

Oral communication skills of international medical graduates: Assessing empathy in discourse

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Abstract

We examine a dataset consisting of 11 International Medical Graduates (IMGs) performing an Objective Structured Clinical Examination (OSCE). Our aim is to address questions about the linguistic realization of empathy in the clinical discourse of IMGs and the extent to which OSCE examiners are sensitive to relevant features of the discourse. We analyse three aspects of the dataset as manifestations of empathy: sequential organization to provide reassurance; responsiveness to the simulated patient's lexical choices for emotionally charged words; and the organization of turn-taking in the interaction. Our analysis suggests that in each of these areas it is possible to identify discourse strategies which realize empathy. These strategies are used by IMGs who are good communicators and not used by poor communicators. Our evidence suggests that of the features we examine, the most salient for the examiner is a greater than normal occurrence of transition pauses. We argue that it is only in the area of the organization of conversation that the problems displayed by some IMGs are due to differences in cultural background, and it is therefore significant that the feature we identify as salient comes from this area.

Keywords: empathy; discourse analysis; reassurance; division of work; International Medical Graduate (IMG); OSCE

1. Background

Australia, like many other Western countries (Birrell 1996; Birrell and Hawthorne 2004), relies heavily on international medical graduates (IMGs) to provide medical care to its growing population (Han and

Humphreys 2006). These IMGs bring to Australian medical institutions a considerable diversity in their background training, clinical skills, understanding of the health system and communication skills (McGrath 2004; Whelan 2006). IMGs' professional knowledge, lay-cultural knowledge, socio-cultural assumptions, institutional norms and values, and personal experiences are all in full display in medical events (Sarangi and Roberts 1999; Roberts and Sarangi 2002; Candlin and Candlin 2003; Roberts *et al.* 2003, 2004). A lack of commonality in the participants' inferences and contextual cues may affect the interpretative schema and therefore the comprehension of speech (Gumperz 1971, 1982, 1999) between IMGs and their patients, potentially causing miscommunication in medical visits. Such communication difficulties can have a negative effect on patients' satisfaction in the consultation.¹

This paper addresses some of the communication difficulties that IMGs face during medical consultations by examining how diverse discourse features were used by IMGs to articulate an empathic stance during an OSCE (objective structured clinical examination) and the extent to which the assessor's rating seems to be sensitive to these discourse features. The data we consider here was taken from a training session for IMGs preparing for the actual Australian Medical Council examination. In this case a medical practitioner played the role of the patient. The OSCE scenario assesses candidates' ability to manage the sensitive situation of breaking the bad news and giving reassurance to a male in his 60s who initially refuses bowel cancer (BC) treatment. We will study and reflect upon three aspects of empathy: positive reassurance, responding to emotionally-charged words and one aspect of turn-taking. A distinction, when possible, will be drawn between those IMGs who were rated highly by an OSCE examiner and those who received lower rating.

2. Empathy in medical communication

Attempts have been made to define the concept of empathy within cognitive conceptualization frameworks, nevertheless the various interpretations fail to provide a consistent construct. As Frankel points out: 'The one element that all definitions included was that empathy was a response to another's emotions' (2000: 89).

In defining empathy we follow Bennett (1979) who differentiates between the concepts of sympathy and empathy. While sympathy is understood as one's feeling, as an external observer, in someone else's position or circumstance, empathy focuses on how one recognizes him/herself in the other person's feeling in a given event. Thus Bennett (1979: 417) claims that in an empathic experience there is a 'shift in perspective away from our own to an acknowledgement of the other person's different experience'.

The value of empathy in patient-oriented medical encounters has been demonstrated (Colliver *et al.* 1998), but only a limited number of empirical studies across different languages and medical specialties address the articulation of empathy (Frankel 2000). Frankel (2000: 89) identifies a sequential exchange which he terms an 'empathic opportunity' where physicians can either respond empathically or miss the 'opportunity' by not taking action. Eliciting and addressing patients' emotions and allowing them space to react in has also been identified by Weissmann *et al.* (2006: 662) as an empathic communicative behaviour that helps create a more 'humanistic medical care' which combines the appropriate application of scientific knowledge and technical skills with acknowledgement of and respect for the emotional, social and cultural needs and preferences of individual patients and their families.

A set of discourse features that display an empathic attitude to patients was identified by Cordella (2004a, 2004b) while studying natural medical consultations with general practitioners (GPs). These features are displayed within *Fellow Human voice* (one of the three voices identified in her study), which conveys affiliation, interest and involvement, for example by showing special attentiveness to patients' stories (e.g. mirroring patients' words). In a study focusing on the communication difficulties of final year medical students in the UK, Roberts *et al.* (2003) showed that students' attentive responding, joint problem-solving, and face saving were all featured in good OSCE performances while less successful candidates used 'retractive' questions and responses which did not favour an empathic communication

with their patients. Colliver *et al.* (1998) established that patients' satisfaction in the medical visit partly depends on physicians' empathic behaviour. Patients were more satisfied with those doctors who can 'put patient at ease' and 'concentrate and focus on patient', but they also note 'clearly a measure of empathy is needed' (9–10).

We analyse our corpus of data with the aim of understanding how IMGs articulate empathy in delivering bad news. Maynard (1997, 2006) has studied the delivery sequences of bad (and good) news and has shown that 'deliverers *and* recipients exhibit eagerness with respect to good news, and reluctance in relation to bad news' (Maynard 2003: 174). Our interest in this study is to explore further how IMGs counteract the emotional reactions patients may experience when bad news is delivered and how patients align to doctors' views. How empathy is formulated in scenarios where bad news is being delivered can be the starting point to study how IMGs attend to the emotional needs of patients and how the realization of empathy is achieved through the talk.

The case of IMGs is of special interest here, as their empathic behaviour has to bridge the divide between the socio-cultural expectations which they bring from their background and the expectations current in the cultural setting of the society in which they seek to practice.

This study addresses the following research questions:

1. How do candidates organize, negotiate and display positive reassurance?
2. How do candidates respond to patient's empathic needs?
3. How do candidates respond to emotionally-charged words?
4. How is turn-taking managed by candidates?

3. Methodology

The corpus is based on a video-recorded dataset consisting of 11 IMGs performing an OSCE station designed to provide reassurance to a bowel cancer patient (see Appendix 1). Most members of the group came from an Asian background and all were enrolled in a bridging course in Melbourne in preparation for the Australian Medical Council (AMC) examination. The data were transcribed and edited using the software ELAN to provide the best representation of the verbal production and later analysed using tools

from conversation analysis (CA) and interactional sociolinguistics. In this study, we focus on one of the categories listed under the AMC assessment criteria. This is *Approach to patient*, which includes empathy as one of its components.

Both the simulated patient and the OSCE examiner who participated in this study had been playing these roles for several years in bridging courses in Melbourne and AMC examinations. The OSCE examiner was asked to rate candidates' performance following the same AMC rating scale used in the real examination.² The data represent interactions between a native speaker of English (the simulated patient) and non-native speaker IMGs from various language backgrounds. Informed consent was obtained from every participant. The candidates were aware that the simulated patient (SP) was a doctor, and it might therefore be argued that both participants were, or could be, operating within the biomedical mode of discourse. It was however clear to candidates that they were expected to treat the simulated patient as a lay person.

4. Analysis

We present our analysis in three parts: (4.1) sequential organization (§4.1); (4.2) responses to emotionally-charged words (§4.2); and (4.3) problems in turn-taking (§4.3).

4.1. Sequential organization

Three main patterns emerged from our analysis in relation to the sequential organization of reassurance. Candidates made frequent use of the sequential organizations described in Sections 4.1.1 and 4.1.2 while the one introduced in Section 4.1.3 was least employed.

4.1.1. Candidates initiate a sequence of positive reassurance following bad news delivery

Candidates show a preference in initiating a sequential organization of talk following the delivery of bad news. Positive reassurance markers and account statements – uttered soon after the positive reassurance marker has been delivered – form the basis for the sequence organization. Eight out of 11 consultations presented this sequential organization.

Following the delivery of bad news (e.g. 'you have got cancer') candidates offered a positive marker (e.g. 'the *good news* is') which appears to be playing the role of making patients more receptive to the

information that is coming next. It appears to be a well-established view among oncologists that patients tend to withdraw and do not pay attention to what it is said after the bad news has been delivered.³ The use of a positive marker may play an important role in making patients more receptive to what it is going to be disclosed in the consultation.

The positive marker is accompanied by one or a series of account statements that respond to the question: 'what is the good news?'. These account statements refer to the location and growth of the tumour which in turn can be mitigated (e.g. 'it's just a small tumour') or unmitigated (e.g. 'there is a tumour'). Account statements are also used to indicate the stage of the disease by referring to the patient's bowel cancer spread. This can be uttered by using a positive statement (e.g. 'the tumour is localized') or a negative statement (e.g. 'it isn't spread').

This three-part reassurance sequence (i.e. delivery of bad news, positive reassurance markers and account statements) is usually extended further by continuing the reassurance process with the inclusion of additional positive reassurance markers, followed by supporting account statements that make reference to the treatment and management of the disease. Thus a positive reassurance marker (e.g. 'you've a very good chance') and one or a series of supporting account statements are delivered with either modality markers of certainty (e.g. 'there are a lot of treatments'), uncertainty (e.g. 'it might be cured') or by the use of *if* conditional clauses (e.g. 'if we do the operation soon you have more chance of becoming one hundred per cent normal').

In what follows we analyse a specific example. Transcription conventions are detailed in Appendix 2.

Example 1 (Candidate 6 (C), Patient (P))

20	C:	and it has turned out to be
21		cancer (.) in the bowel cancer
22-31	C:	<reference to the bowel cancer continues>
32	C:	on the other hand (..)
33		at the same time (..) you
34		have a bit of good news (..)
35	P:	oh ... ok/
36	C:	of that (..) that is that
37		the bowel tumour <or
38		the XX they have XX> it is only
39		localized to the bowel mucosa (..)
40		or it has not infiltrated or
41		not gone deep
42		into the deeper layers
43		of the bowel (1) so it's just
44		localized in one particular (..)
45		region of that
46		particular bowel (1.5)
47		so that means it is much

48 easier to manage
 49 (.) as compared to (..)
 50 to the other cancers
 51 which are widely spread all
 52 over the bowel and (..) also the
 53 lymph nodes (..) in the region (.)
 54 so there's (..) im a bit hopeful
 55 for the manage (.) as far as
 56 the management goes
 57 for this particular=

The reassurance sequential organization reflects a scientific discourse where both the scientific reasoning and the medical knowledge are represented. The mitigated positive marker of 'a bit of good news' (line 34) is accompanied by an implicit 'because' which refers to the location and growth of the tumour (lines 36–45) and is subsequently reinforced by medical knowledge about the treatment and management of the disease which answers to 'therefore' (lines 47–56). In brief this sequence organization could be summarized as follows:

Candidate delivers bad news
 Positive reassurance markers
 Because account statements
 Positive reassurance markers
 Therefore supporting account statements (See Appendix 3)

Candidates' delivery of bad news is followed by positive reassurance markers which play the role of remedial proposal sequences (Maynard 2003) and are used before the scientific medical knowledge.

4.1.2. *Patients requesting further reassurance following candidates' reassurance sequence*

Seven out of 11 consultations presented this sequential organization which expanded the pattern already observed in Section 4.1.1. In these cases the patient initiated a direct or indirect question (lines 69–70) to obtain further reassurance as illustrated in Example 2 below. Candidates expand their reassurance providing extra information (e.g. 'taken the right step', 'if we get rid of that (the tumour) by taking it out we are at least minimizing the chance of spread', 'definitely it improves the outcome').

Example 2 (Candidate 6 (C), Patient (P))

69 P: [and uh::] i guess i just wonder
 70 if it's all worth it
 71 C: i would say it is worth it=
 72 P: =you think so
 73 C: at this stage
 74 P: Umm
 75 C: because see at i i would say
 76 that yes we have taken the right

77 step at this stage by doing
 78 a colonoscopy and look
 79 at one just one tumour...
 80 tumour so::: if by if we go by
 81 the colonoscopy report (..) there's
 82 one tumour and (.) if
 83 we get rid of that
 84 by taking it out/
 85 P: Umm
 86 C: we are we are at least
 87 minimizing the chance of spread
 88 to the other organs (..) and
 89 definitely it improves the
 90 outcome (.) outcome of the
 91 of the disease (..)
 92 P: Umm

In brief this sequence organization could be summarized as follows:

Patients request further reassurance
 Candidates respond to patients' request
 Because account statements
 Therefore supporting accounts statements

The patient's initiation of reassurance desirability emerges clearly in line 69, 'i guess i just wonder if it's all worth it', and in line 71, 'you think so', which appear to give the candidate a hint that reassurance needs to be delivered. Asking for an optimistic outlook is not atypical as people in 'interactions structure the social world as a relatively benign one' (Maynard 2003: 182).

4.1.3. *Candidates deliver the bad news and do not initiate sequence of positive reassurance*

Only a few candidates (three out of 11) did not provide a positive marker following the delivery of bad news. In those instances the patient was looking for some reassurance and initiated a talk that gave candidates an indication that such sequential organization was required at that stage. Seeking reassurance was part of the SP's script.

Candidates had a chance to repair their performance by employing a delayed sequential reassurance. See Example 3 below.

Example 3 (Candidate 4 (C), Patient (P))

17 C: ((Delivery of bad news))
 ((absence of positive reassurance))
 27 P: (H)(Hx) well i'm fairly
 28 philosophical about it (.)
 29 I've been thinking about it (.)
 30 and cancer's cancer and I've had
 31 a good life (.) I've had a really
 32 good life (1) you know (..)
 33 it's been good to me and

- 34 C: but there's uh (.) good news uh=
 35 P: =there's good news
 36 C: ye but the cancer (..) according
 37 to what they see in the colonoscopy
 38 (..) it's only (..) uhm (..)
 39 you know on the bowel (1)
 40 line you know like (..) not
 41 P: oh
 42 C: (1) so that means it's quite (..)
 43 uh (.) early stage so
 44 P: oh
 45 C: (...) uh (..) might be a cure
 46 no you know I mean it might be
 47 an easy control (1) so uhm

The candidate delivers the bad news without offering reassurance. This makes the patient dramatize his state (lines 27–33) probably in an attempt to make the candidate repair his omission and initiate the sequential organization of a reassurance. In line 34 the positive reassurance marker 'good news' is followed by account statements referring to location (i.e. 'it's only on the bowel line'), early detection of the disease (i.e. 'early stages') and finally focusing on treatment and management (i.e. 'it might be a cure, it might be easy to control').

At those stations where reassurance was absent the patient was left without sufficient emotional resources to cope with the bad news. In such cases the patient tended to initiate a narrative of fear and use emotionally charged expressions to show his distress.

This sequence could be summarized as follows:

- Candidate delivers bad news
- No positive reassurance markers
- Patient initiates talk
- Delayed positive reassurance marker
- Because account statements
- Therefore supporting account statements

4.1.4. Correlations between assessments and the use of sequential organization

There is a tendency to mark highly those candidates who used the sequential organization presented in Sections 4.1.1 and 4.1.2. Our corpus shows examples from six candidates. Nevertheless those candidates who did not initiate the reassurance process (as illustrated in Section 4.1.3) did not all obtain an unsatisfactory result. This may suggest that the sequential organization alone cannot provide an accurate measurement of the realization of empathy and that further discourse features need to be analysed. Both the OSCE examiner and the patient agreed on those candidates who performed poorly, except for one case in which the patient expressed lack of satisfaction in

the consultation whilst the examiner gave a 'satisfactory' mark to the candidate.

4.2. Responding to emotionally-charged words

Analysis of illness narratives (Bury 2001; Horton-Salway 2001; Murray 2002), including narratives of cancer patients (Jordens *et al.* 2001; Mathieson and Stam 1995), is a well-established research area. One aspect of the language of actual cancer patients which has received attention is the choice of lexical items used to refer to the disease, the afflicted part, and to the disease site post-surgery (for discussions of these issues in relation to breast cancer see Langellier and Sullivan (1998); Manderson and Stirling (2007)).

The SP in the OSCE consultation, as we know, is not producing spontaneous accounts of his illness; rather he is role-playing, following a pre-determined scenario, and producing some consistent reactions across all the consultations. However, the discourse that emerges in the interaction is spontaneous and we suggest that one feature studied in illness narratives can be considered in our data. The lexical choices of the SP in referring to his illness are rather restricted, as will be shown below, but there is variation in the extent to which candidates are aware of and respond to those choices. Avoidance of threatening terms is one strategy which manifests empathy, but we suggest that the extent to which the candidates adopt the lexical preferences of the SP can also be interpreted as indicating the extent to which the candidate empathizes with the patient.

The patient in our consultations consistently refers to his disease as *cancer*, while the candidates use a range of terms, emphasizing the more specific medical term *tumour*. In the 11 consultations, the SP refers to his disease 51 times (including full mentions and anaphoric mentions). Forty-seven of these references (or 92.2%) use the term *cancer* (of which 14 are pronominal mentions where *cancer* was the last full lexeme used); while the term *tumour* is used three times and the term *growth* is used once. The candidates use a wider range of terms comprising the three already mentioned as well as *disease*, *condition*, *problem* and *lesion*. While cancer is still the most common term, tumour is almost as commonly used. The number of uses of each term is shown in Table 1.

Table 2 shows the breakdown of uses of different terms by candidates.⁴

Table 2 reveals several interesting patterns. First, we can see that finding ways to talk about the patient's disease is an important step towards a successful consultation. Five candidates have low

Table 1: Number of uses by candidates of various terms referring to disease

Term	Total mentions	Full	Anaphor	Number of consultations	% of all references
Cancer	99	70	29	11	45.4
Tumour	88	48	40	10	40.4
Growth	11	8	3	2	5.0
Disease	10	10	0	3	4.6
Condition	5	5	0	3	2.3
Problem	4	2	2	2	1.8
Lesion	1	1	0	1	0.5
Totals	218	144	74		100

Table 2: Number of uses of various terms by different candidates

Term	C4	C5	C6	C7	C8	C10	C12	C3	C11	C13	C9
Cancer	25	18	4	11	3	13	13	0	2	5	6
Tumour	0	4	17	10	4	1	9	20	5	5	13
Growth									10	1	
Disease		3	5			2					
Condition					3	1		1			
Problem					2			2			
Lesion		1									
Total	25	26	26	22	12	17	22	23	17	11	19

total mentions of the patient's disease (< 20), and three of these (C9, C11 and C13) were assessed as being unsatisfactory for the criterion *Approach to patient*. Second, the one candidate who seemed to ignore the patient's lexical choices (C3) was also assessed as unsatisfactory. Third, a number of candidates seem to be aware that terms such as *tumour* and *cancer* might be threatening, and they do use alternatives. All of the successful candidates also seem to respond to the lexical preference shown by the patient, and they use the term *cancer* at least part of the time. Guidelines for breaking bad news to patients emphasize the importance of honesty and the avoidance of euphemism. For example, Girgis and Sanson-Fisher (1998) have the following wording in their guidelines:

Give the patient the diagnosis and the prognosis honestly and in simple language but not bluntly. Avoid technical jargon or euphemisms (e.g. *tumour*, *growth*, *metastasis*, *illness*) that obscure the truth. If the patient has cancer, then use the word *cancer*. (56–57).

The justification for such advice is based on reports from patients that they prefer this approach. Therefore adopting it can be interpreted as a manifestation of empathy.

More detailed examination of some instances also reveals interesting patterns. There is one consultation (Example 4 below) in which the term *tumour* does not occur at all. In this case, the patient pre-empts the candidate and makes the conclusion that his test results mean bad news. The candidate responds by maintaining the patient's lexical choice throughout:

Example 4 (Candidate 4 (C), Patient (P))

17 C: uhm (2) so unfortunately the
18 result doesn't (.) show (.)
19 very uh (1) good
20 P: I was very distressed
21 when I see [it (1)]
22 [uh-huh]
23 what's it (.) cancer is it doctor/
24 C: yeah:::(.)=
25 P: =uhm
26 C: it uh shows you have uh (.)
27 another cancer on the (.)
28 on your bowel [(.)]

Example 5 is the clearest case of empathic response to the patient. In this consultation, the candidate begins using the term *tumour* twice (lines 14 and 16). The patient uses *cancer* twice (lines 22 and 24), *tumour* once (line 23), then switches back to *cancer* and the candidate then switches to *cancer*.

Example 5 (Candidate 5 (C), Patient (P))

10 C: uhm (..) well (.) I have to
 11 tell you uhm (..) unfortunately
 12 we found something in
 13 your colon in yo- in your large
 14 bowel which is a tumour (1)
 15 uhm (..) the good
 16 news is that the tumour is (..)
 17 not a big one (..) it's within
 18 the surface layer of
 19 the (.) of your large
 20 bowel (..) and uh
 21 P: so it's cancer (..) you think
 22 it would be cancer doctor (.)
 23 the tumour would be
 24 cancer
 25 C: yes (..) I'm afraid it is
 26 the cancer mr. marks

The candidate then continues to use *cancer* with only two exceptions: there is one use of *lesion* (line 92), and there is one use of *tumour* (line 65) with specific reference to its removal in surgery, but this is preceded by a false start with *cancer*.

Example 6 (Candidate 5 (C))

62 C: Yeah but yeah (.) I think
 63 that in your case as what
 64 it showed in the colonoscopy
 65 that uhm (.) the ca- the tumour is
 66 confined to the <<bowel mucosa>>
 67 that's what the result says
 68 and (.) as i said you have
 69 very good chance
 70 to (.) get rid of
 71 cancer and (..) cure it
 (lines 72–90 omitted)
 91 C: uh::m (.) because it's already found
 92 in the colonoscopy so it won't be
 93 very difficult for the surgeon to get (.)
 94 th- the lesion again (1) yeah (2) and yeah

In contrast, in Example 7 the candidate is much less responsive to the patient's choices. This candidate introduces the term *tumour* (line 15), which is initially echoed by the patient (line 19). However, the patient then switches to *cancer* (line 24), but the candidate sticks with *tumour*.

Example 7 (Candidate 3 (C), Patient (P))

12 C: from to the results we
 13 found out (.) that you know (.)
 14 you have little bit of
 15 tumour in the in the end of
 16 your colon (.) big bowel
 17 large bowel and larger
 18 bowel
 19 P: they found they found a tumour
 20 C: yeah the size is arou::nd (.)

21 two centimetres in diam(.)eter (.)
 22 so roughly (1.5) about
 23 this size around <<the one>>
 24 P: so is that cancer doctor/
 25 C: [long pause +
 26 she mumbles her words]
 27 uh (1) yeah (.) uh (2) they said
 28 P: it's likely to be serious
 29 C: uh (.) I'm sorry (.) it's just
 30 that (.) you know (.)
 31 it's uhm (.) it's a tumour
 32 P: hm::
 33 C: also they did the ultrasound (.)
 34 and said the tumour the good news
 35 is the tumour is you know not goes
 36 everywhere (.) it's only on the
 37 top layer of the you know (.)
 38 of the bowel, on the top layer (.)
 39 it hasn't go too far

This pattern continues throughout almost the entire consultation until the candidate uses two other terms (i.e. *problem* (line 116) and *condition* (line 140)) in the last seconds:

Example 8 (Candidate 3 (C), Patient (P))

113 C: Yeah I want to do that
 114 yeah (.) and any children (.)
 115 because if you have children
 116 if you have this problem
 117 sometimes they have to be followed
 118 up regularly as well (..) sometimes
 119 these things can go in
 120 the family (.)
 (Lines 121–135 omitted)
 136 C: Yeah (.) so you think (.)
 137 anyway I am going to talk to the
 138 surgeon today
 139 regarding your (.) your
 140 condition I'll (.) try to get him to
 141 see you as soon as
 142 possible and we'll go from there
 143 P: really

As we suggested at the start of this section, it is possible to interpret these patterns of lexical choice as giving an indication of the extent to which some candidates are co-constructing the event and collaborating in it by paying attention to the patient's preference in relation to emotionally-charged words. Another way of interpreting these patterns would be in terms of interactive alignment (Garrod and Pickering 2004), a model of dialogue which stresses the extent to which interactants align the linguistic representations which they are using. Garrod and Pickering draw an explicit link between these processes and the way in which behavioural mimicry is used in establishing rapport

(Lakin and Chartrand 2003). Similarly Ferrara (1992) in her work on joint production and Cordella (2004b) in the representation of the Fellow Human voice in medical consultations have pointed out the collaborative nature of discourse that creates affiliation and camaraderie between participants.

4.3. Turn-taking

Turn-taking is a very structured activity (Sacks *et al.* 1974), but also one that has been shown to vary across cultures (Clyne 1996: 188) and it demands that each participant understands the culture-specific rules and accurately reads and supplies appropriate cues. If this cannot be accomplished by one participant, communication can fail.

We have used pausing at transitions between speakers as a diagnostic of the extent to which turn-taking operated smoothly in the current data, taking a pause of 250 ms or greater to indicate a disfluent transition. This threshold was set based on recent cross-linguistic studies. Campione and Véronis (2002) looked at five languages (English, French, German, Italian and Spanish) and found that pauses have a trimodal distribution. They took 200 ms to be the lower bound for medium length pauses, with long pauses lasting more than 1000 ms.⁵ Stivers *et al.* (2009) found that across ten languages, including

six from outside of Europe, turn transitions have a unimodal distribution with the highest number of transitions occurring with an offset between 0 ms and 200 ms. The mean transition time for English in this study was 236 ms, but a response with an offset of 200 ms was subjectively judged to be delayed. These two sets of results suggest that a threshold of 250 ms is appropriate for the identification of delayed responses in English conversation. The procedure is also in line with that adopted in some previous studies (e.g. Thomason and Hopper 1992).

Figure 1 shows the total time taken up by transition disfluencies for each consultation. It seems that this measure is providing a quite reliable correlate for the assessor's perceptions. Of the four candidates who were not satisfactory for the category *Approach to patient*, three have total transition times which are above the mean, while this is true for only one out of the nine successful candidates. We interpret this result as follows. Transition pauses occur when one interactant has expected the other to continue but s/he did not. The second interactant does not initially perceive a 'transition relevance point' (Sacks *et al.* 1974); in other words relevant cues have either not been provided by the first interactant, or have not been read by the second interactant. The second interactant then realizes that the conversation will not progress unless they take a turn,

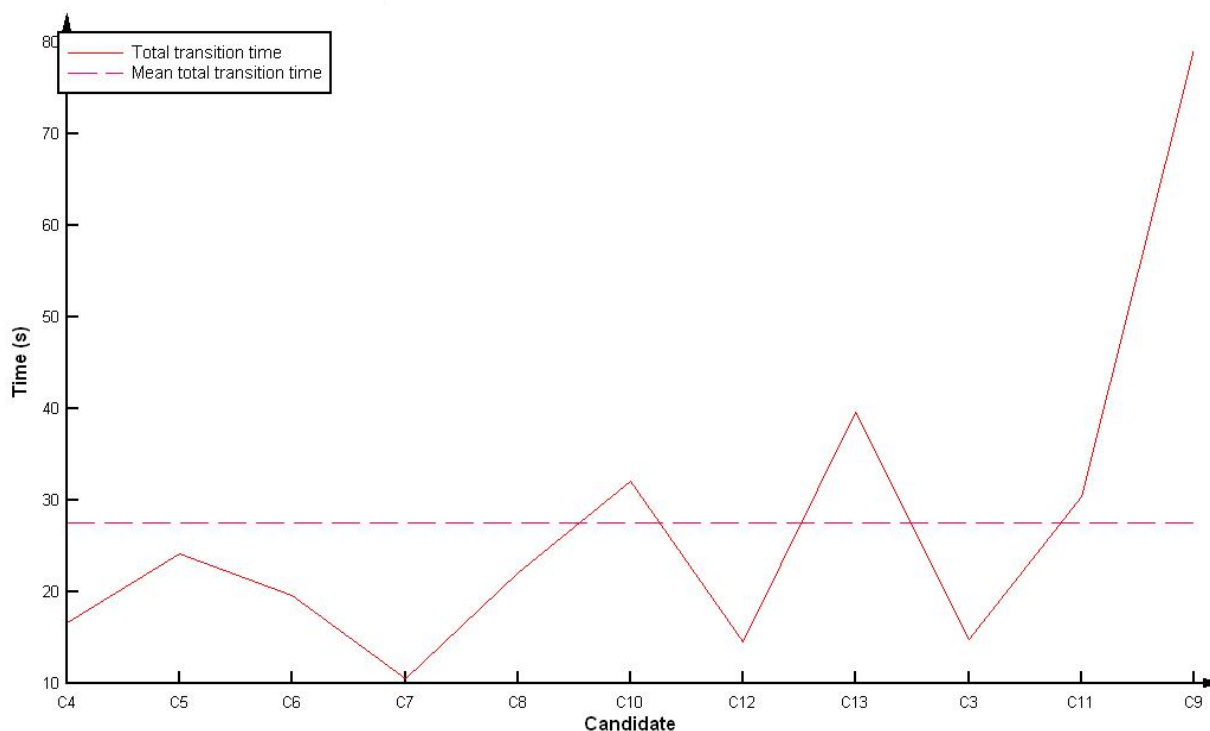


Figure 1: Total transition times for station BC

and they proceed to do so. These transition pauses therefore indicate where problems are occurring in the use of turn-taking cues, and in the progress of communication.

It is immediately obvious from Figure 1 that one candidate was exceptional in the extent to which transitions took up time in the consultation. Candidate 9 has a total transition time which is twice as great as the next highest. It is therefore very interesting that this is the only candidate who was assessed as 'Very unsatisfactory' for the category *Approach to patient*. It is our impression that communication almost completely broke down on several occasions in this consultation. It is, however, hard to specify how much of this is due to the candidate's (lack of) communication skills, and how much is due to the difficulty in accessing and verbalizing relevant medical knowledge.

Our interpretation of the transition time data is supported when we look at Figure 2, which shows the total time for the pauses which occurred within the candidates' turns in each consultation. These are pauses where the candidates successfully gave cues that indicated they would continue the turn. In some cases, these pauses were very long with the mean value of the longest pause in each consultation being 2.33 seconds. This is considerably larger than the 'standard

maximum' silence of approximately one second which Jefferson (1989) proposes as being part of the interactional norms of English speakers, but these are nevertheless examples of successful turn-taking. Note that there is no obvious relationship between the amount of time candidates used for within-turn pauses and how they were assessed in this station. Figure 2 suggests that this measure is tracking individual variation in communicative styles.

4.4. Summary

The examples of empathy in the BC station are summarized in Table 3.

5. Discussion

Empathy is achieved through a variety of discourse features which have been analysed in detail in this study. The successful accomplishment of empathy does not depend on one particular feature but on the cumulative effect that independent but co-occurring features produce in the consultation. Thus the sequential organization and lexical choice

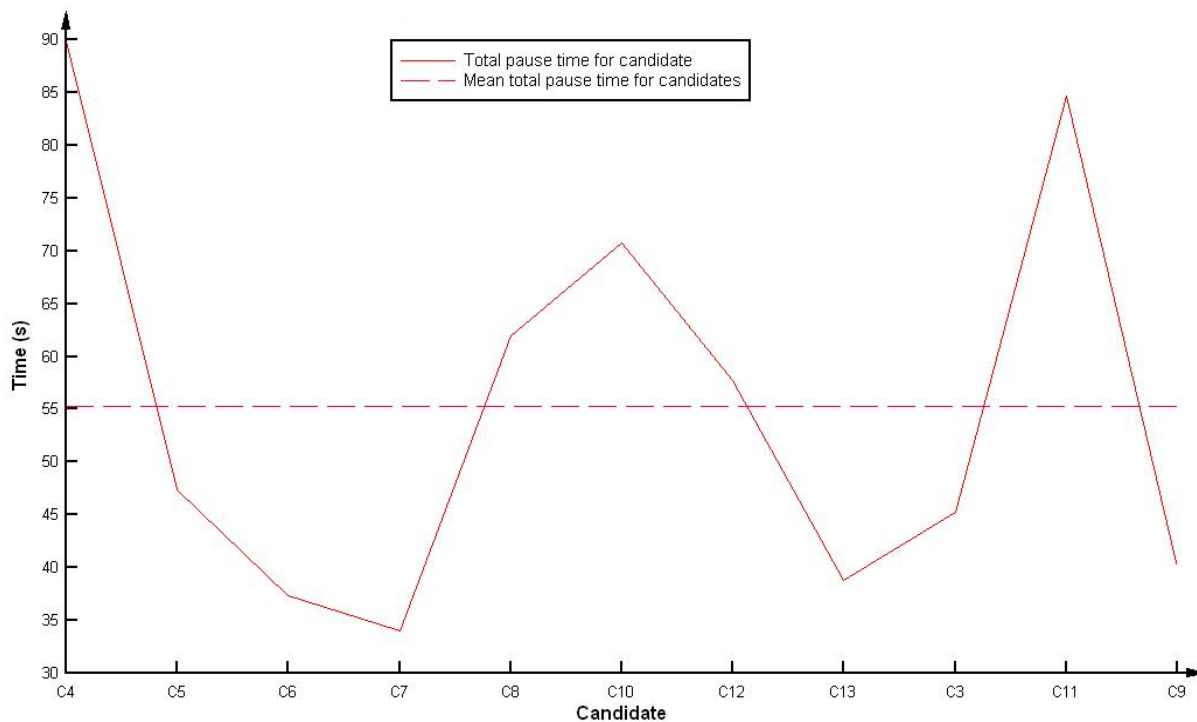


Figure 2: Total pause time for candidates in station BC

Table 3: *Examples of empathy in the BC station*

Discourse features that indicate candidates' good communication skills in the category <i>Approach to patient</i> in the AMC oral examination	Discourse features that indicate candidates' poor communication skills in the category <i>Approach to patient</i> in the AMC oral examination
<ul style="list-style-type: none"> • Sequential organization: Reassurance pattern • Reassurance is accomplished by a sequential organization which follows the structure of a scientific argument 	<ul style="list-style-type: none"> • Sequential organization: Non-reassurance pattern • Failure to initiate and sustain reassurance • Sequential organization alone cannot provide an accurate measurement of the realization of empathy
Patient-centred Attentive listening Using patient's own words (naming the disease) to respond emotionally to charged lexicon. Use of turn taking <ul style="list-style-type: none"> • Candidates sustain the floor and successfully manage transitions 	Non-patient centred Lack of attentive listening and failure to pick up patient's own words to respond emotionally to charged lexicon. Use of turn taking <ul style="list-style-type: none"> • Failure to sustain the floor • Longer transitions.

contribute to the realization of an empathic event, as does control of turn-taking. However, we would argue that these conversational features may not be necessarily specific to IMGs; rather they may be used by any OSCE candidate to communicate across the divide between the modes of thought and discourse characterized by Mishler (1984) as biomedical and humanistic. Our study also shows that those candidates who received a higher score managed this confluence well. They deployed a scientific argument after the bad news was delivered and then used both medical knowledge (e.g. account statements) and interpersonal communication synergistically to comply with the medical agenda and also to support empathically a patient who was reluctant to undertake the cancer treatment.

We have shown that candidates who structure reassurance sequences effectively are utilizing the structure of a scientific causative argument (X because Y and Z and therefore W) within the category *Fellow Human voice* to achieve the desired outcome in a humanistic sense, and the second feature we analysed can be interpreted in a similar fashion. Responding to the patient's choice of lexical terms is an empathic strategy that bridges the divide between medical and lay discourse. Differences in the extent to which candidates responded to the patient's lexical choices should not be attributed to differing cultural backgrounds or diverse understandings of the nature of the interaction. Rather, the difference was between candidates who were unable to find alternatives to the purely biomedical discourse and those who appreciated that the patient might feel more comfortable if other terms were used.

It is only in our data on the conversational structure of the consultation that we see effects which we would attribute to differing understandings of the interaction. Some candidates failed to give and read turn-taking cues in an appropriate way. In such cases, the behaviour can be seen as a failure of empathy, because of an inability to appreciate that the candidate's turn-taking system did not correspond to that of the patient. The candidates who had problems in this area were consistently assessed as unsatisfactory, suggesting that such problems significantly affect OSCE examiners' perception of the consultation. In related work, a machine learning approach, that is a purely statistical approach, has been applied to this dataset (Mistica *et al.* 2008) and has also found that assessors are responding to some discourse features of the interaction which unfolds in an OSCE.

6. Conclusion

Empathy can be achieved by different linguistic means throughout the discourse to provide reassurance to a patient who has received bad news. The use both of medical knowledge and of interactional moves contribute to the display of empathy in the visit. Both SP and OSCE examiners appeared to be also sensitive to those features and rated OSCE performances accordingly. We conclude that successful candidates tend to respond to the requirement of the medical oral examination by constructing their discourses in a scientific fashion

and also to the patient's interactional needs. A consultation which exhibits medical knowledge while overlooking the importance of forming interactional links with a patient can be as damaging

as one that shows defective medical knowledge. Integration of both medical knowledge and interactional moves is an essential part of a successful medical consultation.

Appendix 1: Management of patient diagnosed with bowel cancer

Time allowed: 2 minutes reading time and 8 minutes to conduct the station.

Construct: This station tests the candidate's ability to manage a patient who has been diagnosed with bowel cancer and who refuses further treatment.

Appendix 2: Transcript symbols

Unit	Truncated syllable (first)	,
	Truncated syllable (middle and final)	-
Speakers	Speaker identity/turn start	:
	Overlapping talk begins	[
	Overlapping talk ends]
	Latching	=
	No silence left between first speaker and second speaker's turn	
Tone	Low falling tone	\
	Rising tone	/
Pause/silence	Silence timed in seconds	(1)
	Pause of less than half a second	(.)
	Pause longer than half a second	(..)
Vocal noises	Inhalation	(H)
	Exhalation	(Hx)
Quality voice	Emphasis	EMPHASIS
	Perceived change based on volume or pitch change	
	Lower in volume than the rest of the talk	* *
	Laugh quality	<@@>
Lengthening	Vowel/consonant elongation	:::
Transcribers' perspective	Researcher's comment	(())
	Uncertain hearing	<X X>

Appendix 3: Reassurance chart

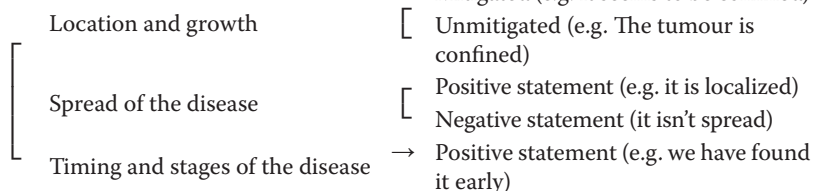
DELIVERY OF BAD NEWS
(e.g. There is a bad news you have cancer)



EMPATHY: POSITIVE REASSURANCE
MARKERS
(e.g. the good news is)



ACCOUNT STATEMENTS
(BECAUSE)

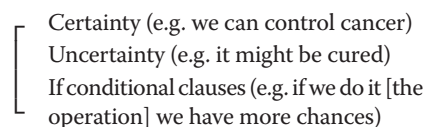


POSITIVE REASSURANCE MARKER
(THEREFORE)
(e.g. you've a very good chance)



SUPPORTING ACCOUNT
STATEMENTS

→ Modality markers



Notes

1. Communication problems may also affect IMGs' performance beyond the doctor-patient relationship, for example in dealing with patients' relatives and in peer-to-peer communication. Of course, communication problems may also arise among people coming from the same socio-cultural background.
2. The main categories are: approach to patient/relative, history, interpretation of investigation, initial management and patient counselling/education.
3. Patients and families may receive information about the disease and treatment via oral communication (e.g. USA and Chile) or via both oral and written communication (e.g. Australia).
4. This table, and the corresponding labelling of the horizontal axis in all the figures presented later are arranged as follows: Of 15 candidates originally scheduled to take part in our research, four did not participate: C1, C2, C14 and C15. Numerical codes had been pre-assigned to candidates, and these codes have been maintained.

5. The 11 remaining candidates are arranged as follows: candidates 4–8 plus 10 and 12 were all assessed as satisfactory for the BC station and satisfactory for the category *Approach to patient*. Candidate 3 was assessed as satisfactory for the BC station but unsatisfactory for the category *Approach to patient*, Candidates 11 and 13 were assessed as unsatisfactory for the BC station and unsatisfactory for the category *Approach to patient*, and Candidate 9 was assessed as unsatisfactory for the BC station and very unsatisfactory for the category *Approach to patient*. The arrangement therefore groups successful candidates to the left and unsuccessful candidates to the right.
- Campione and Véronis argue that using thresholds can be dangerous in the analysis of pauses, but their arguments are not relevant to the present study. Their argument is based on the fact that variation between speakers and between genres is greatest at the extremes. We are not interested in variation in very short pauses here, and we have set no upper threshold. Therefore our procedure captures the variation which is relevant for our purposes.

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