simulated patients for the CSPX. Scripts are a genre, a recognizable and typical type of document that constitutes communication skills.

In Scripts, communication is conceptualized as a neutral tool of information exchange, which is in tension with the dynamic of practice that is observable in Simulated Consultations and Open-Ended Response Items. Scripts recruit simulated patients to portray concerned persons in need of medical care. Medical care occurs through communication skills, which provide providers access to a patient's problems and the resources for a medical solution. This is observable in how Scripts are organized in two-column tables that depict a MS asking questions and a SP giving answers. Only once are SPs shown to ask MSs a question, "the Challenge Question." The purpose of MSs asking so many questions is to demonstrate to SPs what communication skills look like. "Effectiveness" occurs when medical students follow a structure of question-asking that is the means of obtaining all seemingly necessary information. Scripts standardize patients, simplify communication as a neutral information gathering tool that values

what is being asked rather than *how* it is being asked, which places the burden of effective communication on providers and characterized patients as passive givers of information.

In Chapter V, I looked at how matters of communication skills "come to life" in Simulated Consultations. Because Simulated Consultations are a form of hybrid discourse– part educational assessment and part medical consultation– simulated patients and medical students use various framing strategies to "make it happen." I asked: (2.0) How are communication skills conceptualized in Simulated Consultations? (2.1) What strategies do the Communication Skills Learning Center, simulated patients, and medical students use to constitute communication skills in Simulated Consultations? (2.2) What are the implications of communication skills in Simulated Consultations?

In Simulated Consultations, the CSLC, MSs, and SPs work together to make communication skills happen. I demonstrate how the CSLC, spaces, objects, medical students, and simulated patients work *together* to enact the consultation; there are material, embodied, linguistic, and paralinguistic strategies for making communication skills happen. In this, communication skills are distributed among multiple participants in a dynamic. Communication skills are negotiated moment by moment. They are not isolated tasks or static traits. Through simulated consultations, medical students and simulated patients learn and make real the entailments of communication for medical practice.

Furthermore, there is always potential for metacommunication in simulated and actual consultations. Through this, simulated consultations can be seen as eventful sites for the negotiation of communication skills. Medical students and simulated patients make known and ratify alternative versions of "good" or "bad" communication through their metacommunicative performances. The same potential holds true for actual consultations, in which participants metacommunicate and consider the strengths or weaknesses of other's positions about communication. That SPs have and perform their own views of what constitutes skilled

communication presents a challenge to CSLC's authority over communication skills. However, the CSLC is not a monolith of absolute power, but a site of practice and negotiation.

In my final analysis chapter (Chapter VI), I examined the CSPX Assessment Form– how its multiple-choice items are constructed and how open-ended responses are completed. I asked: (3.0) How are communication skills conceptualized in the Assessment Form? (3.1) What strategies does the Communication Skills Learning Center use to conceptualize communication skills in Multiple-Choice and Open-Ended items? (3.2) What strategies do simulated patients use to complete Open-Ended items? (3.3) What are the implications of communication skills in the Assessment Form?

In completing the Form, SPs create a record of student actions and assess those actions along the continuum of patient preference, which promotes institutional know-how under the guise of a patient perspective. The form also directs SPs in how to perform their role as patient. Yet, SPs complete the Assessment Form in strikingly different and strategic ways. In examining the quantitative totals of the multiple-choice items, SPs tend to be "easy," "average," or "hard" graders, but medical students are universally "successful," consistently earning average or above average marks. The discrepancies in MS scores are more likely due to the random chance of which SP they met with than actual skill.

Additionally, when SPs complete open-ended items, they exercise the multi-positionality that being a simulated patient affords– promoting an institutional, patient, and/or evaluator perspective. Simulated patients leverage epistemic claims to experience as proto-professionals, proficient in the logic and language of communication skills. Such strategies can bolster or discount their evaluations. Nonetheless, responses to the Open-Ended Items stand in contrast to the seemingly objective multiple-choice form. The Assessment Form and the SPs who complete

it work within and around CSLC's version of communication skills. In the Assessment Form, communication skills are actively negotiated.

Considering Communication

I began this project with the premise that communication is an essentially observable practice. By paying attention to the ways we talk about talk, I considered the entailments of practical metadiscourse. I take this a step forward in claiming that this approach offers the field of communication a way to study and consider the implications of practical metadiscourse. As Craig (2016) states in his reflection of the metamodel, "[it] connects the 'theoretical metadiscourse' of the discipline to the 'practical metadiscourse' of everyday life" (p. 356). By examining the metadiscourse in simulated patient practices, I reconstruct the theoretical conceptualization(s) of communication at play at the CSLC; in turn this is a way of considering the possibilities they offer, while also reconciling the tensions at play. The following considerations are meant to "jump-start" the dialogue of practical communication theory.

Communication as Information Exchange

Per the Script and multiple-choice items of the Assessment Form, patients contain objective medical "information," which can be accessed by effective questioning and diagnostic practice. Medical students are skilled (or unskilled) communicators, based on the information they retrieve and the tasks they complete in consultations with SPs. The conceptualization of communication as information exchange rings true with the notion of transmission, where communication is the process of transferring information from one object to another. While much has been written about the shortcomings of communication as transmission, it persists and is culturally valued (Craig, 1999).

Conceptualizing communication as information exchange isolates the differences between physician and patient. Much like the relationship-centered approach, there is a recognition that patients and providers have different experiences and expectations. Communication is the means of making these differences known to one another. Additionally, information is exchanged for the purpose of accomplishing a goal. There is a purpose in going to the doctor, so knowing whether, where, and how long a patient has been experiencing pain is important information in treating that pain or its underlying cause. Communication skills in the form of questions are the means of accessing this information.

However, when communication is solely conceptualized as a means of gathering information, communication becomes a disembodied and opaque phenomenon. The image of talking heads with connecting speech bubbles is present in almost every basic communication theory or public speaking textbook. This depiction of communication relies on the container paradigm, but also removes the body from part of the communication experience. Part of the performance I included in the previous chapter calls attention to the body as foundational to communication skills in medical practice. SPs and patients are embodied humans with their own feelings, experiences, and pains. There is a deep irony in removing the body from conceptualizations of communication in medical practice, as physicians are often criticized for being too focused on the physical and not the emotional. Yet this conceptualization draws on a form of Cartesian dualism between mind and body that can only be resolved by an either-or attribution.

Most often, communication is attached to some sort of inner state or subjective experience encapsulated in the person. When communication is a matter of skill– an individual trait that can be measured as more or less present– there is a paradox. Students either do or do

not possess skills, yet they can develop skills through the institution's logic of practice. During my work as a SP, I often heard statements like, "well they don't have the personality for this," or "they just can't get it." This disembodied opaqueness breeds infinite skepticism and constant vigilance amongst providers and patients. Are patients lying about their pain? Are physicians faking empathy? I think of the empathysim.com, where no way of expressing empathy ever leads to success. There is a double-bind– if you try to fail and if you don't try you fail. Such a dynamic produces apathy.

Communication as information exchange also leads to blame and demands causal explanations for communication disfluencies, which are often unidentifiable except through *ex-post facto* assessments. Communication as information exchange prevents medical students from succeeding without the help of some technical authority. The language of communication in multiple-choice items relies on cognitivist conceptions like empathy or listening that cannot be proven except through authoritative forms. Moreover, in technologizing communication as a medical skill, the CSLC uses terms, like "eliciting a chief complaint," or "painful maneuvers," they create a functional knowledge asymmetry for those participating in its practices. Essentially, the CSLC's technologization of communication as a medical skill creates a way of conceptualizing communication that potentially serves their own interests rather than the interests of their students or their future patients.

Communication as Distributed and Dynamic

However, the Communication Skills Learning Center is not a monolith of power and control. In Simulated Consultations and Open-Ended Items, participants strategically advance their own views about communication skills demonstrating how communication is distributed and dynamic. In Simulated Consultations, SPs, MSs, objects, and spaces work together to make

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the Simulated Consultation happen. Communication is a collaborative process, which curtails

individual blame and attends to what we do together through the work of communication.

Communication as distributed and dynamic emphasizes action and agency to offer a way of

moving forward. In Simulated Consultations, MSs and SPs often "go meta" to suggest

alternative versions of communication skills competency. Similarly, by completing the Open-

Ended Items of the Assessment Form, SPs strategically advance their own views of what

constitutes skilled communication. SPs use the phrase "I feel" to posit emotional experience as

shared. This relationally bound notion of joint experience holds medical students as accountable

to those feelings. However, in the context of a seemingly objective and technical multiple-choice

form, these evaluations may seem like mere opinions. Through implicit and explicit

metacommunication, communication skills are flexible. Communication skills are not isolated to

what the CSLC claims they are, but they are negotiated in moment by moment interaction.

Craig (1999) emphasizes the distinction between first and second order theories,

suggesting that the metaposition of communication as constitutive metadiscourse should not be

confused with other first-order approaches that are built on the premise that communication is

the means of social production (and reproduction). For instance, the sociocultural tradition of

communication theory that is foundational to many language and social interaction approaches

(like conversation analysis) is a first-order theory; it is just one of many ways of conceptualizing

communication. I see communication skills in Simulated Consultations and Open-Ended items

being resonant with the first-order constitutive approach because they call attention to the claims

of simulated patients and the coordination of communication skills.

To reconceptualize communication as a distributed dynamic requires a radical reframing

of communication from the culturally salient container paradigm of communication where

communication is information exchange or transmission. Not only is it challenging to reconceptualize this "talking heads" notion of communication, but it is important to locate communication in the body. Our entire bodies participate with the spaces and objects around us as communication, and to neglect any of these elements is an oversimplification. Additionally, the alternative conceptualization of talk and collaborative and embodied can be intimidating. There are many attempts to make constitutive approaches, like conversation analysis, more publicly relevant and understandable, but it is undeniable that it is a language game that benefits from "communication specialists" (Albert et al., 2018). Furthermore, the notion of communication as a dynamic activity shares many features in common with the metaposition that communication is constitutive, but it does not shift to a second-order understanding. What is left out is reflexivity, or self-awareness of the consequentiality of one's actions, as well as the consideration that other ways of understanding communication can and do occur. It is important to take the next step up, which offers a way of moving simulated patient practices forward.

Future Recommendations

The diverse conceptualizations of communication demonstrated in simulated patient practices offer an opportunity to consider the relationship between theory and practice. Medical practice is a key site for considering communication, as we live in a thoroughly medicalized society. I am grateful that communication is recognized by the field of medicine as vital to quality medical practice. But communication requires more than creating a Communication Skills Learning Center or checking whether medical students ask all the right questions in the right order before they take their licensing exam. It is also more than suggesting we each have our own perspectives of what makes for good communication. In the constitutive metamodel, communication as information exchange is not contradictory with communication as dynamic

and distributed, but each conceptualization enriches meanings of communication. My metaposition that communication is constitutive is a pragmatic way to consider many theorizations of communication without ironically taking one as the one true way of conceptualizing communication. Moreover, the considerations that I have offered of the affordances and constraints of various conceptualizations are meant to improve the practice of communication skills training, whether in medical practice or in other fields. I finish this project with three recommendations for future practice: (1) emphasize the importance of communication and observability; (2) improve (simulation-based) education through communication research; (3) and facilitate reflexive dialogues about communication practices.

Emphasize the Consequentiality of Communication for Simulated Patient Practices

Sigman (1995) argues for the consequentiality of communication, which he simply defines as "what transpires during, within, and as parts of person's interactive dealings with each other has consequences for those persons" (p. 2). Medical students and simulated patients should be taught that communication matters from day one of their onboarding. For organizations that exist, like the CSLC, this could be emphasized in an introductory session, and for institutions where such specialist organizations do not exist, they should be emphasized by teaching physicians or communication scholars during orientation.

I suggest that one of the first sessions medical students should experience in their orientation should focus on communication. I opened this project with observations from my previous research on couple's narratives of pregnancy loss. The stories shared with me made a difference for my own understanding of communication in medical practice. Everyone has a story about a time they were interacting with a health care professional and the communication therein made a lasting impact, whether positive or negative. I suggest students and simulated

patients share stories with one another about their interactions with healthcare providers to emphasize the importance of talk and practice talking about communication.

Enrich Simulation-Based Education through Communication Research

My second suggestion involves improving simulation-based education through research on communication. I am struck by Heritage and Robinson's (2011) comparison of soliciting patient's additional concerns. I suggest that communication scholars need to continue to develop research that tests the effectiveness of certain strategies and that such research should be incorporated into communication skills curriculum. Teaching this evidence-based approach to medical interaction early in medical school offers medical students the opportunity to join in on the project as they may have questions about what works best. While requiring medical students to complete discourse analytic projects in the midst of medical school is a bit demanding, offering elective courses on Communication Research or asking them what they would like to know more about advances interdisciplinary research and practical relevance. Furthermore, teaching simulated patients the basics of conversation can address the "authenticity" issue of simulated consultations.

I am of the position that simulated consultations will never be authentic or accurate. Sure, there are things that can be done to make them more "life like," but the value of simulated consultations is that medical students are practicing communication in the moment and learning to attend to metacommunication. Through Chapter V, I demonstrated the affordances of simulated consultations in how medical students and simulated patients metacommunicate about communication skills– they show one another what is working and what is not working.

Facilitate Reflexive Dialogue about Communication

My third recommendation entails teaching simulated patients and medical students to attend to and make evident metacommunication. Simulated consultations allow medical students to practice communicating with "patients" in the moment and to develop a self-awareness around communication. If medical students are taught to pay attention to what simulated patients are doing and simulated patients are taught to do things that indicate "good" or "bad" communication, they can provide one another an in-the-moment practice round and cite interactional evidence in post-simulation discussion.

The CSPX has a unique role in preparing medical students for their licensing exam. But not all simulated patient practices need to emphasize product over process. Through recommendations one and two, medical students and simulated patients are shown the importance of communication to medical practice and what strategies are more likely to produce desirable outcomes (i.e., that the patient has had the opportunity to discuss all they want to with their physician). Simulation-based education offers a site for medical students to practice communicating with a proxy of patients in real time. Yet to take full advantage of this practice, I suggest medical students and simulated patients sit down together, watch their simulated consultations, and make explicit their implicit metacommunication. Iedema et al. (2015) refer to the practice of watching videotaped footage of medical providers with medical providers as "video reflexive ethnography." The focus of their study is on watching videos of entering and exiting rooms to identify sites where infection risk can be better managed through personal hygiene and sanitation. By asking participants to select important clips and bringing their own clips, they are able to reduce the risk of infection. I want to take a similar approach to watching simulated consultations that allows SPs and MSs to make transparent to one another their

assumptions about communication. I call this a reflexive dialogue, because it entails looking back at communication to talk about and change future communicative actions. I describe this process as one that is facilitated because inviting the expertise of communication scholars, especially those trained in discourse-based approaches, to walk participants through interaction without relying on cognitivism offers participants real resources for working with patients.

Reflexive dialogue emphasizes the consequentiality of communication, the observability of communicative action, and how communication is an ever evolving and changing practice. I appreciate how de la Croix and Veen (2018) emphasize that reflection is performative, and I want to take advantage of those performances. I also recognize that reflection is different for each person. But if medical students and simulated patients are guided through discussions together about what works and what does not work (not as it relates to feelings, but as it relates to the next possible action), we are drawing on the affordances of both transmission and constitutive approaches.

Conclusions

A practice approach makes observable what occurs in the taken-for-granted minutiae of a routine educational activity. It also demonstrates a method for examining the practical metadiscourse that brings life to our communicative worlds. My hope is that this project demonstrates an approach for studying meanings of communication in any context, whether medical education, veterinary education, or a Department of Communication. Indeed, communication matters, and by observing the ways it matters in practice, we can better understand and shape with greater focus the meanings of communication around us. Rather than conceptualizing communication as a skill, decontextualized from something we already do (something we are already "good" at), what if we took a meta-approach and asked what are we

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already doing through communication? And what are the implications for how we talk about

talk? Maybe then we could find a way to approach our practical and situated concerns.

REFERENCES

Abbott, A. (1991). The order of professionalization: an empirical analysis. *Work and Occupations, 18*(4), 355-584. https://doi.org/10.1177/0730888491018004001

Agar, M. (1985). Institutional discourse, *Text: Interdisciplinary Journal for the Study of Discourse, 5*(3), 147–168. https://doi.org/10.1515/text.1.1985.5.3.147

Ainsworth-Vaughn, N. (2015). The Discourse of Medical Encounters. In D. Schiffrin, D. Tannen & H.E. Hamilton (Eds.) *The Handbook of Discourse Analysis.* (pp. 453-469). Blackwell. https://doi.org/10.1002/9780470753460.ch24

Ajjawi,R., Bearman, M., & Boud, D. (2019) Performing standards: A critical perspective on the contemporary use of standards in assessment. *Teaching in Higher Education.* http://doi.org/10.1080/13562517.2019.1678579

Albert, S., Albury, C., Alexander, M., Harris, M.T., Hoffstetter, M., Holmes, E.J.B., and Stokoe, E., (2018). The conversational roller coaster: Conversation analysis and the public science of talk. *Discourse Studies 20*(3), 397-424. https://doi.org/10.1177/1461445618754571

Antaki, C., & Rapley, M. (1996). `Quality of Life' Talk: The Liberal Paradox of Psychological Testing. *Discourse & Society, 7*(3), 293–316. https://doi.org/10.1177/0957926596007003002

Ashcraft, K. L., Muhr, S.L., Rennstam, J., & Sullivan, K. (2012). Professionalization as a Branding Activity: Occupational Identity and the Dialectic of Inclusivity- Exclusivity.

Gender, Work & Organization, 19(5), 467-488.
https://doi/10.1111/j.14680432.2012.00600.x

Association of American Medical Colleges. (1998) Emerging trends in the use of standardized
patients. *Contemporary Issues in Medical Education*. Association of American Medical
Colleges.

Association of American Medical Colleges. (1999) *Contemporary Issues in Medicine:
Communication and Medicine*. Association of American Medical Colleges.

Atkins, S. (2019). Assessing health professionals' communication through role-play: An
interactional analysis of simulated versus actual general practice consultations. *Discourse
Studies*, *21*(2), 109-134. https://doi.org/10.1177/1461445618802659

Atkins, S., & Roberts, C. (2018). Assessing institutional empathy in medical settings. *Journal of
Applied Linguistics and Professional Practice*, *13*(1), 11-33.
https://doi.org/10.1558/japl.31861

Atkins, S., Roberts, C., Hawthorne, K., & Greenhalgh, T. (2016). Simulated consultations: A
sociolinguistic perspective. *BMC Medical Education*, *16*(1), 16.
https://doi.org/10.1186/s12909-016-0535-2

Austin, J. L. (1962). *How to do Things with words*. Harvard University Press.

Barrows, H. S. (1993). An overview of the uses of standardized patients for teaching and
evaluating clinical skills. *Academic Medicine, 68*(6).
http://sites.uci.edu/medsim/files/2015/03/Overview-of-standardized-pat.pdf

Bartesaghi, M. (2009a). Conversation and psychotherapy: How questioning reveals institutional
answers. *Discourse Studies,* 11(2), 153–177. https://doi.org/10.1177/1461445608100942

Bartesaghi, M. (2009b). How the therapist does authority: Six strategies for substituting client accounts in the session. *Communication & Medicine, 6*(1), 15-25. https://doi.org/10.1558.cam.v5i2.15

Bartesaghi, M. (2015). Intertextuality. In K. Tracy, C. Ilie, & T. Sandel (Eds.), *International encyclopedia of language and social interaction* (pp.901-906). John Wiley & Sons. https://doi.org/10.1002/9781118611463.wbielsi105

Bartesaghi, M. & Castor, T. (2009). Tracing our Steps Through Communication Social Construction: Six Propositions for how to go on. In G. Galanes & W. Leeds-Hurwitz (Eds.) *Socially Constructing Communication.* (pp. 225-243). Hampton Press. https://scholarcommons.usf.edu/spe_facpub/660

Bartesaghi, M., Cooren, F., & Matte, F. (2020). The Authority of the Broader Context: What's not in the Interaction? In N. Benchekeri, F. Matte & F. Cooren (Eds.) *Authority and Power in Social Interaction: Methods and Analysis.* Routledge.

Bateson, G. (1999). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. University of Chicago Press. (Originally Published in 1972) https://doi.org/10.7208/chicago/9780226924601.001.0001

Bazerman, C. (1997). Discursively structured activities. *Mind, culture, and activity*, *4*(4), 296-308. http://dx.doi.org/10.1207/s15327884mca0404_6

Bearman, M., & Ajjawi, R. (2018). From "Seeing Through" to "Seeing With": Assessment criteria and the myths of transparency. In *Frontiers in Education*, *96*(3). https://doi.org/10.3389/feduc.2018.00096

Bearman, M., & Ajjawi, R. (2019). Can a rubric do more than be transparent? Invitation as a new metaphor for assessment criteria, *Studies in Higher Education.* https://doi.org/10.1080/03075079.2019.1637842

Bearman, M., & Ajjawi, R. (2018). Actor-network theory and the OSCE: Formulating a new research agenda for a post-psychometric era. *Advances in Health Sciences Education*, *23*(5), 1037-1049. http://dx.doi.org/10.1007/s10459-017-9797-7

Bearman, M., Greenhill, J. & Nestel, D. (2019). The Power of Simulation: A large scale narrative analysis. *Medical Education, 53*, 369-379 https://doi.org/10.1111/medu.13747

Beeke, S., Maxim, J., & Wilkinson, R. (2007). Using conversation analysis to assess and treat people with aphasia. *Seminars in Speech and Language 28*(2), 136-147. https://doi.org/10.1055/s-2007-970571

Benoit-Barné, C. & Cooren, F. (2009). The accomplishment of authority through presentification: How authority is distributed among and negotiated by organizational members. *Management Communication Quarterly, 23*(1), 5-31. http://dx.doi.org/10.1177/0893318909335414

Bhatia, V.K., Flowerdew, J. & Jones, R.H. (2008). *Advances in Discourse Studies*. Routledge. https://doi.org/10.4324/9780203892299

Berkenkotter, C. (2001). Genre systems at work: DSM-IV and rhetorical recontextualization in psychotherapy paperwork. *Written communication*, *18*(3), 326-349. https://doi.org/10.1177/0741088301018003004

Biber, D. (2010). What can a corpus tell us about registers and genres. In A. O'Keeffe & M. McCarthy (Eds.) *The Routledge Handbook of Corpus Linguistics*, (pp. 241-254). https://doi.org/10.4324/9780203856949.ch18

Billig, M. (1999). Whose terms? Whose ordinariness? Rhetoric and ideology in conversation analysis. *Discourse & Society*, *10*(4), 543-558. https://doi.org/10.1177/0957926599010004005

Boisy, A., Windover, A.K., Bokar, D., Karafa, M., Neuendorf, K., Frankel, R.M, Merlino, J., & Rothberg, M.B. (2016). Communication Skills Training for Physicians Improves Patient Satisfaction. *Journal of General Internal Medicine*, *21*(7), 755-761. https:/doi.org/10.1007/s11606-016-3597-2

Buckman R. (1984). Breaking bad news: why is it still so difficult? *BMJ Clinical Research 288*(6430), 1597–1599. https://doi.org/10.1136/bmj.288.6430.1597

Brown, J. B., Boles, M., Mullooly, J. P., & Levinson, W. (1999). Effect of Clinician Communication Skills Training on Patient Satisfaction: A Randomized, Controlled Trial. *Annals of Internal Medicine, 131*(11), 822–829. https://doi.org/10.7326/0003-4819-131-11-199912070-00004

Brown, J. B., Stewart, M., & Ryan, B. L. (2003). Outcomes of patient-provider interaction. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of Health Communication* (pp. 141–162). Lawrence Erlbaum Associates, Inc.

Bucholtz, M. (2007). Variation in transcription. *Discourse Studies*, *9*(6), 784–808. https://doi.org/10.1177/1461445607082580

Cameron, D. (2000). *Good to talk? Living and working in a communication culture*. Sage Publishing.

Caronia, L. (2019). Following and Analyzing an Artifact: Culture-through-Things. In F. Cooren & F. Malbois (Eds.) *Methodological and Ontological Principles of Observation and Analysis: Following and analyzing Thing and Beings in our Everyday World.* Routledge.

Cegala, D. J., & Lenzmeier Broz, S. (2002). Physician communication skills training: a review of

theoretical backgrounds, objectives and skills. *Medical Education, 36*(11), 1004-1016.

http://dx.doi.org/10.1046/j.1365-2923.2002.01331.x

Committee on Quality of Health Care in America (n.d.). Crossing the quality chasm: a new

health system for the 21st century.

http://www.iom.edu/~/media/Files/Report%20Files/2001/ Crossing-the-Quality-

Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf. Updated 2001.

Accessed 20 Nov 2017

Cooren, F. (2004). Textual agency: How texts do things in organizational settings.

Organization, *11*(3), 373-393. https://doi.org/10.1177/1350508404041998

Cooren, F. (2018). Materializing Communication: Making the Case for a Relational

Ontology, *Journal of Communication*, *68*(2), 278–288, https://doi.org/10.1093/joc/jqx014

Cooren, F., Kuhn, T., Cornelissen, J. P., & Clark, T. (2011). Communication, Organizing and

Organization: An Overview and Introduction to the Special Issue. *Organization Studies*,

32(9), 1149–1170. https://doi.org/10.1177/0170840611410836

Coupland, J., Robinson, J. D., & Coupland, N. (1994). Frame Negotiation in Doctor-Elderly

Patient Consultations. *Discourse & Society*, *5*(1), 89–124.

https://doi.org/10.1177/0957926594005001005

Craig, R. T. (1999). Communication theory as a field. *Communication Theory, 9*(2), 119–161.

https://doi.org/10.1111/j.1468-2885.1999.tb00355.x

Craig, R. T. (2008). The rhetoric of "dialogue" in metadiscourse: Possibility/impossibility

arguments and critical events. In E. Weigand (Ed.), *Dialogue and rhetoric* (pp. 55–67). John

Benjamins. https://doi.org/10.1075/ds.2.06cra

Craig, R.T. (2015). The Constitutive Metamodel: A 16-year Review. *Communication Theory, 25,* 356-374. https://doi.org/10.1111/comt.12076

Craig, R.T. (2016) Metacommunication. In K.B. Jensen & R.T. Craig (Eds.) *The International Encyclopedia of Communication Theory and Philosophy.* Wiley & Sons. https://doi.org/10.1002/9781118766804.wbiect232

Craig, R.T. (2008). Metadiscourse. In W. Donsbach (Ed.), *The International Encyclopedia of Communication.* Blackwell. https://doi.org/10.1002/9781405186407.wbiecm078

Craig, R.T. & Tracy, K. (2014). Building Grounded Practical Theory in Applied Communication Research: Introduction to the Special Issue. *Journal of Applied Communication Research*, *42*(3), 229-243. https://doi.org/10.1080/00909882.2014.916410

Dance, F. E . X. (1967) Speech Communication Research in the Soviet Union. In L. Thayer (ed.) Communication: Theory and Research, pp. 273–288. Charles C. Thomas.

de la Croix, A., & Skelton, J. (2009). The reality of role-play: Interruptions and amount of talk in simulated consultations. *Medical Education*, *43*(7), 695–703. http://dx.doi.org/10.1111/j.1365-2923.2009.03392.x

de la Croix, A. & Skeleton, J. (2013). The Simulation Game: An analysis of interactions between students and simulated patients. *Medical Education, 47*(1)*,* 49-58. https://doi.org/10.1111/medu.12064

de la Croix, A., Veen, M. (2018) The reflective zombie: Problematizing the conceptual framework of reflection in medical education. *Perspectives in Medical Education, 7,* 394–400. https://doi.org/10.1007/s40037-018-0479-9

De Swaan, A. (1990). *The management of normality: Critical essays in health and welfare.* Routledge.

Duffy, F.D., Gordon, G.H., Whelan, G., Cole-Kelly, K., & Frankel, R. (2004). Assessing
Competence in Communication and Interpersonal Skills: The Kalamazoo II Report.
Academic Medicine, 79(6), 495-507. http://dx.doi.org/10.1097/00001888-200406000-
00002

Eagles J.M., Calder S.A., Nicoll K.S., & Walker L.G. (2001). A comparison of real patients,
simulated patients and videotaped interview in teaching medical students about alcohol
misuse. *Medical Teacher, 5,* 490–493. https://doi.org/10.1080/01421590120075733

Edwards, D. (1995). Sacks and Psychology. *Theory & Psychology, 5*(4), 579–596.
https://doi.org/10.1177/0959354395054006

Englar, R. (2017). A Novel Approach to Simulation-Based Education for Veterinary Medical
Communication Training Over Eight Consecutive Pre-Clinical Quarters. *Journal of
Veterinary Medical Education, 44*(3), 502-522. https://doi.org/10.3138/jvme.0716-118R1

Epstein, R.M. & Street, R.L. (2007). Patient Centered Communication in Cancer Care:
Promoting Health and Reducing Suffering. *National Cancer Institute, NIH Publication*
No. 07-6225. https://cancercontrol.cancer.gov/brp/docs/pcc_monograph.pdf

Epstein, R.M. & Street, R.L. (2011). The Values and Value of Patient-Centered Care. *Annals of
Family Medicine 9*(2), 100-103. https://doi.org/10.1370/afm.1239.

Fairclough, N. (2013). *Language and Power.* (Originally Published in 1989) Longman.
http://dx.doi.org/10.4324/9781315838250

Fairclough, N. (2010). *Critical Discourse Analysis: The Critical Study of Language.* Longman.

Federation of State Medical Boards of the United States & the National Board of Medical
Examiners (2017) *Content Description and General Information: Step 2 Clinical Skills
(CS).* Retrieved from http://www.usmle.org/pdfs/step-2-cs/cs-info-manual.pdf

Feeley, T.H., Anker, A.E., Sorinio, R., Friedman, E. (2010) Using Standardized Patients to

Educate Medical Students about Organ Donation. *Communication Education, 59*(3), 249-

263. https://doi.org/10.1080/03634521003628289

Flexner, A. (1910). *Medical Education in the United States and Canada Bulletin Number Four*

(The Flexner Report). Carnegie Bulletin.

http://archive.carnegiefoundation.org/pdfs/elibrary/Carnegie_Flexner_Report.pdf

Flowerdew, L. (2004). The argument for using English specialized corpora to understand

academic and professional language. *Discourse in the professions: Perspectives from*

corpus linguistics, 11-33. http://dx.doi.org/10.1075/scl.16.02flo

Forbes, S. (2015). Measuring disability: The agency of an attention deficit/hyperactivity disorder

diagnostic questionnaire. *Discourse Studies*, *17*(1), 25–40.

https://doi.org/10.1177/1461445614557759

Frankel, R. M. (2004). Relationship-centered care and the patient-physician relationship. *Journal*

of general internal medicine, *19*(11), 1163-1165. http://dx.doi.org/10.1111/j.1525-

1497.2004.40901.x

Galasiński, D. (2008). Constructions of the self in interaction with the Beck Depression

Inventory. *Health, 12*(4), 515–533. https://doi.org/10.1177/1363459308094423

Garfinkel, H. (1967). *Studies in Ethnomethodology.* Polity Press.

Gee, J. P. (2015). Discourse, small d, big D. In K. Tracy, C. Ilie, and T. Sandel (Eds.), *The*

International Encyclopedia of Language and Social Interaction, (pp. 1-5). Wiley-

Blackwell. https:/doi.org/10.1002/9781118611463.wbielsi016

Gill, V. T., & Maynard, D. W. (2006). Explaining illness: Patients' proposals and physicians'

responses. *Studies in Interactional Sociolinguistics*, *20*, 115.

http://dx.doi.org/10.1017/CBO9780511607172.007

Goffman, E. (1959). *The Presentation of Self in Everyday Life.* Doubleday.

Goffman, E. (1961). Asylums: Essays on the social situation of mental patients and other

inmates. New York: Bantam Doubleday Dell Publishing Group.

http://dx.doi.org/10.4324/9781351327763

Goffman, E. (1967). *Interaction ritual: Essays on face-to-face behavior*. Doubleday.

http://dx.doi.org/10.4324/9780203788387

Goffman, E. (1974). *Frame analysis: An essay on the organization of experience.* Harvard

University Press.

Goffman, E. (1981). *Forms of Talk.* University of Pennsylvania Press.

Goffman, E. (1983). The Interaction Order: American Sociological Association, 1982

Presidential Address. *American Sociological Review, 48*(1), 1-17. Retrieved March 1,

2020, from www.jstor.org/stable/2095141

Greer, T., Bussinguer, V., Andrade, S., Butterfield, J., & Mischinger, A. (2009). Receipt through

repetition. *JALT Journal, 31*(1), https://doi.org/10.37546/JALTJJ31.1

Grice, P. (1975). Logic and conversation. In P. Cole and J. Morgan (Eds.), *Syntax and

semantics, Volume 3: Speech Acts*. Academic Press.

http://dx.doi.org/10.1163/9789004368811_003

Gumperz, J.J. (1982). *Discourse Strategies.* Cambridge University Press.

http://dx.doi.org/10.1017/CBO9780511611834

Gumperz, J.J. (1992). Contextualization and Understanding. In A. Duranti & C. Goodwin (Eds.) *Rethinking context: Language as Interactive Phenomenon.* (pp. 229-252). Cambridge University Press.

Hak, T. & de Boer, F. (1994). Formulations in First Encounters. *Journal of Pragmatics 25*(1), 83-99. https://doi.org/10.1016/0378-2166(94)00076-7

Halliday, M. A. K., & Martin, J. R. (1993). General orientation. In M.A.K. Halliday & J.R. Martin (Eds.) *Writing science: Literacy and discursive power*, 2-24. University of Pittsburgh Press.

Heath, C. (1981). The opening sequence in doctor-patient interaction. In P. Atkinson & C. Heath (Eds.) *Medical work: Realities and routines*, (pp. 71-90). Gower.

Heath, C. (1986). *Body movement and speech in medical interaction.* Cambridge University Press. http://dx.doi.org/10.1017/CBO9780511628221

Heller, A. (2016). *Everyday Life.* Routledge. (Originally Published in 1984) http://dx.doi.org/10.4324/9781315682495

Heritage, J. (1998). Oh-prefaced responses to inquiry. *Language in Society, 27*(3), 291-334. https://doi.org/10.1017/S0047404500019990

Heritage, J. (2015). *Well*-prefaced Turns in English conversation: A conversation analytic perspective. *Journal of Pragmatics (88),* 88-104. https://doi.org/10.1016/j.pragma.2015.08.008

Heritage, J. & Maynard, D. (2006). *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge University Press. http://dx.doi.org/10.1017/CBO9780511607172

Heritage, J., & Robinson, J. D. (2006). The structure of patients' presenting concerns: physicians' opening questions. *Health communication*, *19*(2), 89-102. http://dx.doi.org/10.1207/s15327027hc1902_1

Heritage, J., & Robinson, J. D. (2011). 'Some'versus 'any'medical issues: Encouraging patients to reveal their unmet concerns. In *Applied conversation analysis* (pp. 15-31). Palgrave Macmillan.

Hoppe, R. B., King, A. M., Mazor, K. M., Furman, G. E., Wick-Garcia, P., Corcoran-Ponisciak, H., & Katsufrakis, P. J. (2013). Enhancement of the assessment of physician-patient communication skills in the United States Medical Licensing Examination. *Academic Medicine*, *88*(11), 1670–1675. https://doi.org/10.1097/ACM.0b013e3182a7f75a

Hulsman, R. L., & Visser, A. (2013). Seven challenges in communication training: Learning from research. *Patient Education and Counseling, 90*(2), 145-146. http://dx.doi.org/10.1016/j.pec.2012.12.005

Iedema, R. (2011). Discourse studies in the 21st century: A response to Mats Alvesson and Dan Kärreman's "Decolonializing discourse." *Human Relations, 64*(9), 1163–1176. https://doi.org/10.1177/0018726711408365

Iedema, R., Hor, S., Wyer, M., Gilbert, G. L., Jorm, C., Hooker, C., & O'Sullivan, M. (2015). An innovative approach to strengthening health professionals' infection control and limiting hospital-acquired infection: video-reflexive ethnography. *British Medical Journal: Innovation, (1),* pp. 157-162.

Irby, D. M., & Hamstra, S. J. (2016). Parting the Clouds. *Academic Medicine, XX*(X), 1. https://doi.org/10.1097/ACM.0000000000001190

Jamison, L. (2014.) *The Empathy Exams: Essays*. Macmillan.

Jenkins, L., Cosgrove, J., Ekberg, K., Khedar, A., Sokhi, D. & Reuber, M. (2015). A brief

    conversation analytic communication intervention can change history taking in the

    seizure clinic. *Epilepsy behavior*, 52, 62-67. https://doi.org/10.1016/j.yebeh.2015.08.022

Jones, R. (2016). *Spoken Discourse*. Bloomsbury.

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://dx.doi.org/10.4300/JGME-D-10-00024.1

Kaplonyi, J., Bowles, K. A., Nestel, D., Kiegaldie, D., Maloney, S., Haines, T., & Williams, C.

    (2017). Understanding the impact of simulated patients on health care learners'

    communication skills: a systematic review. *Medical education*, *51*(12), 1209-1219.

    http://dx.doi.org/10.1111/medu.13387

Katriel, T., & Philipsen, G. (1981). "What we need is communication": "Communication" as a

    cultural category in some American speech. *Communication Monographs, 48,* 301–317.

    https://doi.org/10.1080/03637758109376064

King, A. & Hoppe, R.B. (2013). "Best Practice" for Patient-Centered Communication: A

    Narrative Review. *Journal of Graduate Medical Education, 5*(3), 385-393

    http://dx.doi.org/10.4300/JGME-D-13-00072.1

Koester, A. (2006). *Investigating Workplace Discourse.* Routledge.

    http://dx.doi.org/10.4324/9780203015742

Krippendorff, K. (1993). Major Metaphors of Communication and Some Constructivist

    Reflections on Their Use. *Cybernetics & Human Knowing, 2* (1), 3-25.

    https://repository.upenn.edu/asc_papers/84/

Krippendorff, K. (1997). Seeing Oneself Through the Eyes of Another in Social Inquiry. In M. Huspek & G.P. Radford (Eds.) *Transgressing Discourses: Communication and the Voice of Other*. (pp. 47-72). SUNY Press.

Krippendorff, K. (2017) Three concepts to retire, *Annals of the International Communication Association, 41*(1), 92-99. https://doi.org/10.1080/23808985.2017.1291281

Kruijver, I. P., Kerkstra, A., Bensing, J. M., & Van De Wiel, H. B. (2001). Communication skills of nurses during interactions with simulated cancer patients. *Journal of advanced nursing*, *34*(6), 772-779. http://dx.doi.org/10.1046/j.1365-2648.2001.01807.x

Kuhn, T., Ashcraft, K.L., & Cooren, F. (2017). *The work of communication: Relational perspectives on working and organizing in contemporary capitalism*. Routledge. http://dx.doi.org/10.4324/9781315680705

Kurtz S.M. & Silverman J.D. (1996). The Calgary—Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmes. *Medical Education, 30*(2), 83–9. http://dx.doi.org/10.1111/j.1365-2923.1996.tb00724.x

Kurtz, S., Silverman, J., Benson, J., & Draper, J. (2003). Marrying content and process in clinical method teaching: enhancing the Calgary–Cambridge guides. *Academic Medicine*, *78*(8), 802-809. http://dx.doi.org/10.1097/00001888-200308000-00011

Kurtz, S.M., Silverman, J. and Draper, J. (1997). *Teaching and Learning Communication Skills in Medicine*. Radcliffe Medical Press. http://dx.doi.org/10.1201/9781315378398

Labov, W., & Fanshel, D. (1977). *Therapeutic discourse: Psychotherapy as conversation*. Academic Press.

Labov, W. & Waletzky, J. (1967). Narrative analysis. In J. Helm (Eds*.), Essays on the Verbal and Visual Arts*. University of Washington Press. Reprinted in Journal of Narrative and Life History 7:3-38, 1997.

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. https://doi.org/10.1016/j.pec.2007.02.011

Latour, B. & Woolgar, S. (1976). *Laboratory Life: The Construction of Scientific Facts.* Princeton University Press.

Lee, P. (1976). Impositive Speech Acts. *The Ohio State University Working Papers in Linguistics 21*, pp. 98-114.

Lee, D. Y. (2010). What corpora are available. In A. O'Keefe & M. McCarthy (Eds.) *The Routledge handbook of corpus linguistics*, (pp. 107-121). http://dx.doi.org/10.4324/9780203856949.ch9

Levinson, S. (2009). Activity types and language. *Linguistics*, *17*(5-6), 365-400. https://doi.org/10.1515/ling.1979.17.5-6.365

Levinson, W., Lesser, C. S., & Epstein, R. M. (2010). Developing physician communication skills for patient-centered care. *Health Affairs, 29*(7), 1310–1318. https://doi.org/10.1377/hlthaff.2009.0450

Levinson, W., Roter, D., Mullooly, J. P., Dull, V., & Frankel, R. (1997).Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *The Journal of the American Medical Association, 277*(7), 553–559. https://www.ncbi.nlm.nih.gov/pubmed/9032162

Linell, P., & Thunqvist, D. P. (2003). Moving in and out of framings: Activity contexts in talks with young unemployed people within a training project. *Journal of pragmatics*, *35*(3), 409-434. http://dx.doi.org/10.1016/S0378-2166(02)00143-1

Lipkin, M. (2010). The history of communication skills knowledge and training. In D. Kissane, B. Bultz, P. Butow & I. Finlay (Eds.) *Handbook of Communication in Oncology and Palliative Care.* Oxford Scholarship Online. https://doi.org/10.1093/acprof:oso/9780199238361.003.0001

Makoul, G. (2001). Essential elements of communication in medical encounters: The Kalamazoo consensus statement. *Academic Medicine, 76*(4), 390-393. http://dx.doi.org/10.1097/00001888-200104000-00021

Marín-Arrese, J. I. (2011). Epistemic legitimizing strategies, commitment and accountability in discourse. *Discourse Studies, 13*(6), 789–797. https://doi.org/10.1177/1461445611421360c

Maynard, D. W. (2003). *Bad News, Good News: Conversational Order in Everyday Talk and Clinical Settings.* University of Chicago Press.

Mirivel, J. C. (2008). The physical examination in cosmetic surgery: Communication strategies to promote the desirability of surgery. *Health Communication*, *23*(2), 153–170. http://dx.doi.org/10.1080/10410230801968203

Nestel, D., & Bearman, M. (2015). Theory and simulation-based education: definitions, worldviews and applications. *Clinical Simulation in Nursing*, *11*(8), 349-354. http://dx.doi.org/10.1016/j.ecns.2015.05.013

Nestel, D.& Tierney, T. (2007). Role-play for medical students learning about communication:

    Guidelines for maximising benefits. *BMC Medical Education, 7*(3), 1-9.

    https://doi.org/10.1186/1472-6920-7-3

Mishler, E. (1984). *The Discourse of Medicin*e. Ablex

Monrouxe, L. V., Rees, C. E., & Bradley, P. (2009). The Construction of Patients' Involvement

    in Hospital Bedside Teaching Encounters. *Qualitative Health Research, 19*(7), 918–930.

    https://doi.org/10.1177/1049732309338583

Murtagh, G.M. (2015). Simulated interaction and authentic interaction – a place for conversation

    analysis? In D. Nestel & M. Bearman (Eds.) *Simulated Patient Methodology: Theory,*

    Evidence, and Practice. Wiley, 46-53. http://dx.doi.org/10.1002/9781118760673.ch7

Ochs, E. (1979) `Transcription as Theory', in E. Ochs and B.B. Schieffelin (Eds.) *Developmental*

    Pragmatics, (pp. 43-72). New York Academic Press.

Peabody, F. W. (1927). The Care of the Patient. *The Journal of the American Medical*

    Association, 88(12), 877–882. https://doi.org/10.1001/jama.2014.12070

Peters, J.D. (1999). *Speaking into the Air.* University of Chicago Press.

    http://dx.doi.org/10.7208/chicago/9780226922638.001.0001

Peters, G. (2017). Our Miscarriage: Pregnancy Loss and Narrative Entitlement. *Women &*

    Language, 39(2), 71-92.

Pilnick, A., Trusson, D., Beeke, S., O'Brien, R., Goldberg, S., & Harwood, R. H. (2018). Using

    conversation analysis to inform role play and simulated interaction in communications

    skills training for healthcare professionals: identifying avenues for further development

    through a scoping review. *BMC medical education*, *18*(1), 1-10.

    http://dx.doi.org/10.1186/s12909-018-1381-1

Platt, F.W. & Gaspar, D.L., Coulehan, J.L., Fox, L., Adler, A.J. Weston, W.,Stewart, M. (2001). Tell me about yourself: The patient centered interview. *Annals in Internal Medicine 134*(11), 1079-1085. http://dx.doi.org/10.7326/0003-4819-134-11-200106050-00020

Pomerantz, A., & Heritage, J. (2012). Preference. In J. Sidnell & T. Stivers (Eds.), *The Handbook of Conversation Analysis* (pp. 210-228). Wiley-Blackwell Publishing.

Porter, R. (1999). *The Greatest Benefit to Mankind: A medical history of humanity.* Norton & Co.

Potter, J. & Hepburn, A. (2003) "I'm a Bit Concerned"--Early Actions and Psychological Constructions in a Child Protection Helpline. *Research on Language and Social Interaction, 36*(3), 197-240. https://doi.org/10.1207/S15327973RLSI3603_01

Robinson, J.D. (1998). Getting Down to Business: Talk, Gaze, and Body Orientation During Openings of Doctor-Patient Consultations. *Human Communication Research*, 25*(1),* 97–123. https://doi.org/10.1111/j.1468-2958.1998.tb00438.x

Robinson, J.D. (2003) An Interactional Structure of Medical Activities During Acute Visits and Its Implications for Patients' Participation, *Health Communication*, 15*(1),* 27-59. https://doi.org/10.1207/S15327027HC1501_2

Robinson, J.D. (2004). The Sequential Organization of "Explicit" Apologies in Naturally Occurring English. *Research on Language and Social Interaction*, *37*(3), 291-330, https://doi.org/10.1207/s15327973rlsi3703_2

Robinson, J. (2006). Soliciting Patients' Presenting Concerns. In J. Heritage & D. Maynard (Eds.) *Communication in Medical Care: Interaction between primary care physicians*

and patients, (pp. 48-85). Cambridge University Press.

    http://dx.doi.org/10.1017/CBO9780511607172.004

Roberts, C., Atkins, S., & Hawthorne, K. (2014). *Performance features in clinical skills*

    assessment: Linguistic and cultural factors in the Membership of the Royal College of

    General Practitioners examination. Centre for Language, Discourse & Communication,

    King's College: England.

Roberts, C., & Sarangi, S. (1999). Hybridity in gatekeeping discourse: Issues of practical

    relevance for the researcher. *Talk, work and institutional order: Discourse in medical,*

    mediation and management settings, 473-504.

    http://dx.doi.org/10.1515/9783110208375.4.473

Roberts, C., & Sarangi, S. (2002). Mapping and assessing medical students' interactional

    involvement styles with patients. *Unity and diversity in language use*, 99-117.

Roberts, C., Wass, V., Jones, R., Sarangi, S., & Gillet, A. (2003). A discourse analysis of 'good'

    and 'poor' communication in an OSCE: A proposed new framework for teaching

    students. *Medical Education, 37*(3), 192-202. https://doi.org/10.1046/j.1365-

    2923.2003.01443.x

Rose, D. (2013). Genre in the Sydney school. In J.P. Gee & M. Handford (Eds.) *The Routledge*

    Handbook of Discourse Analysis (pp. 235-251). Routledge.

    http://dx.doi.org/10.4324/9780203809068.ch15

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. http://dx.doi.org/10.1097/00001888-200108000-00023

Ruesch, J.,&Bateson,G. (1968). *Communication: The social matrix of psychiatry*. Norton.

(Original Work Published 1951). http://dx.doi.org/10.4324/9781315080932

Sacks, H. (1985). Notes on methodology. In J.M. Atkinson (Ed.) *Structures of Social Action:*

Studies in Conversation Analysis (pp. 21-27). Cambridge University Press.

http://dx.doi.org/10.1017/CBO9780511665868.005

Sacks, H. (1995). *Lectures on Conversation: Volumes I and II* (G. Jefferson and E. Schegloff,

Eds.). Blackwell Publishing. http://dx.doi.org/10.1002/9781444328301

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization

of turn taking for conversation. In *Studies in the organization of conversational*

interaction (pp. 7-55). Academic Press. http://dx.doi.org/10.2307/412243

Sarangi, S. (2010). Healthcare interaction as an expert communicative system: An activity

analysis perspective. In. J. Streeck (Ed.) *New Adventures in Language and Social*

Interaction. (pp. 167-198). John Benjamins Publishing Company.

Schatzki, T.R. (2001). Introduction: Practice Theory. In T.R. Schatzki, K. Knorr & E. von

Savigny (Eds.), *The Practice Turn in Contemporary Theory,* (pp. 10-23). Routledge.

Schiffrin, D. (1987). *Discourse markers*. Cambridge University Press.

http://dx.doi.org/10.1017/CBO9780511611841

Schegloff, E. A. (1998). Reply to Wetherell. *Discourse & Society*, *9*(3), 413-416.

http://dx.doi.org/10.1177/0957926598009003006

Schegloff, E. A. (1999). Schegloff's texts 'as Billig's data': A critical reply. *Discourse &*

Society, *10*(4), 558-572. http://dx.doi.org/10.1177/0957926599010004006

Schiffrin, D. (2001). Discourse Markers: Languge, Meaning, and Context. In D. Schiffrin, D.

Tannen & H.E. Hamilton (Eds.) *The Handbook of Discourse Analysis* (pp. 54-75). Wiley.

Seale, C., Butler, C.C., Hutchby, I., Kinnersley, P., & Rollnick, S. (2007). Negotiating frame ambiguity: a study of simulated encounters in medical education. *Communication in Medicine*, *4*(2), 177–187. http://dx.doi.org/10.1515/CAM.2007.021

Sigman, S. J. (1995). *The consequentiality of communication*. Psychology Press.

Smith, D. (2001). Texts and the ontology of organizations and institutions. *Studies in Cultures, Organizations and Societies, 7*(2), 159-198. https://doi.org/10.1080/10245280108523557

Smith, D. (2005) *Institutional Ethnography: A sociology for people*. Landham, MD: AltaMira.

Starr, P. (1982/ 2017). *The Social Transformation of American Medicine.* Basic Books.

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *Canadian Medical Association Journal, 152(*9), 1423. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1337906/

Stivers, T. (2002). Participating in decisions about treatment: Overt parent pressure for antibiotic medication in pediatric encounters. *Social science & medicine*, *54*(7), 1111-1130. http://dx.doi.org/10.1016/S0277-9536(01)00085-5

Stivers, T. (2005). Parent resistance to physicians' treatment recommendations: one resource for initiating a negotiation of the treatment decision. *Health Communication*, *18*(1), 41-74. http://dx.doi.org/10.1207/s15327027hc1801_3

Stivers, T. (2005). Modified Repeats: One Method for Asserting Primary Rights From Second Position. *Research on Language and Social Interaction, 38*(2), 131-158, https://doi.org/10.1207/s15327973rlsi3802_1

Stokoe, E. (2011). Simulated interaction and communication skills training: The "Conversation Analytic Role-play Method*.* In C. Antaki (Ed.) *Applied conversation analysis: Changing institutional practices* (pp. 119-139). Palgrave Macmillan.

Stokoe, E. (2013). The (in) authenticity of simulated talk: comparing role-played and actual interaction and the implications for communication training. *Research on Language and Social Interaction* (46)2, 165–85. https://doi.org/10.1080/08351813.2013.780341

Streeck, J., & Mehus, S. (2005). Microethnography: The study of practices. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of language and social interaction* (pp. 381–404). Lawrence Erlbaum Associates, Inc.

Stubbe, M., Lane, C., Hidler, J., Vine, E., Vine, B., Marra, M., Holmes, J., & Weatherall, A. (2003). Multiple discourse analyses of a workplace interaction. *Discourse Studies, 5*(3), 351-388. http://dx.doi.org/10.1177/14614456030053004

Suchman, A. L. (2005). The current state of the biopsychosocial approach. *Families, Systems, & Health*, *23*(4), 450. http://dx.doi.org/10.1037/1091-7527.23.4.450

Swales, J. (1990). *Genre analysis: English in academic and research settings*. Cambridge University Press.

Tannen, D., & Wallat, C. (1987). Interactive Frames and Knowledge Schemas in Interaction: Examples from a Medical Examination/Interview. *Social Psychology Quarterly, 50*(2), 205-216. www.jstor.org/stable/2786752

Taylor, T.J. (1992). *Mutual Misunderstanding: Skepticism and Theorizing of Language and Interpretation.* Duke University Press. http://dx.doi.org/10.1215/9780822383000

Thompson, L., & McCabe, R. (2016). 'Good 'communication in schizophrenia: a conversation analytic definition. In M. O'Reilly, M. Lester, & J. Nina (Eds.) *The Palgrave Handbook of Adult Mental Health* (pp. 394-418). Palgrave Macmillan.

Tottie, G. (2015). Turn management and the fillers *uh* and *um*. In K. Aijmer & C. Rühlemann (Eds.) *Corpus Pragmatics*. Cambridge University Press.

Tracy, K. (1995). Action-Implicative Discourse Analysis. Journal of Language and Social

      Psychology, 14(1–2), 195–215. https://doi.org/10.1177/0261927X95141011

Tracy, K. (2005). Reconstructing communicative practices: Action-implicative discourse

      analysis. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of language and social*

      interaction (pp. 301–322). Lawrence Erlbaum Associates.

Tracy, K. (2015). Discourse Analysis in Communication. In D. Schiffrin, D. Tannen & H.E.

      Hamilton (Eds.) *The Handbook of Discourse Analysis.* (pp. 725 -749).

      http://dx.doi.org/10.1002/9780470753460.ch38

Tribble, C. (2002) 'Corpora and corpus analysis: new windows on academic writing', in J.

      Flowerdew (Ed.) *Academic Discourse*, (pp. 131–149). Longman.

Tracy, K., & Craig, R. T. (2010). Studying interaction in order to cultivate communicative

      practices: Action-implicative discourse analysis. In J. Streeck (Ed.), *New adventures in*

      language and interaction (pp. 145–165). John Benjamins.

Turner, V.W. (1967). Betwixt and between: The liminal period. In V. Turner (Ed.) *Rites de*

      passage. In *The forest of symbols: Aspects of Ndembu ritual* (pp. 93–111). Cornell

      University Press.

Van Hasselt, V. B., Romano, S. J., & Vecchi, G. M. (2008). Role playing: Applications in

      hostage and crisis negotiation skills training. *Behavior modification*, *32*(2), 248-263.

      http://dx.doi.org/10.1177/0145445507308281

Vásquez, C. (2014). *The discourse of online consumer reviews*. Bloomsbury Publishing.

White, S.J., & Casey, M. (2016.) Understanding Differences between

      Actual and Simulated Surgical Consultations: A Scoping Study, *Australian Journal of*

      Linguistics, 36(2), 257-272. https://doi.org/10.1080/07268602.2015.1121534

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://dx.doi.org/10.1080/01421590500126296

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-

    structuralism in dialogue. *Discourse & Society*, *9*(3), 387-412.

    http://dx.doi.org/10.1177/0957926598009003005

Wittgenstein, L. (2010). Philosophical Investigations. (G.E.M. Anscombe, P.M.S. Hacker and

    Joachim Schute, Trans.). (Originally Published in 1953). Wiley Blackwell Publishing.

Zayyan, M. (2011). Objective Structured Clinical Examination: The Assessment of Choice.

    Oman Medical Journal 26(4), 219-222 https://doi.org/10.5001/omj.2011.55

Zoppi, K., & Epstein, R. M. (2002). Is Communication a Skill? Communication Behaviors and

    Being in Relation. *Family Medicine*, *34*(5), 319-24.

APPENDICES

Appendix A: Letter from the Institutional Review Board

December 21, 2017

Grace Peters,
Communication
Tampa, FL 33612

RE: **Expedited Approval for Initial Review**
IRB#:   Pro00032331
Title: Communication Skills in Medical Education

Study Approval Period: 12/21/2017 to 12/21/2018

Dear Dr. Peters:

On 12/21/2017, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents contained within, including those outlined below.

 Approved Item(s):
 Protocol Document(s):
  CSME.12202017.v1.docx

 Consent/Assent Document(s)*:
  Informed Consent Form.docx.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110. The research proposed in this study is categorized under the following expedited review category:

(5) Research involving materials (data, documents, records, or specimens) that have been

collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board

Appendix B: Informed Consent Form

Informed Consent to Participate in Research Involving Minimal Risk

Pro # 00032331

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:
Communication Skills in Medical Education
The person who is in charge of this research study is Grace Peters. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. She is being guided in this research by Mariaelena Bartesaghi, Ph.D..

The research will be conducted at the Morsani College of Medicine's Clinical Skills Education Center at the Center for Advanced Medical Learning and Simulation.

Purpose of the study

The purpose of the study is to examine how "communication skills" are taught at the Morsani College of Medicine. The PI is analyzing everyday educational processes, including Medical Student- Standardized Patient encounters, written and verbal feedback from Standardized Patients and Preceptors.

Why are you being asked to take part?

We are asking you to take part in this research study because you are part of everyday educational processes, either as a medical student, preceptor, standardized patient, faculty, or staff member of the Clinical Skills Education Center.

Study Procedures:

If you take part in this study, you will be asked to:

- Permit review of audiovisual recordings of past, current and future standardized patient- medical student simulated encounters, which are part of regular educational activities.
- Permit examination of standardized patient and preceptor evaluation checklists, which are ungraded forms completed as part of regular educational activities.
- Participate in audiovisual recordings of post-encounter verbal feedback sessions, which are completed as part of regular educational activities.
- Recognize all audiovisual recordings take place as part of ungraded Clinical Skills Education Center activities at the Center for Advanced Medical Learning and Simulation.
- Participation in the data collection will continue until December 2019.
- All recordings and data will be maintained on a password-protected online database, which can be accessed by the PI, Grace Peters, and the research guide, Dr. Mariaelena Bartesaghi.
- Following the completion of the study, tapes will be destroyed 5 years after the Final Report of submitted to the IRB.

Total Number of Participants

About 900 individuals will take part in this study at USF, including medical students, preceptors, standardized patients, and CSEC faculty and staff.

Alternatives / Voluntary Participation / Withdrawal

You do not have to participate in this research study.

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study. Your decision to participate or not to participate will not affect your job status, employment record, employee evaluations, or advancement opportunities. Your decision to participate or not to participate will not affect your student status, course grade, recommendations, or access to future courses or training opportunities.

Benefits

You will receive no benefit(s) by participating in this research study.

Risks or Discomfort

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation

You will receive no payment or other compensation for taking part in this study.

Costs

It will not cost you anything to take part in the study.

Conflict of Interest Statement

The PI Reports no Conflict of Interest in the completion of this study.

Privacy and Confidentiality

We will keep your study records private and confidential. Certain people may need to see your study records. Anyone who looks at your records must keep them confidential. These individuals include:

- The research team, including the Principal Investigator, study coordinator, research nurses, and all other research staff.

- Certain government and university people who need to know more about the study, and individuals who provide oversight to ensure that we are doing the study in the right way.

- Any agency of the federal, state, or local government that regulates this research.

- The USF Institutional Review Board (IRB) and related staff who have oversight responsibilities for this study, including staff in USF Research Integrity and Compliance.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

You can get the answers to your questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, or experience an unanticipated problem, call Grace Peters at 813-974-2145.

If you have questions about your rights as a participant in this study, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638 or contact by email at RSCH-IRB@usf.edu.

Consent to Take Part in this Research Study

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

_____   _____

Signature of Person Taking Part in Study   Date

_____

Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in their primary language. This research subject has provided legally effective informed consent.

_____
_____

Signature of Person Obtaining Informed Consent   Date

_____

Printed Name of Person Obtaining Informed Consent

Appendix C: Transcription Notation

Table C1. Notation Symbols & Meanings	
(.)	Pause, like a breath
(.5), (1.0), (1.5)	Length of pauses, in seconds
[word [word	Overlapping speech
wo:rd	Speaker elongates the sound preceding the colon
word, WORD	Louder and even louder speech, respectively
°word°	Word is whispered
wor-	Abrupt stop
(word)	Unclear speech; analyst's best guess at what was said
((nonverbal))	Notes gestures, laughter, embodied activities
word= =word	Latching, or no pause between speaker turns

Appendix D: Contextual and Linguistic Analysis of CSPX Scripts

Table D1. Tribble's (2002) Analytical Framework	
Contextual Analysis	
1. Name	What is the name of the genre of which this text is an exemplar?
2. Social Context	In what social setting is this kind of text typically produced? What constraints and obligations does it impose on writers and readers?
3. Communicative Purpose	What is the communicative purpose of this text?
4. Roles	What roles may be required of writers and readers in this genre?
5. Cultural Values	What shared cultural values may be required of writers and readers in this genre?
6. Text Context	What knowledge of other texts may be required of writers and readers in this genre?
7. Formal Text Features	What shared knowledge of formal text features (conventions) is required to write effectively in this genre?
Linguistic Analysis	
8. Lexico-grammatical features	What lexico-grammatical features of the text are statistically prominent and stylistically salient?
9. Text relations/ Textual Patterning	Can textual patterns be identified in the text? What is the reason for such textual patterning?
10. Text Structure	How is the text organized as a series of units of meaning? What is the reason for this organization?

Table D2. Tribble's Framework Applied to CSPX Scripts	
Name *What is the name of the genre which this text is an exemplar?*	The Script as CSLC is called a *Script* or a *Case*. Specific Scripts are referred to by the name of the patient, for instance, *Jason Hartman* or simply *Hartman.* In conversations among CSLC staff and SPs, Scripts will be referred to by the diagnosis, like "the sore throat case." The Scripts designed for CSPX are exemplary of the genre since the activity they direct is designed to prepare third-year medical students for their Step 2 Clinical Skills licensing examination, one of the most critical exams MSs take.
Social Context *In what social setting is this kind of text typically produced? What obligations and constraints does this setting impose on its readers?*	The Script is produced for all communication skills activities at CSLC and is a common feature of communication skills practices in medical education. The text recruits readers to portray patients and the obligation of Scripts for SPs is that they will memorize the information to perform it accurately in simulated consultations.
Communicative Purpose *What is the communicative purpose of this text?*	Scripts orient simulated patients to the patients they are to portray, including what they say in response to certain questions and how they respond.
Roles *What roles may be required of writers and readers in this genre?*	The readers and writers of this document are institutional parties enacting communication skills practices as part of their job. Writers may be physicians, medical educators, or CSLC Staff, while readers are simulated patients.
Cultural Values *What shared cultural values may be required of writers and readers of this genre?*	Writers and readers of this genre must share a cultural understanding of what communication skills activities claim to do– teach and assess communication skills competency.
Text Context *What knowledge of other texts may be required of writers or readers of this genre?*	Writers are familiar with the broader discourse of communication skills in medical education (i.e., the Calgary-Cambridge Model or Kalamazoo II), as well as medical questioning and diagnostic practices. Readers participate in this discourse by reading it and through enacting the texts in simulated consultations.
Formal Text Features *What shared knowledge of formal text features (conventions)is required to write effectively into this genre?*	Scripts are based on actual or imagined patient cases and require the writer to have knowledge of a typical primary care interaction as well as a framework for a patient based on their performance in a consultation.

Table D3. Case and Script Subheadings
Case Subheadings
Case Chief Complaint
Case Name
Presenting Situation
Keyword Description
Differential Diagnosis
Actual Diagnosis
Designed For
Script Subheadings
Gender
Age
Race
Socioeconomic
Patient Characteristics
History of Present Illness (HPI)
Past Medical History (PMH)
Family History (FH)
Social History (SH)
Review of Systems (ROS)
Questions You Can Ask the Learner
Physical Examination
Props

Table D4. Questioning and Answering Types			
Physician Question + Question Type	**Patient Response + Answer Type**	**Case**	**Inconsistencies**
What brings you in today? **[Direct Open-Ended]**		**Adams, Hartman, Langley, Romano, Shuster, Wheeler**	
	My voice has been hoarse for several months now. I think it's getting worse [Epistemic Responses]	Adams	
	Sore Throat [Short Responses]	Hartman	Shorter answer than other Scripts with similar opening question
	I feel tired and weak I don't feel like I have much energy [Epistemic Responses]	Langley	
	It was quite scary when this morning I woke up and peed blood, it was red with clots [Epistemic Responses]	Romano	
	My daughter/son is concerned about my drinking, and they brought me here. They are out in the waiting room. [Account Responses]	Shuster	The patient accounts for a family member's concern as the reason for visiting the doctor.
	I have been sweating every night, to the point where my clothes, and the bed are wet. [Account Responses]	Wheeler	
What's going on with [name]? **[Indirect Open-Ended]**		**Mateese**	
	A fever [Short Responses]	Mateese	Strikingly less information, no account given

Table D4. (Continued)			
When did this pain begin/ When did it start? **[Indirect Closed-Ended]**		**Daniels, Fields, Wright**	
	About 2 weeks ago [Short Responses]	Daneils	
	2 days ago [Short Responses]	Wright	
	The pain started last night, and has been getting progressively worse (about 12 hours ago) [Extended Account]	Fields	More information given than those with similar question forms
When did you first notice the dizziness? When did you first notice this? **[Direct Closed-Ended]**		**O'Conner, Parker**	
	2 days ago [Short Responses]	O'Conner	
	About 1 week ago, I was lifting some heavy boxes at my job [Extended Account]	Parker	Provides an account for unsolicited information

Appendix D5. Hartman Script
VII. **Simulated Patient Case**

Case Chief Complaint: Sore throat

Case Name: Jason Hartman

Presenting Situation: 20 year old college student presents to clinic complaining of sore throat X 3 days

Keyword Description:

Differential Diagnosis:
- Strep throat
- Viral pharyngitis (sore throat)
- Mononucleosis
- Gonococcal pharyngitis

Actual Diagnosis: Streptococcal (strep) throat

Designed For: MS3 Students

VIII. **Simulated Patient Script**

Gender: Male or Female

Age: 20 years

Socioeconomic: Middle-class college student; lives in dorms on campus

Patient Characteristics: Calm, cooperative. Appears ill but not in acute distress. Dressed in clean, comfortable street clothes (college sweatshirt or t-shirt is great).

Opening Statement: "My throat has been sore for 3 days and it is getting worse!" "I have a soccer tournament tomorrow, will I be able to play?"

Question	Patient Response
Chief Complaint What brings you in today	Sore throat
History of Present Illness When did you first notice the sore throat?	3 days ago
Is it getting worse?	Yes it has slowly been getting worse
Can you rate the pain on a scale of 1/10	When it started it was 1 4/10, and now it is a 7/10
What makes it better?	I tried Nyquil OTC, but it didn't really help
What makes it worse?	Swallowing solids makes it worse
Have you ever had a sore throat like this before?	No. The pain is more severe than other times that I have had sore throats.
Do you have any runny nose, cough, congestion?	No
Is anyone ill who you've been exposed to?	No
Does anyone have similar symptoms?	No
Do you have muscle aches?	No
Do you have a rash?	No
Do you have hoarseness?	Yes for the past day
Do you have swollen glands in your neck?	I think I felt some neck lumps
Do you fever? Chills?	I might have a fever, I did not take my temperature. I do not have chills
Have you had mono?	No
Have you ever had strep throat?	No
Do you have nausea, vomiting, diarrhea, or abdominal pain?	No
Past Medical History	

Have you been diagnosed with any medical problems?	No
Have you had any surgeries?	No
Family History: How old are your father and mother?	Mom 45, dad 47; both alive and well
Do you have brothers and sisters?	No
Social History: What kind of work do you do?	I'm a college student, and I'm studying accounting
Do you smoke? At what age did you start smoking and how much do you smoke?	No cigarettes
Do you drink alcohol? How much and how often?	None
Have you used recreational drugs (IV drugs)?	None
Living situation	I have a roommate and live in a college dorm
Diet:	I have a meal plan at college, and try to eat a balanced meal
Recreational activities?	I am on my college soccer team
Are you sexually active?	Yes
Are you sexually active with men, women, both?	Heterosexual only
One partner? Or multiple partners?	Multiple partners in the last 6 months
Do you use protection?	Yes, ==condoms with intercourse==, but unprotected oral sex
When were you most recently sexually active?	Only oral sex within the last 2 weeks
Meds: Do you take any medications? How long?	Only the Nyquil over the counter since my sore throat started
Are you allergic to any medications?	No

Review of Systems: Do you have night sweats, fever, or weight loss?	No night sweats. Yes I think I have had fever but I did not take my temperature. No shaking chills if asked specifically.
Do you have dry mouth, runny nose, sore throat, nasal bleeding, stuffiness, blurry vision, oral sores?	Yes sore throat as above
Do you have skin rashes?	No
Do you have diarrhea, blood in the stools or black stools, nausea, vomiting?	No
Do you have urinary urgency frequency, or blood in the urine?	No
Do you have pain or stiffness in your joints?	No
Do you have intolerance to the heat or cold, Do you have increased thirst?	No
Do you have numbness, tingling, weakness, slurred speech, or seizures?	No
Do you have unusual bruising or bleeding?	No
Do you have depression? Anxiety?	No

Physical examination	
Appearance:	You feel ill, but you are not in acute distress
Skin	No rashes
HEENT	Your anterior (front) neck lymph nodes are swollen, and tender. This will be created by moulage. There is no pain when your neck is flexed (touching chin to chest). The back of your throat is red due to the inflammation. This can be created by sucking a red candy.
Cardiac	Normal
Pulmonary	Normal
Abdomen	Normal

| Musculoskeletal exam, and extremities | Normal |

Associated symptoms: You have been a little hoarse since yesterday and you have also noted the glands in your neck are bigger. You haven't had a cough, no rhinorrhea (runny nose), no myalgias (muscle aches), and no rashes. No significant fatigue. <mark>**Note: You are able to drink fluids okay but cannot tolerate eating solids. It's much harder to swallow because it hurts so much.**</mark>

Important negative symptoms: No cough, no runny nose, no muscle pain/aches, no rashes. No significant fatigue. Note: able to drink fluids OK, cannot tolerate eating solids due to the throat pain.

<mark>**Cards: We do not distribute Cue Cards**</mark>
    <mark>**1. n**</mark>

Pharynx is inflamed and erythematous with white particulate matter in the posterior oropharynx.

    2. <mark>**NO CARDS**</mark>

The neck exam reveals enlarged, mildly tender lymph nodes in the anterior cervical chain bilaterally.

<mark>The remainder of the exam is normal.</mark>

Appendix E: Simulated Consultations Analysis

Table E1. Metadiscursive Strategies in Simulated Consultations		
Metadiscursive Strategy	**Example**	**Implication**
Pre-Openings		
Design of the Clinic Room	Doors to enter and exit the clinic room	Communication skills are observable in the relevant context of the clinic room.
Objects in/out of the Clinic Room	Exam table with paper layer	Communication skills are a temporary phenomenon that occurs with a temporary patient.
Announcements	"Students you may knock and enter"	Communication skills are framed as a student-based activity where students are accountable to what happens.
Door Notes	Patient: Jason Hartman Chief Complaint: Sore Throat	Communication skills occur within the goal of the physician solving a patient's medical problem.
Performing Waiting	Becky takes a deep breath, sits up, and puts on her shoes right after the announcement, "Students you may knock and enter"	Communication skills require a patient to be prepared and waiting for the medical student to initiate the simulated consultation.
Openings/ Introductions		
Introducing "Patients"	Miss Hartman?	Medical students display knowledge of a patient's name.
Introducing "Doctors"	A patient of mine	Medical student's introductions of themselves communicate various degrees of authority and accountability.
Questioning/ Answering		
Opening Questions/ Answers	MS: What's going on? SP: I'm having really bad back- lower back pain MS: Okay I'm sorry about that well (.) right that can be pretty frustrating	Simulated patient complaints can enable or prohibit medical students from performing certain communication skills tasks, evidencing the distributed sense of communication skills.

Table E1. (Continued)		
Self-Initiated Self-Repairs in Simulated Patient Answers	SP: That makes actually sixty	Simulated patients prefer stating correct answers and will break the framing of the consultation to ensure this occurs.
Medical Student Responds to Troubles	MS: Sixty (.) okay (.) I apologize (.) heheheh ummm	Medical students may acknowledge the troubles that occur from simulated patient utterances, which metadiscursively steps out of the simulated consultation and demonstrates a preference for the in-the moment activity.
Medical Student Does Not Respond to Troubles	SP: About three packs- heheh I'm sorry (.) about heh a pack heh a day= MS: =one pack a day? okay	Medical students may not acknowledge the troubles that occur from simulated patient utterances, which moves along the simulated consultation and the goal of demonstrating communication skills.
Simulated Patients Offer Additional Information with a Metadiscursive Cue	SP: I'm a third-year student ((smiles))	Simulated patients may attempt to "go meta" on the simulated consultation by their paralinguistic moves.
Simulated Patients Reward Medical Students Metadiscursive Work	MS: you must be good with numbers SP: Yeah ((laughs))	Simulated patients reward medical students when they extend beyond the questioning of the medical consultation.
Physical Exam		
Clothing v. Patient Gown	MS: Um (3.0) do you mind if I (1.6) press on your belly a little bit and see if I feel anything in your liver?	Plain clothes or the presence of a gown impact how medical students request physical exams, although they strive to complete the physical exam as a way of demonstrating their communication skills.

Table E1. (Continued)		
Moving the Exam Table	SP:°You'll want to get back over there° ((points))	Communication skills are able to occur when objects do what they are supposed to. Simulated patients and medical students work to ensure this occurs.
Pointing to and Touching Bodies	MS: Okay and you're feeling pain over here? SP: Yeah its (.) not as bad but- MS:Okay not as bad	Simulated patients and medical students work to co-produce pain as medically intelligible.
Diagnosis and Treatment		
Transitioning Back	MS: So so is this tender right here?	Medical students work to make performing actions outside of the typical organization they occur in relevant, which often appeals to communication skills.
Medical Students Build a Case for Diagnosis	MS: So uh along with the night sweats and the weight loss. It's a little bit concerning.	Diagnosis involves building the case for a simulated patient based on repeating patient complaints, a performed communication skill that validates the notion of concern and doctorability.
Closing		
Medical Students and Simulated Patients Perform Understanding of Next Actions	MS: Ok don't do any heavy lifting SP: With the note I wont	Stating next actions demonstrates a shared orientation towards the activity as goal oriented.
Medical Students and Simulated Patients Acknowledge the Framing of the Announcement	OH: [Students this marks the end of your encounter (...) SP: [Hehehe thank you MS: [heheh	Participants show an awareness of the temporality of the simulated consultation and the additional goal of displaying communication skills.

Appendix F: Assessment Form Analysis

Table F1. Types of Communication Skills Tasks in the Computerized Assessment Form	
Types of Tasks **(Approximate % of Items)**	**Item Number and Item Description (Excluding Answer Options)** *Italics added to mark distinctions*
Medical Student-Based Tasks (39%)	
(1) Medical Student and Object-Based Tasks (8%)	1. The student *knocked* on the door before entering 24. The student *washed* (or *sanitized*) his/her hands before the physical exam? 26. The student used respectful *draping*?
(2) Medical Student Assertion-Based Tasks (8%)	2. The student *introduced* themself by name (first and last) to me. 3. The student *identified* his/her role or position to me. 5.The student *inquired*/*explained* the purpose of the visit.
(3) Medical Student Question-Based Tasks (23%)	10. The student *asked* me questions in a systematic and efficient method, asking questions that were logical to follow. 18. The student *elicited* the chief complaint. 19. The student *asked* if you have a history of smoking? 20. The student *asked* if you have a history of drinking alcohol? 21. The student *asked* if you have a history of taking recreational drugs? 22. The student *asked* what medications you take? 23. The student *asked* if you had any allergies? 25. The student *asked* permission to start the physical exam? 37. The student *asked* if the you had any additional questions or concerns?

Table F1. (Continued)	
Medical Student and Simulated Patient Tasks (56%)	
(4) Medical Student and Simulated Patient Body-Based Tasks (15%)	6. The student maintained good *eye contact and body language* with me.
	27. The student did not repeat *painful maneuvers* on you when you said it was painful?
	28. The student listened to your *heart* (if applicable)?
	29. The student listened to your *lungs*, (if applicable)?
	30. The student examined your *abdomen* (if applicable)?
	31. The student examined your *extremities* and performed *reflexes* (if applicable)?
(5) Medical Student and Simulated Patient Assertion-Based Tasks (36%)	4. The *student* correctly used the *patient's name*.
	9. The *student summarized my concerns*, often using my own words.
	11. Partnership: The *student worked with you to identify the main concerns* (ie: let's deal with this together,... or we can do this...using these types of sentences)
	12. Empathy: The *student acknowledged and demonstrated understanding of your feelings* (ie: that sounds hard,... or, you look upset...)
	13. Apology: The *student took personal responsibility where appropriate* (ie , ... I'm sorry this happened to *you*)
	14. Respect: The *student valued your choices, behaviors, and decisions,* and was non-judgmental in their discussions with you.
	15. Legitimization: The *student validates and shows understanding for your feelings and choices* (ie., Anyone would be concerned with these symptoms)
	16. Support: The *student offers you support*. (example: I am here to help determine the cause of your symptoms...)
	32. Did the student *request or advise you that they would do any additional pertinent physical exams* that are not appropriate for this particular encounter, but would be applicable to the case that you are playing (i.e., rectal exam, pelvic / bimanual exam, etc.)?
	33. The student *discussed their initial diagnostic impressions with you*.

Table F1. (Continued)	
	34. The student *provided a basic differential diagnosis (or a set of differentials) using terms that made it easy for you to understand*. 35. The student *discussed their initial management plans with you*. 36. The *student mentioned specific tests they would like to have done to get additional information on you*. 38. The *students answered your final questions and/or concerns so you feel comfortable*?
(6) Medical Student and Simulated Patient Question-Based Tasks (5%)	7. The *student asked an open-ended question and actively listened to the response* (i.e.,...can you tell me about...I understand that you are saying...or what happens when...I see, so in other words you mean...)? 8. The *student asked me to list my concerns and listened to the response without interrupting me*.
Simulated Patient Post-Facto Questions (5%)	
(7) Simulated Patient Based-Tasks (5%)	17. Please elaborate your reflections on the student here, discuss what you would have preferred to student to do from a patient's point of view: 39. General Comments: Please state any additional comments you would like to share with the student regarding their encounter with you.

Table F2. Strategies for Regulating Communication Skills Competency in Multiple-Choice Items	
Strategy (Approximate % of Items)	Items Number and Item Description
(1) Extended Questions (26%)	2. The student introduced themself by name (first and last) to me. (Not Done/Done) 9. The student summarized my concerns, often using my own words. (Not Done/Done) 24. The student washed (or sanitized) his/her hands before the physical exam? (Not Done/Done, Not Applicable) 27. The student did not repeat painful maneuvers on you when you said it was painful? (Below Expectations/ Meets Expectations) 28. The student listened to your heart (if applicable)? (Not Done/Done, or not applicable to this case) 29. The student listened to your lugs, (if applicable)? (Not Done/Done, or not applicable to this case) 30. The student examined your abdomen (if applicable)? (Not Done/Done, or not applicable to this case) 31. The student examined your extremities and performed reflexes (if applicable)? (Not Done/Done, or not applicable to this case) 32. Did the student request or advise you that they would do any additional pertinent physical exams that are not appropriate for this particular encounter, but would be applicable to the case that you are playing (i.e., rectal exam, pelvic / bimanual exam, etc.)? (Not Done/Done, or not applicable to this case) 38. The students answered your final questions and/or concerns so you feel comfortable?

Table F2. (Continued)	
Parenthetical Sample Statements (15%)	7. The student asked an open-ended question and actively listened to the response (i.e.,...can you tell me about...I understand that you are saying...or what happens when...I see, so in other words you mean...)? 11. Partnership: The student worked with you to identify the main concerns (ie: let's deal with this together,... or we can do this...using these types of sentences) 12. Empathy: The student acknowledged and demonstrated understanding of your feelings (ie: that sounds hard,... or, you look upset...) 13. Apology: The student took personal responsibility where appropriate (ie , ... I'm sorry this happened to you) 15. Legitimization: The student validates and shows understanding for your feelings and choices (ie., Anyone would be concerned with these symptoms) 16. Support: The student offers you support. (example: I am here to help determine the cause of your symptoms...)
Qualified Answers (15%)	6. The student maintained good eye contact and body language with me. 8. The student asked me to list my concerns and listened to the response without interrupting me. 10. The student asked me questions in a systematic and efficient method, asking questions that were logical to follow. 14. Respect: The student valued your choices, behaviors, and decisions, and was non-judgmental in their discussions with you. 26. The student used respectful draping? 34. The student provided a basic differential diagnosis (or a set of differentials) using terms that made it easy for you to understand.

Table F2. (Continued)	
Unqualified Items (38%)	1. The student knocked on the door before entering
	3. The student identified his/her role or position to me.
	4. The student correctly used the patient's name.
	5. The student inquired/explained the purpose of the visit.
	18. The student elicited the chief complaint.
	19. The student asked if you have a history of smoking?
	20. The student asked if you have a history of drinking alcohol?
	21. The student asked if you have a history of taking recreational drugs?
	22. The student asked what medications you take?
	23. The student asked if you had any allergies?
	25. The student asked permission to start the physical exam?
	33. The student discussed their initial diagnostic impressions with you.
	35. The student discussed their initial management plans with you.
	36. The student mentioned specific tests they would like to have done to get additional information on you.
	37. The student asked if the you had any additional questions or concerns?
Open-Ended Items (5%)	17. Please elaborate your reflections on the student here, discuss what you would have preferred to student to do from a patient's point of view:
	39. General Comments: Please state any additional comments you would like to share with the student regarding their encounter with you.

Table F3. Types of Answer Forms in Multiple-Choice Items	
Answer Format (Approximate % of Items)	Item Number, Item Description, and Answer
Not Done/ Done (70%)	1. The student knocked on the door before entering. Not done Done 2. The student introduced themself by name (first and last) to me. Not done Done 3. The student identified his/her role or position to me. Not done Done 4. The student correctly used patient' s name. Not done Done 5. The student inquired/explained the purpose of the visit. Not done Done 7. The student asked an open-ended question and actively listened to the response, (i.e., ...can you tell me about...I understand that you are saying..., or what happens when... I see, so in other words you mean...)? Not done Done

Table F3. (Continued)	

	9. The student summarized my concerns, often using my own words.
	
	    Not done
	
	    Done
	
	11. Partnership: The student worked with you to identify the main concerns (ie: let's deal with this together, ...or we can do this...using these types of sentences)
	
	    Not done
	
	    Done, or not applicable.
	
	12. Apology: The student took personal responsibility where appropriate (ie. , .. I'm sorry this happened to you)
	
	    Not done
	
	    Done (or not applicable)
	
	15. Legitimization: The student validates and shows understanding for your feelings and choices (ie., Anyone would be concerned with these symptoms)
	
	    Not done
	
	    Done, or not applicable
	
	18. The student elicited the chief complaint.
	
	    Not done
	
	    Done
	
	19. The student asked if you have a history of smoking?
	
	    Not done
	
	    Done, or not applicable

Table F3. (Continued)	

	21. The student asked if you have a history of taking recreational drugs?
	
	    Not done
	
	    Done, or if not applicable
	
	22. The student asked what medications you take?
	
	    Not done
	
	    Done, or not applicable
	
	23. The student asked if you had any allergies?
	
	    Not done
	
	    Done, or not applicable
	
	24. The student washed (or sanitized) his/her hands before the physical exam?
	
	    Not done
	
	    Done, or not applicable
	
	25. The student asked permission to start the physical exam?
	
	    Not done
	
	    Done, or not applicable
	
	27. The student listened to your heart (if applicable)?
	
	    Not done
	
	    Done, or not applicable to this case.

Table F3. (Continued)	
	29. The student examined your abdomen (if applicable)?
	Not Done
	Done, or not applicable to this case.
	32. Did the student request or advise you that they would do any additional pertinent physical exams that are not appropriate for this particular encounter, but would be applicable to the case that you are playing (i.e., rectal exam, pelvic / bimanual exam, etc.)?
	Not done
	Done, or not applicable to this case.
	33. The student discussed their initial diagnostic impressions with you.
	Not done
	Done
	34. The student discussed their initial management plans with you.
	Not done
	Done
	36. The student mentioned specific tests they would like to have done to get additional information on you.
	Not done
	Done
	37. The student asked if the you had any additional questions or concerns?
	Not done
	Done

Table F3. (Continued)	
Three-Point Items (15 %)	10. The student asked me questions in a systematic and efficient method, asking questions that were logical to follow. Below Expectations: The student seemed scattered, inefficient, and had multiple inaccuracies. Meets expectations: The student was organized, fairly efficient, and asked mostly accurate questions. Above expectations: The student asked efficient and consistently accurate questions with a smooth flow to the questioning. 11. Empathy: The student acknowledged and demonstrated understanding of your feelings (ie:that sounds hard,...or, you look upset...) Not done Below Expectations: The student did not acknowledge my feelings very often Infrequently, less than two times. Meets Expectations: The student consistently acknowledged my feelings and verbalized this in empathy statements. 14. Respect: The student valued your choices, behaviors, and decisions, and was non-judgemental in their discussions with you. Below Expectations: Inconsistently - The student did not always value your decisions. Meets Expectations: Mostly - The student often valued your decisions and discussions with you. Above Expectations: Consistently - The student consistently valued your decisions and discussions with you.

Table F3. (Continued)	

	26. The student used respectful draping?
	
	    Not done
	
	    Below Expectations: The student simply handed you the drape to place on your lap.
	
	    Meets Expectations:
	    The student handed you the drape and used it a few times during the physical exam; OR the drape was not applicable to this case.
	
	30. The student did not repeat painful maneuvers on you when you said it was painful?
	
	    Below expectations:
	    The student repeated painful maneuvers.
	
	    Meets Expectations:
	
	    Either not applicable, or student did not repeat painful maneuvers.
	
	31. The student examined your extremities and performed reflexes (if applicable)?
	
	    Not done
	    Meets Expectations:
	
	    Either, this was not required of the case OR the student performed ½ of the above components.
	
	    Above Expectations:
	    The student performed both of these components, both examining your extremities and performed reflexes.

Table F3. (Continued)	
Four-Point Items (10 %)	6. The student maintained good eye contact and body language with me. Not done Below expectations: Infrequently: the student rarely made eye contact with me, focused too much on note taking and/or presented a defensive pose when talking with me (arms crossed, leaning away). Meets Expectations: Mostly: The student frequently glanced at me and leaned in when talking with me. Exceeds Expectations: Consistently: The student maintained a comfortable level of eye contact and was very engaged in our discussions. 8. The student asked me to list my concerns and listened to the response without interrupting me. Not done Below Expectations: Infrequently: The student kept interrupting me while I was trying to answer and/or the student kept asking me questions without waiting for a response. Meets Expectations: Mostly: In general, the student asked me my concerns and listened to my responses without interruptions. Above Expectations: Consistently: The student always asked me to respond to a prompt and waited for my response before moving on.

Table F3. (Continued)		
	15. Support: The student offered you support. (example: I am here to help determine the cause of your symptoms...)	
		Not done
		Below Expectations:
		Inconsistently – The student rarely used words that reflected their support of you as a patient.
		Meets Expectations: Mostly – The student frequently used words that reflected their support of you as a patient.
		Above Expected
	35. The student provided a basic differential diagnosis (or a set of differentials) using terms that made it easy for you to understand.	
		Not done
		Below expectations, The student mentioned one or two differential diagnoses, but did not offer to explain them to me.
		Meets expectations, The student told me one – two differential diagnoses and explained them to me, or answered my questions when asked.
		Exceeds expectations, The student discussed three differential diagnoses with me in terms that I understood without questions.

Table F3. (Continued)	
Open-Ended Items (5 %)	17. Please elaborate your reflections on the student here, discuss what you would have preferred the student to do from a patient's point of view: 39. General Comments: Please state any additional comments you would like to share with the student regarding their encounter with you.