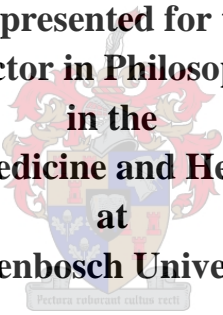# ENGAGING PATIENT-CENTREDNESS IN AN UNDERGRADUATE MEDICAL CURRICULUM.

by

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**Dissertation presented for the degree of
Doctor in Philosophy
in the
Faculty of Medicine and Health Sciences
at
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Co-supervisor: Prof. Ben van Heerden

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DECLARATION

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: December 2016

Elize Archer

ABSTRACT

There is ample evidence that medical students' empathy with their patients and their inclination towards patient-centredness decline from the time they enter medical school until they complete their medical education. Patient-centredness, an approach that puts the patient at the centre of the consultation, thus focusing on patients instead of on their disease, has been identified by most medical schools worldwide as a desired core competence of their graduates. It thus seems vital that medical schools foster patient-centred values and behaviour in their graduates.

However, there seems to be a focus on the biomedical aspects of patients in the practice and theory of teaching and learning in undergraduate medical curricula; therefore, students tend to become cynical and soon tend to focus on the disease of their patients. The expectation that doctors should be patient-centred has thus caused medical curriculum planners worldwide to pay attention to aspects such as communication skills training, the inclusion of subjects from the humanities and placements of students in longitudinal clerkships. Relevant literature reports that despite some of these initiatives, undergraduate medical students often still display a lack of patient-centredness by the time they graduate. This state of affairs is reason for concern and it was thus deemed important to explore the possible factors that enable or inhibit the teaching and learning of patient-centredness in undergraduate medical curricula. The aim of this study was therefore to gain a better understanding of the factors that influence the learning of patient-centredness in at least one undergraduate medical programme.

An explorative programmatic case study design, rooted in an interpretive knowledge paradigm, was considered most appropriate for the study in which final-year medical students and their lecturers participated. Observations of clinical teaching activities were also conducted and curriculum documents of the undergraduate medical (MB,ChB) curriculum at Stellenbosch University were analysed. Themes of meaning were deduced from the data by employing components of an integrated behaviour model (IM).

The findings of the study revealed that the following factors play a role in students' learning about patient-centredness: background characteristics of students and their lecturers, attitudinal factors, acquired skills and knowledge, subjective norms (the hidden curriculum), student self-efficacy, assessment of learning, and the environment or context within which patient-centredness is taught and learnt. Two factors that have proved to have a highly significant effect

on the learning of patient-centredness are subjective norms and assessment. Subjective norms refer to the clinical learning environment where the students are exposed to role models, as well as opportunities to practise patient-centredness on real patients. The latter is highly important in the process by which students develop self-efficacy, especially if followed by opportunities for feedback from a clinician teacher as well as opportunities for reflection on such feedback in order to discover new meanings and learn new practices. Assessment is recognised as an important factor that drives student learning, and the lack of assessment of patient-centredness in many departments renders a message strongly favouring the biomedical component of patient care.

The study provides new insights into the teaching and learning of patient-centredness in an undergraduate medical curriculum by suggesting an adapted version of Fishbein's IM and an improved understanding of enablers and disablers in the teaching and learning of patient-centredness. This study further points to a need for a jointly planned and well-coordinated approach to the formal, informal and hidden curriculum spaces within one MB,ChB programme with well-trained clinician teachers/faculty members who understand the importance and application of patient-centredness in modern medical practice.

OPSOMMING

Daar is vele bewyse dat mediese studente se empatie met hul pasiënte en geneentheid tot pasiënt-gesentreerdheid afneem vandat hulle met hul mediese onderrig begin totdat hulle dit voltooi. Pasiënt-gesentreerdheid, 'n benadering wat die pasiënt in die middelpunt van die konsultasie plaas en op die pasiënt fokus in plaas van op sy/haar siekte, word deesdae deur die meeste mediese skole ter wêreld geïdentifiseer as 'n gewenste kernvaardigheid van hul graduandi. Dit is dus baie belangrik dat mediese skole pasiënt-gesentreerde waardes en gedrag in hul graduandi koester.

Daar blyk egter nog steeds 'n fokus te wees op die biomediese aspekte van pasiënte in die voorgraadse mediese kurrikula se leer- en onderrigpraktyke en teorie en dit het tot gevolg dat studente geneig is om sinies te raak en op die siektes van 'n pasiënt te konsentreer, eerder as op 'n volwaardige mens. Die verwagting dat dokters pasiënt-gesentreerd moet wees, het veroorsaak dat mediese kurrikula regoor die wêreld aandag begin gee het aan aspekte soos opleiding in kommunikasievaardighede, die insluiting van vakke van die humaniora, en plasings in longitudinale kliniese rotasies. Relevante literatuur dui aan dat, ten spyte van sekere van hierdie inisiatiewe, daar steeds 'n tekort is aan pasiënt-gesentreerdheid in voorgraadse mediese studente teen die tyd wat hul gradueer. Hierdie situasie is kommerwekkend; daarom was dit belangrik om uit te vind wat die faktore is wat die leer en onderrig van pasiënt-gesentreerdheid in voorgraadse kurrikula aanhelp of inhibeer. Die studie was dus daarop gemik om beter te verstaan wat die faktore is wat die leer en onderrig van voorgraadse mediese studente beïnvloed wat betref pasiënt-gesentreerdheid in ten minste een voorgraadse mediese studieprogram.

'n Eksploratiewe programmatiese gevallestudie-ontwerp, gegrond in 'n interpretatiewe kennisparadigma, is aanvaar as die toepaslikste vir die studie waaraan finalejaar mediese studente en hul dosente deelgeneem het. Observasies van kliniese leeraktiwiteite is gedoen tesame met die analise van die kurrikulumdokumente van die voorgraadse mediese (MB,ChB) program van die Universiteit Stellenbosch. Temas van betekenis is afgelei van die data deurdat komponente van Fishbein se Geïntegreerde Gedragsmodel (IM) gebruik is.

Die bevindinge van die studie het aangetoon dat die volgende faktore 'n rol speel in die studente se leer van pasiënt-gesentreerdheid: agtergrond-eienskappe van studente en hul dosente,

faktore ten opsigte van hul houding, aangeleerde vaardighede en kennis, subjektiewe norms (die verskuilde kurrikulum), studente se selfwerksaamheid, assessering van leer, en die omgewing of konteks waar pasiënt-gesentreerdheid geleer word. Daar is bevind dat twee faktore 'n groot invloed op die leer van pasiënt-gesentreerdheid het, naamlik subjektiewe norms en assessering. Subjektiewe norms verwys na die kliniese leeromgewing waar die studente blootgestel word aan rolmodelle sowel as aan geleenthede waar hul pasiënt-gesentreerdheid op pasiënte kan beoefen. Laasgenoemde is baie belangrik in die proses waartydens student selfwerksaamheid ontwikkel, veral as dit gevolg word deur terugvoergeleenthede van kliniese dosente sowel as kanse om te reflekteer op die terugvoer in 'n poging om nuwe begrippe en nuwe praktyke aan te leer. Assessering is ook uitgewys as 'n belangrike faktor wat studente se leer rig, aangesien die nie-assessering van pasiënt-gesentreerdheid in baie departemente 'n boodskap uitstuur dat die biomediese komponent van pasiëntesorg die belangrikste is.

Die studie verskaf nuwe insigte in die leer en onderrig van pasiënt-gesentreerdheid in 'n voorgraadse kurrikulum en stel 'n aangepaste weergawe van die IM-model voor. Dit dra ook daartoe by dat die faktore wat die leer van pasiënt-gesentreerdheid aanhelp of inhibeer beter verstaan word. Die studie wys verder op die behoefte van 'n gesamentlik beplande, goed gekoördineerde benadering tot die formele, informele en verskuilde kurrikulumruimtes in een MB,ChB-program saam met goed opgeleide kliniese dosente wat die belangrikheid van die toepassing van pasiënt-gesentreerdheid in moderne mediese praktyk verstaan.

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TABLE OF CONTENTS

Chapter 3

CONTEXTUALISING THE STUDY **61**

Chapter 4

Chapter 5

THE RECEIVED CURRICULUM: FINDINGS FROM THE STUDENT INTERVIEW DATA 105

LIST OF DIAGRAMS

LIST OF TABLES

LIST OF ADDENDA

Chapter 1

ORIENTATION TO THE STUDY

1.1   INTRODUCTION AND BACKGROUND

The structure, content and delivery of undergraduate medical curricula have undergone important transformations over the last two decades. Some of these changes can be seen as a response to discussions that place increasing emphases on patient-centred, collaborative and partnership approaches to health care (Donetto, 2012; Frenk, Chen, Bhutta, Cohen, Crisp, Evans, Fineberg, Garcia, Ke & Kelley, 2010; Jones, Higgs, De Angelis & Prideaux, 2001). Medical education curricula have emphasised – amongst other changes – more structured teaching and learning of communication skills as well as a shift away from approaching patients in paternalistic ways, rendering a more patient-centred approach (Donetto, 2012).

Patient-centred medical care seems to be important due to various reasons: it builds caring relationships between healthcare providers and patients; it improves health outcomes and reduces costs (Bower, Mead & Roland, 2002), while it can also increase levels of patients' quality of life (Lewin, Skea, Entwistle, Zwarenstein & Dick, 2001). There is also evidence that a patient-centred approach can increase doctor and patient satisfaction, reduce anxiety in patients and improve quality of life (Lorig, 2002; Stewart, Brown, Donner, McWhinney, Oates, Weston & Jordan, 2000). Another important motivation for patient-centred care within institutions is the link between patient-centred care, quality and patient safety (Australian Commision of Safety and Quality in Health Care, 2016). Following all these motivations in favour of patient-centredness, it is not surprising that various authors, institutions and accrediting bodies, both internationally (Frank, 2005; Little, Everitt, Williamson, Warner, Moore, Gould, Ferrier & Payne, 2001; Tsimtsiou, Kerasidou, Efstathiou, Papaharitou, Hatzimouratidis & Hatzichristou, 2007; Stewart, 2003) and nationally (HPCSA,2016) have recommended that patient-centredness should form a central paradigm for teaching the skills of clinical practice in undergraduate curricula.

Despite an increased awareness of patient-centredness and intentions to foster this attitude in undergraduate medical students, there does not seem to be consensus on what the term really means (Mead & Bower, 2000b). From relevant literature it seems as if it is almost easier to

understand what a patient-centred approach should not be, rather than what it is. The definition of patient-centredness proposed by Stewart is probably the most cited; it differentiates between a 'patient-centred' approach and a 'disease-centred' approach (Stewart, 1995). Such a definition makes it clear that the patient is more than his/her disease (also see 2A.2.3). While there is no consensus on the exact definition of patient-centredness, most authors would agree that a patient-centred approach that aims to incorporate the patient's viewpoint in all respects of the health-care experience should be a core principle of medicine, and thus also of medical education in general (Bleakley & Bligh, 2008; Bombeke, Symons, Debaene, De Winter, Schol & Van Royen, 2010; Howe, 2001; Pelzang, 2010).

Most of the studies related to patient-centredness have involved already qualified doctors and patients, while medical students and how patient-centredness is taught and learned in the curriculum have been far less studied (Bleakley & Bligh, 2008). The studies that focused on undergraduate medical students mainly emphasised their attitudes towards patient-centredness and it has been reported that students develop more doctor-centred and disease-centred attitudes as they progress through the curriculum (Bombeke et al., 2010; Haidet, Dains, Paterniti, Hechtel, Chang, Tseng & Rogers, 2002; Lee, Seow, Luo & Koh, 2008; Tsimtsiou et al., 2007). While it might be difficult to reconcile the positive attitudes and idealism first-year medical students have with the cynicism and paternalistic attitudes many medical graduates develop, most studies, including a study conducted at Stellenbosch University (SU) (Archer, Bezuidenhout, Kidd & Van Heerden, 2014), confirm this trend (Batenburg & Smal, 1997; Haidet, Dains, Paterniti, Chang, Tseng & Rogers, 2001; Krupat, Pelletier, Alexander, Hirsh, Ogur & Schwartzstein, 2009; Ribeiro, Krupat & Amaral, 2007; Wahlqvist, Gunnarsson, Dahlgren & Nordgren, 2010). What has been researched less and thus not well understood is how and why these changes are happening in medical curricula. Current literature on factors that have the potential to enhance or inhibit the development of patient-centredness in undergraduate medical students (Bombeke et al., 2010; Bombeke, Van Roosbroeck, De Winter, Debaene, Schol, Van Hal & Van Royen, 2011; Bombeke, Symons, Mortelmans, Debaene, Schol, Van Royen & De Winter, 2013; Scheffer, Tausche & Edelhäuser, 2011) has indicated several reasons. Inhibitors include time pressure and fatigue (Bombeke et al., 2010), the loss of idealism coupled with the adoption of a more realistic view of medicine and the potentially negative influence of the unintended curriculum (Woloschuk, Harasym & Temple, 2004), and certain factors which are more prevalent in the clinical learning environment (Hafferty & Franks, 1994; Lempp & Seale, 2004). Furthermore, role modelling of those doctors that are in

more senior positions within the clinical learning environment can have either a positive or a negative effect, since it is a factor that has a potentially powerful influence on the behaviour of undergraduate medical students (Cruess, Cruess & Steinert, 2008; White, Kumagai, Ross & Fantone, 2009). Another factor that seems to cause students to focus on the disease component of patients is the fact that the biomedicine aspects are assessed more extensively than the so-called 'soft skills' around patient-centredness (Claramita, Sutomo, Graber & Scherpbier, 2011).

Worldwide, medical schools have sought to address the challenges of developing a patient-centred approach in medical students by either designing new curricula or supplementing existing ones with additional courses and experiences to enhance patient-centredness (Krupat et al., 2009; Ogur, Hirsh, Krupat & Bor, 2007). Many of these initiatives are centred on the teaching and learning of communication skills (Bombeke et al., 2011; Noble, Kubacki, Martin & Lloyd, 2007), and while communication skills are acknowledged as key enablers for patient-centredness one should be careful not to reduce patient-centredness to communication skills only (Pelzang, 2010). Despite attempts to incorporate principles of patient-centred care into formal curricula, there is evidence that such attempts are often undermined by social processes and messages that underplay the learning and practice of patient-centred care (Haidet, Kelly & Chou, 2005), since students are often taught one approach to patients in medical school, while they observe other, less patient-centred approaches in practice where the hidden curriculum is prevalent (Donetto, 2012).

Some medical schools that are currently implementing curriculum initiatives as mentioned above are also starting to put more emphasis on non-cognitive factors such as communication skills as part of their student selection processes. This leaves one with the question whether some of the attitudes and behaviour relevant to the standards of what is expected of doctors, such as being patient-centred, can actually be selected for (Gordon, 2003).

It would thus appear that having a clearer understanding of the factors that are involved in the learning and teaching of patient-centredness for undergraduate medical students could contribute to the emerging body of knowledge related to the concerns of graduating students that are not patient-centred.

1.2   DESCRIPTION OF THE PROBLEM

The majority of studies relevant to the topic of patient-centred teaching and learning seem to have been undertaken in traditionally resource-rich countries as opposed to South Africa – a country that is generally not considered as resource-rich. Since the practice of patient-centredness happens in the clinical environment where poor resources are evident in staff shortages, for example, one can expect that many of the issues regarding the teaching and learning of patient-centredness potentially pose even greater challenges than elsewhere in the world. A study at the Faculty of Medicine and Health Sciences (FMHS), SU, where the Patient-Practitioner Orientation Scale (PPOS) was used to measure attitudes of medical students towards patient-centredness, confirmed the international trend that patient-centred attitudes seem to decline during medical school (Archer et al., 2014). This study, as well as most others mentioned previously in section 1.1 concerning the decline in medical students' attitudes towards patient-centredness, generated quantitative results, resulting in a limited understanding about the reasons for this decline, especially in the SU context. Another limiting factor is the fact that several of the studies that were concerned with the development of patient-centredness in medical students focused on certain aspects of this multi-dimensional construct, such as attitudes, empathy or patient-centred communication skills (see 1.1). While the literature suggests a variety of curriculum initiatives to combat these globally identified shortcomings, the question in my mind with regard to the SU curriculum and context was what the problem areas were and, following that, which curriculum initiatives needed to be implemented in our context.

The research gap that was identified in the current literature was that there is a limited and sometimes naïve understanding of the factors involved in the teaching and learning of patient-centredness in undergraduate medical curricula. This study therefore set out to address this problem with regard to how undergraduate medical students report to have learnt (or failed to have learnt) patient-centredness by considering factors that could influence the teaching and learning thereof in one undergraduate medical curriculum. The aims of the study as well as the research questions and methodology are explained next, where after relevant key terms used in the study are briefly defined.

1.3   RESEARCH QUESTION

Based on the knowledge gap that was identified, the following research question was formulated:

How, if at all, do students in an undergraduate medical curriculum learn to be patient-centred?

In order to answer the main research question, three subsidiary questions had to be addressed:

- What constitutes 'patient-centredness' in an undergraduate medical curriculum?

- What factors enhance or inhibit the learning of patient-centredness by undergraduate medical students?

- What learning opportunities for patient-centredness are created, or have failed to be created, by the clinician trainers involved in the teaching of undergraduate medical students?

1.4   RESEARCH AIMS AND OBJECTIVES

The aim of this study was to explore teaching and learning experiences of medial students in the MB,ChB programme at SU in order to determine how undergraduate medical students learn (or do not learn) patient-centredness.

1.4.1   Objectives

The objectives to support the aim of the study were threefold;

- To explore what constitutes 'patient-centredness' in an undergraduate medical curriculum.

- To understand what factors enhance or inhibit the learning of patient-centredness by undergraduate medical students.

- To determine what learning opportunities for patient-centredness are created or fail to be created by the clinician teachers involved in the teaching of undergraduate medical students.

1.5   SCOPE OF THE STUDY

The focus of this study is the teaching and learning of patient-centredness and it is positioned within the field of Health Professions Education (HPE). The study was executed at the FMHS at SU. Since medical education is grappling with the challenges to deliver graduates that are patient-centred (see 1.1), the aim of the study was to contribute to the growing body of knowledge investigating the factors that influences this competence through the teaching and learning of medical students. In addition, by investigating the factors involved in a specific

medical curriculum, this study links into curriculum studies as a field of inquiry. It therefore offers additional insights to curriculum developers seeking to understand the factors that play a role in the learning of patient-centredness for undergraduate medical students.

Health professions education is a relatively new field in South Africa. The Centre for Health Professions Education (CHPE) at SU, where the study is registered, was founded in 2006 to promote studies and investigations in the field of medical and health education in higher education. This current study is thus embedded in both health sciences education and higher education as areas of inquiry.

The background of the researcher as a nursing practitioner and her work as a clinical skills lecturer was a key facilitator for embarking on this research (see 4.4.5). The study therefore drew on practical experience of working with already qualified doctors, medical students and patients over some years (Henning, Van Rensburg & Smit, 2004). However, of relevance to the reader is that this study was not conducted from the perspective of a family physician or a nurse; its focus was rather on factors influencing the teaching and learning of this highly sought after competence as a health science education and curriculum issue.

1.6   OVERVIEW OF THE RESEARCH METHODOLOGY

This study was conducted within an interpretive paradigm (Merriam & Tisdell, 2015) and qualitative data were utilised. Qualitative methods focus on aspects of meaning, experience and understanding that assist in the investigation of human experience in the context where the action takes place, and from the viewpoint of the research participant (Brink, Van der Walt & Van Rensburg, 2006). The research design selected for this study was an exploratory case study (Yin, 2014), which goes beyond description and aims at providing an understanding of the case against the background of both its wider and narrower context (Kyburz-Graber, 2004).

1.6.1   Methods of data collection

Triangulation of data was achieved by making use of various data sources and multiple perspectives for interpretation. Thus students, clinician trainers as well as curriculum documents were included in the study (Yin, 2013). Data collection comprised document analysis of MB,ChB study guides, focus group interviews with final-year MB,ChB students, individual interviews with five clinician trainers as well as observations of practical clinical sessions of the clinician trainers.

1.6.2   Population and sampling

The study population comprised the final-year medical students in the MB,ChB programme at SU during 2014 as well as the clinician trainers involved in the teaching of these students. Final-year medical students were selected because they had almost completed their undergraduate curriculum and could provide appropriate data to inform a better understanding of the factors that potentially enhance or inhibit the learning of patient-centredness. For the focus group interviews with the students, convenience sampling (Maree, 2007) was used and students participated until saturation of data was reached (Creswell, 2013). A total of 10 focus group interviews, involving 60 students out of a total population of 208 students, were conducted during the last semester of their training. With regard to the clinician trainers involved in the teaching of patient-centredness to undergraduate medical students, data collection was done through in-depth interviews as well as observation of clinical practice sessions. One clinician trainer from each of the five disciplines through which students rotate during their third, fourth, fifth and sixth year was sampled. By making use of the purposive sampling technique (De Vos, Delport, Fouché & Strydom, 2011) these five persons were invited to be part of the study. These 'big' disciplines are Family Medicine/Community Health/Rehabilitation, Internal Medicine, Obstetrics and Gynaecology, Paediatrics and Child Health, and Surgery. Either the departmental head of each of these mentioned five disciplines or their undergraduate teaching coordinator was asked to identify a clinician trainer that is regarded as a suitable teacher when it comes to the facilitation of patient-centredness to undergraduate medical students. The person that was recommended by the Department head/ teaching coordinator formed part of the study.

1.6.3   Data analysis

Data from the study guides were analysed by making use of content analysis (De Vos et al., 2011), while the field notes of the observation encounters were used to verify the data of the clinician trainers. The interviews with the students and the clinician trainers were digitally recorded, transcribed and then coded.

The three-tiered phases of data analysis of Miles and Huberman (Miles & Huberman, 1994) were followed to structure the data analysis (see Diagram 4.1). As part of the first analysis phase, the elements of an existing model, the Integrated Behaviour Model (IM) (Fishbein, 2000), were used as sensitising concepts in order to organise and later report the qualitative data. The reason why the IM was chosen will be explained later in the study (Chapter 2). While

a deductive analysis process was followed by making use of the IM's various elements as themes (Patton, 2002), there was a constant comparative process between the themes of the IM and the data so that additional aspects that were evident in the data but not present in the themes of the IM could be identified as new themes. Following this procedure, sub-coding was done (Saldaña, 2012), by which each of these larger themes was collapsed into smaller categories that emerged inductively within each theme (Patton, 2002). During the second phase of the analysis the themes that were identified from the findings of the students and the clinician trainers were combined and compared against the current literature. As the last phase, an explanatory conceptual framework emerged from this final synthesis and integration aimed at answering the research questions that were formulated.

1.7   ETHICAL CONSIDERATIONS

Approval to conduct the research was obtained from the Health Research Ethics Committee of the FMHS and institutional permission was sought from SU and the Department of Health for the relevant clinical sites. The selected students as well as clinician trainers were invited by email, telephone calls and in person to participate in the study. Participation was on a voluntary basis and informed consent was obtained from each participant. The anonymity of the reported data for all participants was guaranteed and information was kept confidential at all times. The recorded interviews were sent anonymously and directly for transcription to a person not attached to the FHMS and all the data were stored in a locked facility or on a password-protected computer.

Patients were not directly involved in the study and their standard assessment and management were not influenced by this study in any way. No information that could identify any patients was documented or used and there were no risks involved or any side-effects anticipated during the data-collection process of this study.

1.8   DEFINITION OF KEY TERMS

The understanding of patient-centredness, along with other related terms, is critical in this study and is explored in depth in Chapter 2 as part of the reviewed literature. In order to enhance a shared understanding, the next section briefly clarifies some working definitions pertinent to this study.

1.8.1   Patient-centredness

This study accepts Stewart's (2003) definition of patient-centredness, namely that the essence of patient-centredness is an approach which means the acceptance of two understandings: (1) a perspective change from a disease focus to a focus on the whole patient's feelings and experience and (2) a shift from the doctor controlling the relationship, communication and decision-making to involving patients (Stewart, 2003).

1.8.2   Clinician trainer

During the students' medical training they are exposed to a variety of individuals from whom they learn. These individuals include lecturers appointed by the university or by a partner employer such as the Provisional Government of the Western Cape who are medical doctors, as well as some doctors in the clinical areas that have a primary responsibility to deliver a clinical service to patients. Some of these clinicians are appointed on the joint establishment of the university and the Provincial Government of the Western Cape and therefore also have additional academic responsibilities, including the teaching of medical students. In this dissertation the term 'clinician trainer' was chosen as the most appropriate overarching term for lecturers, doctors, registrars or consultants, since the majority of the teaching and learning of patient-centredness takes place in the clinical learning environment.

1.8.3   Clinical learning environment

The clinical learning environment, which is where most of the teaching and learning of patient-centredness occurs, is sometimes referred to as the clinical area or clinical teaching platform where workplace-based learning occurs. The students are placed here for their various clinical rotations.

1.9   STRUCTURE OF THE STUDY

Chapter 1 has provided a brief overview of the rationale of study, its research aim and objectives, and its methodology. Chapter 2 outlines key theoretical perspectives that form the theoretical framework for the study. This chapter starts with a detailed discussion of the concept 'patient-centredness', followed by a curriculum perspective on patient-centred learning. Lastly, how patient-centredness forms part of medical curricula is explored. Chapter 3 explains the context of this study, addressing various matters such as the disciplinary, the international and

the national as well as the institutional and programmatic context at SU. Lastly, it provides information related to the analysis of the relevant study guides with the aim of contextualising patient-centredness as observed in the formal documentation of the MB,ChB programme at SU.

The research methodology is described in Chapter 4, which includes an explanation of the research design, the process of data collection and data analysis. Chapter 5 and 6 present the findings of the data generated from the students and the clinician trainers. Students were first interviewed as part of the data gathering process (Chapter 5) and then as a follow up process lecturers were involved (Chapter 6). These two chapters lay the foundation for Chapter 7 where the findings of the two datasets are synthesised and discussed as informed by literature pertinent to the issue of patient-centred teaching and learning. Chapter 8 concludes this dissertation by providing a synthesis of the findings in the form of an explanatory conceptual framework, also drawing a number of important conclusions and pointing out implications from the study for theory, practice and future research.

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Chapter 2

THE TEACHING AND LEARNING OF PATIENT-CENTREDNESS IN UNDERGRADUATE MEDICAL CURRICULA

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In order to understand how medical students acquire patient-centredness in an undergraduate medical curriculum as well as the factors that might influence the learning of patient-centredness, it was necessary to explore a number of salient aspects. This chapter provides a theoretical perspective on the teaching and learning of patient-centredness in undergraduate medical curricula. The chapter is divided into three sub-sections, namely Parts A, B and C. Part A deals with the concept of patient-centredness, Part B considers some general curriculum aspects before it narrows down to the context of medical education, and Part C explores the teaching and learning of patient-centredness in undergraduate medical curricula.

PART A: THEORETICAL PERSPECTIVES ON PATIENT-CENTREDNESS

2A.1   INTRODUCTION

In this sub-section the development of the concept of patient-centredness (2A.2.1); the significance thereof (2A.2.2) and then the definition of patient-centredness and related terms (2A.2.3) are explored. Following this the doctor-patient relationship (2A.4), with patients' preferences against or for patient-centredness (2A.5), with factors affecting doctors to be patient-centred (2A.6) and finally the measurement of patient-centredness (2A.7) are discussed.

2A.2   PATIENT-CENTREDNESS: A BROAD OVERVIEW

2A.2.1   Development of the concept of patient-centredness

Patient-centredness has become an accepted term in medicine and health care; yet, on examining the various interpretations thereof it seems to be poorly understood and often

misinterpreted. Many sources attempt to explain patient-centredness by stating what it is not; namely a doctor-centred or disease-centred approach to a patient. Some healthcare providers consider patient-centredness equal to a psychosocial approach, while others think of it as a position where patients get all that they ask for (Epstein, 2000). The more recent emphasis on patient-centredness and patient-centred care was mainly driven by changes in health care over the last few decades. Some of these changes can be seen in the rise of consumerism, an increased access for patients to health information, the challenge of traditional medical paternalism (Gillespie, Florin & Gillam, 2004; Krupat, Rosenkranz, Yeager, Barnard, Putnam & Inui, 2000) and the emphasis on safe and quality health care (Jorm, Dunbar, Sudano & Travaglia, 2009). Some authors have also suggested that another contributing factor is the new generation of baby boomers wanting to be part of the decision-making process by bringing their own preferences into medical care (Laine & Davidoff, 1996). Since the learning of patient-centredness is the focus of this study, a deeper explanation of the history and interpretation of the concept is needed. Whilst exploring the concept of patient-centredness in its historical context, it may also be appropriate to refer to other related terms and concepts that emerged during this period.

The manner in which doctors approach patients and the problems with which they present are largely influenced by the conceptual models around which their knowledge is organised (Engel, 1981). The traditional model for a doctor-patient interaction stems from the biomedical model of disease which defined medical care as the treatment of physical disease where cure is defined by objective indicators. The approach during the interaction has typically been doctor-centred or disease-centred (De Valck, Bensing, Bruynooghe & Batenburg, 2001; Engel, 1977). The biomedical model was devised by medical scientists for the study of diseases and this model assumes that all diseases can be accounted for by measuring deviations from the normal biological parameters (Engel, 1977). Together with this approach, the doctor has an authoritarian relationship with the patient in which he or she is the medical expert and the patient has a more passive role (De Valck et al., 2001). This traditional clinical approach tends to focus on identifying and treating standard disease entities, reducing the disease to a set of signs and symptoms in need of investigation and interpretation (Mead & Bower, 2000b).

In the late 1970s a psychiatrist, George Engel, recognised not only the physical symptoms and signs of a patient, but also the psychological and social dimensions of wellness and disease. He then proposed the biopsychosocial model of medicine (Engel, 1977) which suggested a holistic alternative and a new way of viewing illness, suffering and healing. This view was in opposition

to the biomedical model that had been the norm since the mid-20th century (Borrell-Carrió, Suchman & Epstein, 2004). The biopsychosocial model provided the space for a discussion of psychosocial matters during the consultation where the patient has a more active role and is seen as the expert on his or her own health status (Engel, 1981). An important addition to the original biopsychosocial model followed in 2002 when it was recognised that each person has a spiritual history; hence a spiritual dimension was added to the model, extending it further to the so-called biopsychosocial-spiritual model of care (Sulmasy, 2002).

Although the biopsychosocial model has been accepted in many medical schools since then and most medical practitioners are familiar with the concept (Adler, 2009), the critique has been that it does not provide one with guidelines on how to achieve a biopsychosocial understanding of the patient (Stewart, 1995). The criticism was that whilst this model may be valuable in emphasising the importance of dimensions such as personal and social aspects of the patient and his or her illness, it does not explain when or how to include such dimensions. The perceived limitations subsequently led to the development of more comprehensive models of care (Stewart, 1995), which are discussed next.

In the 1980s a group of family physicians from Western Ontario developed a 'patient-centred' approach that could be used to assist with the implementation of the previously discussed biopsychosocial model (Levenstein, McCracken, McWhinney, Stewart & Brown, 1986; McWhinney, 1997; Stewart & Roter, 1989). The term 'patient-centredness' was first introduced to the field of medical practice by Balint in 1969 as a way to understand the patient's complaints not only in terms of pathology, but to include everything the doctor knows and understands about his or her patients and takes their unique individuality into account (Balint, 1969). The development of the concept of patient-centredness in medicine mainly stems from within the field of General Practice (Family Medicine); however, over the years other disciplines have also shown interest. Some examples are those in Internal Medicine (Haidet et al., 2001; Smith, Marshall-Dorsey, Osborn, Shebroe, Lyles, Stoffelmayr, Van Egeren, Mettler, Maduschke & Stanley, 2000; Zandbelt, Smets, Oort, Godfried & de Haes, 2006), Paediatrics (Latour, Van Goudoever & Hazelzet, 2008), Emergency Medicine (Dale, Sandhu, Lall & Glucksman, 2008), Oncology (Ong, Visser, Lammes & De Haes, 2000), Surgery and Orthopaedics (Tongue, Epps & Forese, 2005) and Obstetrics and Gynaecology (Chan & Ahmad, 2012; Huppelschoten, Van Duijnhoven, Hermens, Verhaak, Kremer & Nelen, 2012).

Considering the vast amount of literature around the topic of patient-centredness, it seems as if patient-centredness has been accepted by many health professionals and institutions as the preferred approach to patients in health care today.

Before moving on to an exploration of the concept of patient-centredness and related terms that are of relevance, it may be important to consider the significance of patient-centredness first.

2A.2.2   Significance of patient-centredness

Despite the considerable amount of research focusing on the benefits of a patient-centred approach, the lack of a clear definition of patient-centredness has limited its theoretical and empirical development (Mead & Bower, 2000b). From an ethical point of view, patient-centred care is an approach to care that is perceived as 'the right thing to do', irrespective of whether it achieves other measurable outcomes or not (Epstein, Fiscella, Lesser & Stange, 2010). Also, one can argue that it is morally required since there is empirical evidence that patient-centredness can lead to improved outcomes for patients (Duggan, Geller, Cooper & Beach, 2006).

The literature also suggests that patient-centredness is often embraced from the doctors' side as a defence against the increase in malpractice lawsuits that have become more prevalent (Hudon, Fortin, Haggerty, Lambert & Poitras, 2011; Levinson, Roter, Mullooly, Dull & Frankel, 1997). By involving patients more in their diagnosis and treatment options, doctors can protect themselves to a certain extent from unfavourable patient outcomes or patient dissatisfaction.

At the level of health outcomes, there seems to be evidence that a patient-centred approach has benefits for patients' well-being by reducing their anxiety levels and depression. This approach has the effect that patients can cope better with difficulty, they understand their disease better and they have better compliance (Street, Makoul, Arora & Epstein, 2009). Furthermore, it has been shown that patient-centred care improves patients' care due to shared understanding and better adherence to medications. There is also a reduction in costs, since patients who perceived their visits to be patient-centred required fewer diagnostic tests and had fewer referrals to other physicians (Stewart et al., 2000). A group of patients who should benefit from a patient-centred approach are patients who are very sick, have low literacy and are members of marginalised groups, because they tend to ask fewer questions and therefore they would get less information than their fellow patients that do not have these issues. A patient-centred approach with these

patients should bridge differences between patients and doctors with regard to issues such as health beliefs, race, ethnicity and culture (Epstein et al., 2010; Saha, Beach & Cooper, 2008).

Furthermore, patient-centredness can increase patient safety by ensuring that patients' behaviours, choices and needs are communicated to doctors. For example, if doctors have a trusting relationship with their patients, their open-ended questions will provide them with the information that is needed and which might otherwise not have been shared by the patients (Epstein et al., 2010). An example is the use of Viagra in the context of a patient presenting with chest pain. It is therefore not surprising that quality and safety agencies in some countries have prioritised the philosophy and practice of patient-centred care as being at the core of effective models of care delivery (Kitson, Marshall, Bassett & Zeitz, 2013).

There is, however, also research that suggests a patient-centred approach is not necessarily the best approach for all patients in all circumstances and that varying factors can play a significant role (De Haes, 2006). These factors which might influence the preference for patient-centredness are elaborated on in section 2A.5.

2A.2.3   Definition of patient-centredness and related terms

A scrutiny of relevant literature revealed no single definition for patient-centredness. It rather seems that various authors interpret this multi-dimensional concept in relation to their own contexts by often focusing on only one or two aspects of what patient-centredness actually means. The next section deals with the most prominent definitions found in the literature.

At more or less the same time that Balint (1969) emphasised patient-centredness as a particular way in which doctors should communicate and interact with patients, patient-centredness was described by Byrne and Long as a style of consulting in which the doctor uses the patient's knowledge and experiences to direct the consultation (Buijs, Sluijs & Verhaak, 1984). Byrne and Long described various general practitioner styles of consultation varying from 'doctor-centred' to 'patient-centred'. The doctor-centred style is a consultation that is dominated by the doctor's skills, knowledge and behaviour, such as closed-ended questions with much direction; whilst a patient-centred consultation implies recognition of patient needs and preferences with opportunities created for patients to speak and work in partnership with the medical practitioner (Buijs et al., 1984). This widely cited research has led to the conception that 'patient-centredness' can be contrasted with 'doctor-centredness' – the two styles that doctors could apply during consultations (Buijs et al., 1984, Mead & Bower, 2000b).

On the other hand, the patient-centred clinical method (Stewart, 1995) developed to operationalise the biopsychosocial model was primarily built on the understanding that patient-centredness is practised when the doctor attempts to see the illness through the eyes of the patient (McWhinney, 1986). It was a South African family physician, Dr J Levenstein, who started to refer to his patient-encounters as being 'patient-centred' after listening for patient cues about their concerns, fears and expectations as well as to why they presented themselves to him (Levenstein et al., 1986). This reported patient-centred approach has as its main goal to improve the understanding of the patient as well as the disease and it differentiates between a 'patient-centred' approach and a 'disease-centred' approach, making it clear that the patient is more than his/her disease (Stewart, 1995, 2001). The proposed patient-centred model outlines six dimensions of patient-centred care and has probably become the most cited patient-centred model in medicine, especially in the Family Medicine community.

The six elements that were identified are (1) exploring both the disease and the illness experience, (2) understanding the whole person, (3) finding common ground regarding management, (4) incorporating prevention and health promotion, (5) enhancing the doctor-patient relationship and (6) being realistic (Stewart, 1995). Even though these components of the patient-centred clinical method are presented as separate steps, it is important to realise that they are interwoven and a clinician should be able to move back and forth between these components (Stewart, 1995). The developers of this model claim that it is both a model and a clinical method/approach and it simultaneously provides strategies for implementation and teaching while providing a body of research supporting its use. Despite its proposed benefits, the authors thereof acknowledge that in order to apply this model to clinical practice with all its complexities, much practice and experience is required (Stewart, 1995). This issue in itself is problematic since undergraduate medical students often do not have sufficient exposure to practice and experiences with patients; yet it is often an expectation that students should graduate as doctors who are competent in delivering a patient-centred approach. It is of relevance to mention that the Department of Family Medicine at the FMHS at SU embraces this model of Stewart and her colleagues, and therefore it has been incorporated into the undergraduate medical curriculum (Mash, 2006).

Following on the extensive number of publications over the past few decades looking at various interpretations of patient-centredness, a comprehensive review of the literature describing the features of patient-centred encounters between patients and practitioners was conducted (Mead

& Bower, 2000b). From this widely cited review Mead and Bower clarified the key dimensions of patient-centredness that distinguish 'patient-centred' medicine from the 'biomedical model' in terms of the doctor-patient relationship. These five dimensions are (1) the biopsychosocial perspective, (2) the 'patient-as-person', (3) sharing power and responsibility, (4) the therapeutic alliance and (5) the 'doctor-as-person'. What seems to be absent from the Mead and Bower framework, however, is any mention of disease prevention or health promotion, both of which are elements that are present in the model of Stewart et al. (Hudon et al., 2011). It would seem as if Mead and Bower focused their framework of patient-centredness as a style of interaction and communication while Stewart et al. provided a more comprehensive approach to patient care within a family physician's context (Beach, Saha, Cooper & Fund, 2006). Beach et al. (2006) propose that the definition of patient-centredness as offered by McWhinney (1989), namely that the doctor tries to see the illness through the eyes of the patient, suggests that patient-centredness is about more than only the interaction style of practitioners; it is in fact about a broader health-care system. This helps to explain why some authors have expanded the interpretation of the term to include optimal patient-healthcare system interactions (Saha et al., 2008; Setlhare, Couper & Wright, 2014).

Besides the concept of patient-centredness, other related concepts have also become important in health care over the past few years. These include concepts such as person-, client-, family- and relationship-centred care. In a systematic review done by Hughes, Bamfort and May (2008) with the aim of understanding why the notion of 'centredness' has become so important and how these terms should be understood, it was highlighted that the different concepts stem from different historical backgrounds. Table 2.1 summarises these terms with a brief mention of their respective origins.

Table 2.1: 'Centred'-related concepts explained (Hughes, Bamford & May, 2008)

Person-centred	Client-centred	Family-centred	Relationship-centred
This concept stems from psychology and the work of Carl Rogers in the 1960s. He emphasised communication and relationship (McCance, McCormack & Dewing, 2011).	This approach is used particularly in occupational therapy with the focus on the therapeutic relationship (Sumsion & Law, 2006).	The family-centred approach is used mostly in paediatrics and is linked to the practice of family therapy (Rosenbaum, King, Law, King & Evans, 1998).	This concept developed to be more inclusive, affirming the centrality of relationships in health care (Nolan, Keady & Aveyard, 2001).

It is evident from Table 2.1 that these aforementioned concepts have different meanings for various contexts and that they focus on very specific aspects. It is also clear that all of these concepts have a shared aim to move away from the limiting biomedical view to a much broader biopsychosocial and spiritual view of patients. While Hughes et al. (2008) argue that the different types of 'centredness' are needed for the different contexts where they are used, one could argue that patient-centredness is a sufficiently broad concept to incorporate most of these concepts discussed above. Acknowledging that patient-centredness is a broad concept, exploring the conceptual constructs underlying it seems important.

With patient-centredness being so multifaceted, authors have proposed different constructs that comprise this concept. What seems particularly useful is the interpretation of Krupat et al. who identified two key constructs, namely 'sharing' and 'caring', that underpin patient-centredness (Krupat et al., 2000). Since an operationalisation of such an understanding was used as part of the interviews conducted with the students and the doctors in this study, it is subsequently explained in more detail.

For their first component of sharing, Krupat et al. built their understanding of patient-centredness on the premise that when a patient-centred style is contrasted with a doctor-centred style, it refers to the extent to which power is shared between the doctor and the patient. A doctor-centred consultation will be controlled by the doctor and there will be limited flow of information and involvement of the patient regarding decision-making. The second component, caring, is understood by differentiating between a patient-centred style and a disease-centred style, as Levenstein described in the 1980s. The distinction is the degree to which doctors try to understand the problem by adopting the perspective of the patient by exploring the feelings and expectations of the patient (Krupat et al., 2000).

Some literature suggests that patient-centredness and patient-centred care should be extended more widely than to the patient alone to include policy and administrative concerns as well (Scholl, Zill, Härter & Dirmaier, 2014). In its purest form, however, it still relates most closely to the clinical consultation and thus the doctor-patient relationship (Siriwardena & Norfolk, 2007). Acknowledging that there are discrepancies in the literature about what patient-centredness consists of, the next section will further explore some of the related terminology and finally suggest an understanding of patient-centredness. Since there are some terms that are often used inappropriately when discussions about patient-centredness take place it is important to highlight them.

2A.2.3.1 *Patient-centredness*

'Patient-centredness' seems to be a broader and more philosophical term than 'patient-centred care' or 'patient-centred communication', both of which have more practical and measurable aspects to them. Some authors consider patient-centredness to be a moral philosophy with three core values, namely (1) considering patient's needs, wants, perspectives and individual experiences, (2) offering patients opportunities to provide input into and participate in their care, and (3) enhancing partnerships and understanding in the patient-physician relationship (McWhinney, 1995).

Other authors support this view by defining patient-centredness as a moral philosophy (an attitude that acts as a guiding principle for behaviour) that finds its action in patient-centred care and patient-centred communication being a key enabler to patient-centred behaviour (Saha et al., 2008). Although the focus of this study is on patient-centredness and the learning thereof, it is important to acknowledge the interrelatedness of the other two terms.

2A.2.3.2 *Patient-centred care*

Patient-centred care, according to Epstein, Franks, Fiscella, Shields, Meldrum, Kravitz and Duberstein (2005), refers to actions in service of patient-centredness. This includes interpersonal behaviours, technical interventions and health systems innovation, implying more than the mere interaction between doctors and patients. One of the first patient-centred movements, the Picker-Common Health Program for Patient-Centred Care, started in 1986 was in the USA. It promoted an interpretation that was much wider than individual healthcare providers interacting with individual patients: this view involved an approach to hospitals and health services that concentrated on the wants and concerns of their patients (Gerteis, 1993; Saha et al., 2008). This programme was adopted by some European countries during the 2000s, while in the USA it was taken over by the Institute for Patient and Family Centered Care (IPFCC) in the last few years (Institute for Patient and Family Centered Care, 2016). The Picker Institute Europe is acknowledged for coining the term 'person-centred care' which is discussed later in this chapter (Picker Institute Europe, 2016). Since then there have been various models for patient-centred care, yet the three key features across all the patient-centred care models and frameworks seem to be effective communication, partnerships and health promotion (Constand, MacDermid, Dal Bello-Haas & Law, 2014).

2A.2.3.3 *Patient-centred communication*

Patient-centred communication (PCC) can be seen as a cluster of behaviours that is supposed to assist the healthcare provider in reaching the goals of patient-centred care (Epstein, 2000). It may, however, also be viewed as both a style of practice and the specific behaviour during doctor-patient interaction (Epstein et al., 2005). Good doctor-patient communication is vital in order for patients to be able to experience patient-centredness. According to Epstein et al. (2005), four aspects are involved: (1) eliciting and understanding the patient's perspective, concerns, ideas, needs, feelings and functioning, (2) understanding the patient within his/her unique psychosocial context, (3) reaching a shared understanding of the problem and its treatment with the patient that is concordant with the patient's values, and (4) helping patients to share power and responsibility by involving them in choices to the degree that they wish.

Despite Epstein's attempt to analyse what PCC entails, there has been no consensus on which aspects should be included as part of the full spectrum of patient-centred communication (Arora, 2003). One of the realities that complicate the choice of what should be included is the fact that context hugely influences PCC and different scenarios would thus require doctors to communicate differently. For example, when patients become critically sick they might prefer a more directive approach than if they have a chronic condition; hence the argument that it is not really about the frequency and type of behaviour, but more about the doctor's skills of responsiveness and informed flexibility to portray effective PCC (Epstein et al., 2005).

However one chooses to look at these definitions, using communication skills effectively is regarded as a major component of patient-centredness. It is therefore not surprising that many studies suggest that communication between the doctor and the patient is considered the most important aspect of patient-centredness (Rao, Anderson, Inui & Frankel, 2007; Stein, Frankel & Krupat, 2005; Street et al., 2009). It is within this doctor-patient relationship that empathy skills are vital since a doctor that can understand the feelings, experiences and attitudes of their patient has a good chance of having an effective interview and therapeutic agreement (Hegazi & Wilson, 2013). Empathy as a critical component of patient-centredness is discussed next.

Empathy is viewed as one of the key elements of the doctor-patient communication process and thus plays an important role in achieving patient-centredness (Neumann, Edelhäuser, Tauschel, Fischer, Wirtz, Woopen, Haramati & Scheffer, 2011). While some authors suggest that empathetic doctors are less likely to experience burnout and compassion fatigue (Gleichgerrcht

& Decety, 2013) it is also recognised that too high levels of empathy can cause compassion fatigue and burnout (Zenasni, Boujut, Woerner & Sultan, 2012). However, it is important to realise that being patient-centred is more than just being empathetic. Empathy is defined as the appropriate understanding and communication of the patient's experiences (Pedersen, 2008) and it is a vital prerequisite for the doctor to understand the patient's individual experiences and needs. Doctors should be aware of not being sympathetic, but rather displaying cognitive empathy when interacting with patients. Cognitive empathy refers to the doctor's ability to understand the inner experience and viewpoint of the patient and then the ability to reflect it (Hojat, Gonnella, Nasca, Mangione, Vergare & Magee, 2002). Empathy differs from sympathy in the sense that sympathy is the ability to share someone's emotion or experience and feel it with the individual (Lussier & Richard, 2010). Training methods that have been used based on an affective definition of empathy include hospital experiences and narratives (DasGupta & Charon, 2004). The idea is not to imply that too much compassion or empathy is unwanted, but rather that the acquisition of affective skills in combination with cognitive skills can increase the emotional stability of the doctor (Preusche & Lamm, 2016).

Some authors argue that patients can sense whether a doctor is faking empathy and they will respond better to doctors that are emotionally accurately attuned (Halpern, 2003). Doctors who are in harmony with patients' emotions will be able to sense when to ask questions and when to be silent, which in the end leads to better communication and often disclosure of important information by the patient (Hegazi & Wilson, 2013).

With regard to the definition, some authors argue that empathy should not be defined only in terms of cognitive processes, but that affective processes should also be included (Preusche & Lamm, 2016). Only a few of the many studies that investigated the trend of empathy development in medical students during their training are mentioned here: some studies have indicated that the decline that takes place happens during the later years of training (Chen, Lew, Hershman & Orlander, 2007; Hojat, Mangione, Nasca, Rattner, Erdmann, Gonnella & Magee, 2004; Newton, Barber, Clardy, Cleveland & O'Sullivan, 2008), while others suggest empathy decline is something that happens early on in their curriculum (Austin, Evans, Magnus & O'Hanlon, 2007; Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, Veloski & Gonnella, 2009). However, lately some literature has suggested that the reported decline in empathy has been exaggerated (Colliver, Conlee, Verhulst & Dorsey, 2010). The exact reasons for these trends are not within the scope of this study, and will therefore not be discussed. In the context

of this study empathy would form part of the caring component (Krupat et al., 2000) of patient-centredness; however, it must be realised that patient-centredness requires more than only paying attention to the caring component.

In summarising the discussion in section 2A.3, it is important to note that while the term 'patient-centredness' is interpreted differently by various authors and within different disciplines, they all seem to represent a reaction to the apparent limitations of the traditional medical care approach that focused on the disease and the doctor as a dominating professional. This study embraces the interpretation of Stewart, namely that patient-centredness is essentially an approach which accepts two understandings, namely (1) a perspective change from a disease focus to a focus on the whole patient's feelings and experience and (2) a shift from the doctor controlling the relationship, communication and decision-making to involving patients (Stewart, 2003).

It is within the doctor-patient relationship that this communication and decision-making process takes place and therefore this relationship is acknowledged as a central component of patient-centredness. In the next section the crucial role of communication and decision-making in the doctor-patient relationship is discussed.

2A.3   THE DOCTOR-PATIENT RELATIONSHIP

Since Engel proposed the biopsychosocial model in the 1970s as a way of practising medicine, much has been written about the style of communication between doctors and patients. In one of his papers Engel described the influence psychosocial aspects can have on physical conditions, bearing in mind that these psychosocial issues would only be apparent if the patient communicates it to the doctor (Arora, 2003). Subsequent to the uptake of the biopsychosocial model in medicine there has been much emphasis on communication skills and the teaching of doctors to be able to elicit relevant information from patients (Sarah, 2010). In order to understand why the communication process between doctors and patients is so important, one may consider the various purposes of medical communication. The reasons for communication between doctors and patients include creating a good interpersonal relationship, exchanging information, and making treatment-related decisions (Ong, De Haes, Hoos & Lammes, 1995). There are, however, various opinions about what constitutes a good interpersonal relationship. Some authors suggest that such relationships should entail elements such as friendliness, honesty, compliments and jokes, as well as sharing of life history. However, if a patient-centred

approach is followed, the goal would be to follow the patients' leads in an attempt to understand their experiences from their own perspective (Stewart, 1995). With regard to exchange of information, patients have to share information about their symptoms and concerns while doctors have a responsibility to discuss the diagnosis and treatment plan once it has been established. It would seem as if the traditional paternalistic approach (doctor-centred), where the doctor makes the decisions, has to a large extent been replaced by shared decision-making processes over the past 20 years (Ong et al., 1995).

Over time, several models for the doctor-patient relationship have been described and it would seem as if one can differentiate between four models: (1) the paternalistic model (the physician acts as the patient's guardian and makes decisions on their behalf), (2) the informative or consumer model (the doctor provides the patient with all the relevant information and then leaves them to decide what they want), (3) the interpretive or counsellor model (the doctor provides the patient with all the information and then assists them in deciding what they want) and (4) the deliberative model (acting as a teacher by engaging in a dialogue about what course of action would be best for the patient) (Emanuel & Emanuel, 1992).

A debate that has dominated the literature over the last number of years with regard to the doctor-patient relationship has been the tension between paternalism and patient autonomy. While it is agreed that doctors should not behave paternalistically as an extreme, it also does not make sense that patients are left to control their own care as described by the informative model. It is suggested that the deliberative model be followed, where a caring doctor effectively integrates the patient's medical condition and values before making recommendations (Emanuel & Emanuel, 1992). However, one should be careful not to advocate one model to be superior to the rest, since the practice of medicine is not predictable and no two patients are the same or have the same condition and personal context. It is thus acknowledged that one doctor-patient model will not suit all circumstances (Lussier & Richard, 2008) and that doctors need a repertoire of doctor-patient communication styles that they can use in various clinical conditions and contexts. These include at least four styles, namely the expert-in-charge, the expert-guide, the partner and the facilitator. These styles are explained with some examples below.

In acute, serious circumstances such as a stroke or a myocardial infarction, the doctor makes decisions unilaterally and carries out actions quickly. In this situation the doctor often acts as the expert-in-charge (Lussier & Richard, 2008), which is a kind of paternalistic style and which

may well be appropriate in that situation (Emanuel & Emanuel, 1992). A second possibility is when the doctor acts as an expert-guide when the situation is sub-acute and he/she provides the patient with a professional opinion allowing for patient collaboration. A third option is applicable in more chronic conditions with the doctor acting as a partner and where it is more about building a relationship and the discussion of options. Finally, the style of a facilitator may be more appropriate when the patient has a good knowledge of his/her condition and only needs advice or motivation from the doctor. Authors argue that the dangers of advocating for only one preferred doctor-patient-relationship style is that doctors would soon experience that one style may not be applicable to their everyday clinical practice. The risk they then face is to move into the default traditional style of expert-in-charge, negating situations where one of the other three models could have been more appropriate (Lussier & Richard, 2008).

It is important to acknowledge that patient-centredness in its true meaning does not imply only one style of practice; it will inevitably vary from patient to patient. Although it has a structure in order for students to learn how to use and do it, it implies different conversations with different patients for all the different reasons that have already been mentioned. This notion of flexibility in the doctor-patient relationship is a fundamental aspect that should be emphasised in undergraduate medical students' communication skills curricula since doctors should be able to adapt their approach to suit the patient's needs, context and the urgency of the problems. At the same time they should bear in mind that being sensitive to suffering and personal circumstance should always be relevant regardless whether it is a chronic or a serious surgical or medical condition that is being dealt with (Stewart, Brown, Freeman, Weston & McWilliam, 2009). The core of any doctor-patient relationship should be respect for patients and their autonomy and their right to confidentiality, and behaviour that is guided by concern (Lussier & Richard, 2008).

While it seems evident that patient-centredness can enhance the doctor-patient relationship (Kaba & Sooriakumaran, 2007), some authors believe that the basis of patient-centred care is effective communication (Levinson, Lesser & Epstein, 2010; Ong et al., 1995; Rao et al., 2007). Good communication skills are regarded as a powerful enabler to a patient-centred encounter between the doctor and the patient, and the teaching and learning of these skills are nowadays included in most curricula for medical graduates (GMC,1993; Liaison Committee on Medical Education, 2003; Makoul, 2003). More detail on the teaching and learning of patient-centred communication skills is discussed as a section of Part C in this chapter. However, one has to be

aware that other factors over and above communication skills might also influence the doctor-patient relationship and patient-centredness of any consultation. These factors are discussed in the sections that follow.

2A.4   PATIENTS' (NON-) PREFERENCE FOR PATIENT-CENTREDNESS

It is often assumed that all patients would appreciate a patient-centred approach. However, over the last decade or so there seems to be a realisation that this is not necessarily the case (De Haes, 2006). Patients are not all the same and therefore all would not appreciate the same approach in the doctor-patient interaction or relationship. Patients have varied needs and could appreciate some of the aspects within patient-centredness in a variety of ways. Little et al. (2001) have suggested that most patients would prefer a patient-centred approach; not only a friendly doctor that has good communication skills, but one that can provide health promotion and offers a partnership for the health problem and the treatment thereof.

When considering the copious research on patients' preferences for a patient-centred approach it is important to take note of which interpretation of patient-centredness each study chose before one draws any conclusions from their results. With reference to Krupat et al.'s (2000) interpretation of patient-centredness as having two components, namely caring and sharing: one should be cautious not to reduce patient-centredness to either one of these two components. What makes the interpretation of the available body of research even more challenging is the fact that the results are sometimes contradictory. For example, some research suggests that patients from lower educational backgrounds, those who have a poorer prognosis and those that have high anxiety levels would often not prefer a patient-centred approach (Swenson, Buell, Zettler, White, Ruston & Lo, 2004). At the same time there are studies showing that patients that have a strong preference for patient-centredness seem to be the ones that are vulnerable, either due to a psychosocial issue or just because they are feeling particularly sick or worried (Little et al., 2001). What is more, various studies have confirmed that older patients (over 65 years) generally prefer the doctor to make the decisions on their behalf (Parker, Baile, De Moor; Lenzi, Kudelka & Cohen, 2001; Swenson et al., 2004). Despite these contradictions, one could still argue that all patients would appreciate a doctor that attempts to view the world through their eyes (Levenstein et al., 1986), thus favouring in principle the 'caring' component of patient-centredness. It is the 'sharing' component, dealing with information sharing and

involvement of the patient regarding decision-making that is an aspect not all patients would necessarily prefer. It is possible that some patients might not want to take part in decisions because they are afraid that if they ask too many questions they might appear to be distrustful of their doctor; or they might not be sufficiently assertive to engage in such a conversation (De Haes, 2006). Doctors should be constantly reminded that although not all patients prefer a patient-centred approach, they should encourage their patients to adopt this approach as there is strong evidence that patient-centred communication in the consultation is linked with positive health outcomes (Sheridan, Harris, Woolf & Force, 2004).

Culture is another factor that needs to be mentioned since different cultural practices often play a significant role in the doctor-patient interaction. Some patients would avoid eye contact, which is regarded an important component of the doctor-patient interaction and students are generally taught to use this skill during a consultation. Furthermore, in some cultures there is the belief that if they discuss death and dying with a healthcare provider it might bring it closer to themselves (Curtis, Patrick, Caldwell & Collier, 2000), hence they avoid discussing serious diseases with the doctor.

The awareness that all patients cannot be approached in the same manner and that some patients do not want to know everything about their disease and rather leave decisions to the doctor, implies that patient-centredness is not a one-size-fits-all approach. If patient-centredness, according to the textbook, is practised the same on each and every patient, some patients might experience it as not patient-centred. Perhaps patient-centredness is less about prompting patients for their perspective and engaging them actively, but rather more about respecting their values and needs. Bensing (2000) contends that patient-centred medicine should be more about the doctor being sensitive to where the patient finds him/herself and having the communication skills to handle the different types of consultations that could result from the specific situation. A proposed model of interaction is one where there is a close fit between the doctor's behaviour and the patients' needs, where the doctor has the skills and insight to adapt interventions, giving or withholding information and sharing power according to the needs of the patient (De Boer, Delnoij & Rademakers, 2013; De Haes, 2006). The doctor-patient relationship is complex, because on the one hand there is a patient with very specific preferences regard to patient-centred treatment, while on the other side of the relationship is the doctor who is also influenced by his or her preferences. Patient-centredness, from the perspective of the doctor, is discussed next.

2A.5   FACTORS AFFECTING DOCTORS' PATIENT-CENTREDNESS

There is evidence that a patient-centred approach has benefits for patients (see 2A.2.2). This also applies to doctors, as improved job satisfaction and less burnout have been reported (Bauman, Fardy & Harris, 2003; Shanafelt, 2009; Stewart, 1995). The question is, however, which factors may influence doctors to behave in either a patient-centred manner or not. It is important to mention at this stage that the term 'doctor' is used in this context for both medical students and qualified doctors, since some studies include both of these parties in their research cohorts.

Certain factors influence situations and despite the doctors' intention to be patient-centred it can be either hindering or enabling, depending on whether a particular factor is experienced as positive or negative. For example, the environment in which the doctor works and systemic barriers such as too many patients can determine whether the doctor displays patient-centredness or not. These factors and others will be discussed in more detail later in this chapter when barriers to and enablers of patient-centredness are discussed more comprehensively. However, as previously discussed, the lack of a clear definition of what patient-centredness and patient-centred care actually entail is one of the major contributing factors that could obstruct the implementation and incorporation of patient-centredness in daily practice (Davies, 2007; Pelzang, 2010).

Mead and Bower (2000a) developed a model that explains some factors that can have an influence on a doctor's inclination to be patient-centred or not. This model neatly combines some of the patient-related and doctor-related factors mentioned above. What is prominent about the model is the importance of the doctor-patient relationship that is expressed in the form of behavioural interactions between two parties and which is seen as central to the model. Factors that might influence doctors in being either patient-centred or not are explained below.

 'Shapers' are applicable to both the doctor and the patient in the relationship. In the case of doctors, the shapers are factors such as their cultural norms, socio-economic background, personal experiences and clinical experience. Examples of the doctor's shaper factors are attitudes, values, personality, age, gender and background knowledge. In the case of the patient, some shaper factors could be the nature of the patient's problem, knowledge, age, personality and expectations. Some of the factors that could also have an influence on the doctor are professional norms, government policies and accreditation. Lastly, the model describes the

influences that are at consultation level and which will have the most direct effect on the inclination of doctors to be patient-centred. These are contextual factors such as communication barriers, physical barriers, interruption, the presence of third parties, time limitations and workload pressure. It is clear that patient-centredness is a multi-sided and complex concept. It is thus not surprising that its measurement or evaluation will also be difficult. While it is important to consider the measurement of patient-centredness, it is not the focus of this study and will thus be covered very briefly.

2.A.6   THE 'MEASUREMENT' OF PATIENT-CENTREDNESS

Since patient-centredness is such a complex concept with various interpretations linked to it, it is not surprising that various evaluation instruments have developed over time. The reliability and validity of these instruments or scales are limited due to a lack of theoretical clarity (Mead & Bower, 2000b). The most common methods by which to measure patient-centredness in clinical encounters are either self-assessment by the doctor, or assessing the patient's experience, or an observation of the encounter (Epstein et al., 2005). With regard to observation of consultation behaviours, the various approaches are either rating scales (how much or how well a specific behaviour was performed) or verbal behaviour coding systems (units of the doctor's and patient's speech are categorised). Alternatively, both of these two measurement approaches can be combined as a third method (Mead & Bower, 2000b).

Most of the measurement scales are designed and utilised to determine the patient-centredness of doctors who are actively involved in consulting with patients on a day-to-day basis, while there are fewer scales to determine the attitudes of undergraduate medical students towards patient-centredness. Only two well-described instruments used for undergraduate students could be found in the literature, namely the PPOS (Krupat et al., 2000) and the Doctor Orientation Scale (Monchy, Richardson, Brown & Harden, 1988). Of these two the PPOS has been used far more extensively, therefore it was selected as part of a pilot study of this research project (Archer et al., 2014). The PPOS measures an individual's attitudes towards the doctor-patient relationship along the two dimensions described earlier, namely 'caring' and 'sharing', also referred to as a care-oriented and a cure-oriented approach respectively (De Valck et al., 2001).

The hidden curriculum has been acknowledged by Haidet et al. (2005) as a space that can undermine the learning of patient-centredness; hence these authors developed the

Communication, Curriculum, and Culture Survey (C3) (Haidet et al., 2005). The C3 measures three subscale scores: (1) the extent to which doctors model patient-centred behaviour, (2) the students' personal encounters with patient-centred experiences, and (3) students' perceived support for their patient-centred behaviours, all aspects relating to the perceived norm (hidden curriculum) and self-efficacy of the student. A new instrument called the Self-efficacy in Patient-centredness Questionnaire (SEPCQ) has recently been developed to measure students' self-efficacy in patient-centredness. It looks promising since it attempts to measure more than just patient-centred communications skills (Zachariae, O'Connor, Lassesen, Olesen, Kjær, Thygesen & Mørcke, 2015). However, in this questionnaire there is no reference to components of the hidden curriculum and students' ability to stay self-efficient despite social norms that potentially undermine patient-centredness.

Since the teaching and learning of patient-centredness at undergraduate medical education level is often centred on the acquisition of communication skills (see 2C.2.1), the assessment is also focused on this approach. The Kalamazoo II Report suggested various checklists that can be used for the assessment of communication and interpersonal skills (Duffy, Gordon, Whelan, Cole-Kelly & Frankel, 2004), with some more applicable to workplace-based assessment than others, for example the mini-CEX. The Calgary-Cambridge guide for interviewing (Kurtz, Silverman & Draper, 2005) is promoted by the Family Medicine department in the current MB,ChB curriculum at SU (Mash, 2006) in order to teach and assess medical students' communication skills.

This study, however, is not directly about the measurement of patient-centredness, therefore no further discussion will be devoted to this issue other than recognising that patient-centredness is a complex construct to measure in clinical encounters and that in order to assess this competency the assessment needs to be extended beyond communication skills only. While no single measuring instrument currently exists to measure this competency in students, more than one instrument needs to be utilised. However, after considering the history and definition of patient-centredness, together with the value and factors influencing it, one may argue that patient-centredness needs to be an essential component of any curriculum for the training of doctors. The focus in this chapter thus moves next to curriculum aspects where Part B outlines some general curriculum aspects before it narrows down to the context of medical education. In Part C the teaching and learning of patient-centredness in an undergraduate medical curriculum are explored.

PART B: PERSPECTIVES ON MEDICAL EDUCATION CURRICULA

2B.1   INTRODUCTION

Medical education is an eventful space where several pedagogical practices, educational beliefs and conceptual frameworks come together (Swanwick, 2011). Part B of this chapter explores some of these aspects by starting with a general discussion of what a curriculum is and then moving on to curriculum mapping, factors that have an impact on curriculum design and curriculum models related to the field of medical education.

2B.2   CURRICULUM AS A CONCEPT

The relevant higher education literature indicates that there is no uniform definition for what a curriculum is and that even academics at the same institution and in the same field will often have different understandings of what 'a curriculum' entails. Some might view the curriculum simply as what needs to be learned (Ross, 2000), while others see it as a journey of learning and the experience that accompanies it (Pinar, 2013). Barnett and Coate argue that a curriculum is dynamic and provides a space for understanding that can be challenged (Barnett & Coate, 2005). One reason why curricula are viewed differently by various academics could be because there are different ways in which a curriculum can be designed. For instance, three designs that are commonly used are those curricula that are designed around subjects or disciplines, those that have a student focus or those that focus on (societal) problems (Du Toit, 2011). Du Toit views the curriculum as the stimulus for learning among three constituents, namely students, lecturers and the learning content or what is to be learnt. It would seem that in order for a curriculum definition to be explanatory, it needs to be about more than just a statement with regard to knowledge content. Elements that need to be considered as part of a curriculum are planned educational experiences such as behavioural goals, the teaching methods, and the actual experiences of the learners (Green, 2001).

Posner (1995), who wrote about school curricula, proposed that a curriculum consists of at least seven elements, namely the scope and sequence of intended learning outcomes, the learning content, the content outline, the assessment standards, the sources for learning, the course of study and the planned learning experiences. Scott (2007), on the other hand, takes a more

philosophical-historical view of the development of curricula and summarises its most significant moments by describing it as a series of seven 'episodes'. The first 'episode' starts with individuals who have enthusiasm to apply the scientific method to the study and implementation of curricula. There are also some curriculum theorists who are mainly concerned with knowledge, specifically inspirational knowledge. In contrast, some authors promote the notion of teaching and learning as an innovative pedagogical experiment whereby individuals should be allowed to take responsibility for their own lives and how the curriculum could be responsive to a general need for learning. Interlinked between these two contrasting positions are four further 'episodes' that are focused on the structure of the curriculum, namely socio-cultural models of learning, critical pedagogy, instrumentalism and institutional improvement. These episodes are seen as not sequential, but rather overlapping; and by labelling them, as Scott has done, these events are given chronological boundaries (Scott, 2007).

From another angle, Kelly argues that a curriculum definition should include the purposes of acquiring knowledge as well as the effects that the exposure to knowledge are likely to have on students (Kelly, 2009). While some authors also argue that any view of a curriculum cannot be singular and that there is not only one concurrent curriculum to consider (Posner, 1995), Kelly (2009) identified four components that in her opinion should form part of a curriculum in order to make it a total curriculum (see Table 2.2).

Table 2.2: Interpretation of curriculum components (Kelly, 2009)

The planned curriculum: The intentions of the curriculum planners
The taught curriculum: The procedures adopted to implement the intentions
The received curriculum: The experiences of the students resulting from the teacher's direct attempts
The hidden curriculum: The learning that occurs as a by-product of the organisation of the curriculum

In order to understand students' learning experiences, Kelly's (2009) understanding of what a curriculum consist of seems to be useful in that it can provide a holistic picture of curriculum activities. In this study the experience of students (received and hidden curriculum), the perspectives of some lecturers (taught curriculum) and the content of the study guides (planned

curriculum) – all related to patient-centredness – were explored in order to understand how students learn, or do not learn, patient-centredness in an undergraduate medical curriculum.

It is clear from these various perspectives that a curriculum is a multi-dimensional concept and therefore it cannot be viewed in a simplistic manner. The next section explores curriculum mapping as a specific method to determine how and where specific content in a curriculum is taught and assessed.

2B.3   CURRICULUM MAPPING IN MEDICAL EDUCATION

The idea of curriculum mapping was proposed by English back in 1984, who defined it as a reality-based record of the content that is actually taught, how long it was taught, and the match between what was taught and what was assessed. A curriculum map can be productively used to manage the curriculum and to demonstrate what is taught, how it is taught, as well as how students can be assessed. This process makes the curriculum more transparent to all stakeholders and demonstrates the links between all the components of the curriculum (Harden, 2001).

The methodology of curriculum mapping has been used extensively in medical education (Harden, 2001), with examples such as a study to map cultural competency in a medical curriculum (Wachtler & Troein, 2003). Other authors subsequently added a fourth curriculum map, namely 'assessment' for the mapping of generic skills (Robley, Whittle & Murdoch-Eaton, 2005). When curriculum mapping of any curriculum is done, the ideal is to have a significant amount of information overlap between the various components, since the overlap would be indicative of some coherence in the programme (Dent & Harden, 2013).

In this study the approach that was followed to explore the curriculum was built on the curriculum components suggested by Kelly (2009) as summarised in Table 2.2. This approach is very similar to the approach proposed by Dent and Harden (2013), which suggests that the following three curriculum components need to be explored: the 'declared curriculum' as it is set out in the institutional documents, the 'taught curriculum', which is what happens in practice, and the 'learned curriculum', which is what is actually learnt by the students. The difference between the two discussed approaches is that the one (Kelly, 2009) refers to a hidden curriculum component while the other (Dent & Harden, 2013) does not explicitly make mention of it. One could argue that the 'hidden' curriculum forms part of the 'learned' curriculum, and

therefore that the approaches proposed by both Kelly and Dent and Harden are quite similar. In order to determine how patient-centredness is taught and learned in the various components of a medical curriculum, curriculum mapping seemed to be an appropriate approach.

Questions often arise regarding how a curriculum could be designed and what is to be taught in a curriculum. Since a curriculum is supposed to promote students' development on various levels, this matter is explored in both a broad and a generic manner while also focusing on contemporary issues that are specifically related to the medical education context.

2B.4   CURRICULUM DESIGN AND MEDICAL EDUCATION

The world we live in is becoming increasingly challenging and since this is the same environment where university graduates will end up working one day, it has major implications for curriculum design. Barnett and Coate (2005) argue that although there are numerous systemic challenges, there are mainly three dimensions that one has to respond to in curriculum design. These curriculum dimensions or elements are the 'knowing', the 'acting' and the 'being' in curricula and these dimensions can be explained as follows: 'Knowing' is different from knowledge in three ways. Firstly, knowledge has an active component and is never static; secondly, this state of flux is apparent because knowledge is socially constructed and developed; thirdly, 'knowing' is an act – an act of identity and a claim to ownership (Barnett & Coate, 2005). Furthermore, knowledge is a constant unit that consists of facts, procedures and principles in a particular domain. Application of knowledge represents the ability to use the information in a meaningful way in various situations (Khan & Ramachandran, 2012).

The 'acting' dimension can be seen as involving students in community development or else having them take part in classrooms activities, laboratories or studios. Each discipline obviously has its own set of skills that the students are supposed to develop. In medical education in particular, workplace-based training forms a major component of the curriculum (Barnett & Coate, 2005).

The 'being' dimension implies that although knowledge and skills are important building blocks of any curriculum, these two elements are not sufficient to form a curriculum. The element of 'being' thus speaks to a student's inner self that has to be developed in order for them to acquire durable capabilities in an unknown world. Related terms that are applicable here are self-reliance, capability, resilience and individuals' ability to work things out for

themselves in their own contexts. It is often the case that this component may be experienced as too vague compared to the robust understanding of other, more 'academic' curriculum components. Academics therefore often battle to embrace and understand the 'being' component of the curriculum, and even when academics are willing to acknowledge this component, one has to admit that it is not be easy to incorporate this aspect as a part of a curriculum (Barnett, 2009). This uncertainty is partly the reason why it remains a challenge to develop curricula that foster the so-called softer skills or graduate attributes in students. Incorporating patient-centredness in the curriculum poses similar challenges in the sense that some clinical trainers regard it as something optional; an aspect they will pay attention to once they have time or are done with the 'more important' tasks.

Since 'the curriculum' can be seen as a holistic and in fact also a multi-disciplinary construct, the influence of the broader social context must be acknowledged as a source or force of influence over the design process (Du Toit, 2011). Several factors have influenced curriculum design in medical education quite significantly over the last few years (Jones et al., 2001; McKimm, 2010), yet three factors that are current and are linked to the teaching and learning of patient-centredness are discussed below. These are (1) regulatory issues and professional frameworks, (2) curriculum models and (3) relevant theories of learning (Grant, 2010; Grant, Abdelrahman, Zachariah & Walsh, 2013).

2B.4.1   Regulatory issues and professional frameworks

Since medical education as a field is closely related to one of the main socio-political concerns of governments worldwide, namely the health of a country's people, there is an ever increasing focus on regulation and accountability issues within medical curricula (Swanwick, 2011).

Some countries employ systems where governments have a strong influence in the curricula of medical schools, but few set exact standards of how a curriculum should be designed and what it should consist of. In both the UK and the USA, for instance, medical curricula are guided by accreditation standards set by professional bodies (Grant, 2010), while in other countries, medical curricula are influenced by the relevant professional body. In South Africa this is the task of the Health Professions Council of South Africa (HPCSA) as well as the relevant government department. The details of the relevant medical programme within its regulatory context are further explained in Chapter 3.

The perceived need for better accountability to the society that medicine serves and the pressure to demonstrate quality in both the training and the practice of medical graduates have compelled many medical schools to adopt new accreditation and assessment standards. This includes a competency-based approach to learning (Sherbino, Frank & Snell, 2014). Medical schools have started to define core areas of competence for their graduates. The three frameworks that have had the biggest impact worldwide are the ones from the US Accreditation Council for Graduate Medical Education, the UK General Medical Council and the Royal College of Physicians and Surgeons of Canada (CANMEDS) (Walsh, 2013). These core competency frameworks have much credibility and have subsequently influenced the design and implementation of many medical curricula worldwide. One has to bear in mind, however, that these competency frameworks constitute only guidelines and it is still the task of every medical education institution to design its own curriculum around these guidelines on the basis of its own values and intentions (Grant et al., 2013; Walsh, 2013). Patient-centredness is a competency that is prominent within the various roles of the CANMEDS framework (Frank, 2005). The FMHS at SU, for instance, has chosen to make use of the CANMEDS framework, but with adaptations to make it more context-specific. The detail of this process is discussed in Chapter 3.

These aforementioned frameworks stem mainly from reports that have been calling for change in medical education over the last 10 years and the themes contained in them derive from regulatory issues as well as social and economic development (Irby, Cooke & O'Brien, 2010). They tend to focus on student performance, therefore when adopting them, medical educators are cautioned to bear in mind that the medical professions' own theories of practice must not be completely overshadowed by these performance requirements (Grant et al., 2013). Barnett points out that one must be careful where the emphasis is situated in the curriculum – whether it is on what students have to know, or on what they know and can prove by performance, or rather on their understanding (Barnett, 2009). Curricula that strive to assess all their students' learning outcomes (performance) often run the danger of limiting the ultimate power of an independent graduate that could have contributed to society's greater benefit in other ways than merely being limited to the formal curriculum (Grant et al., 2013).

The issue of performance is becoming an increasingly important focus in medical curricula and it requires some exploration of how learning outcomes-based education (OBE) and competency-based education (CBE) feature in curriculum models.

2B.4.2 Current curriculum models in medical education

In medical education there has been a deliberate shift over the last decade with medical schools starting to utilise newer curriculum models in an attempt to respond to issues such as patients' expectations, healthcare delivery, medical knowledge, qualified doctors' availability and their workload, as well as medical students' requirements (Carraccio, Wolfsthal, Englander, Ferentz & Martin, 2002; Frank, Snell, Cate, Holmboe, Carraccio, Swing, Harris, Glasgow, Campbell & Dath, 2010; Grant et al., 2013). Newer curriculum models include OBE, community-based education, problem-based learning, integrated systems-based approaches, spiral curricula, core and student-selected components, task-based learning, and now the 'old made new' fashion of competence-based curricula. Common features of these new curriculum initiatives have been an attempt to foster adult learning styles, a decrease in the amount of factual knowledge, the early introduction of clinical experience, and the provision of electives for students (Dent & Harden, 2013; Grant et al., 2013).

In a landmark article published by Frenk et al. (2010), the authors made the point that HPE has not kept abreast with the needs of a changing world. They also claimed that the fragmented, outdated and static curricula that many institutions still utilise are to blame for poorly equipped medical graduates. Amongst the shortcomings the authors identified were poor teamwork, a narrow technical focus that lacks a broader contextual understanding, and a predominant hospital orientation at the expense of primary health care. According to these authors, the challenge is therefore to educate graduates that can respond to the needs of society and apply their knowledge and skills in the workplace. The challenge of graduates that are fit for practice resonates with critical pedagogy and critical citizenship education as discussed by Giroux (1992), who suggested that higher education curricula need to be more sensitive to students' opinions. He therefore called on educators to help students to understand how issues such as power and resistance to power may influence justice and equality in both the immediate and the broader society (Costandius & Bitzer, 2015). Furthermore, the global vision for health professionals is that they should be educated to activate knowledge, participate in critical reasoning and technical conduct, and are competent to take part in patient-centred and population-centred health systems (Frenk et al., 2010). One of the responses to the Frenk et al. (2010) publication has been the much wider implementation of competency-based curricula across many medical schools (Grant et al., 2013).

Bearing in mind that patient-centredness can be viewed as a competency that needs to be developed during medical education, it is important to consider some curriculum models that attempt to develop competencies. A discussion of competency-based curricula as well as the more traditional outcomes-based curricula that are also widely used in medical education is therefore appropriate to this study.

2B.4.3   Competency-based education and outcomes-based education

During the 1990s Bernstein identified two models on how to view curriculum design, namely a 'performance' view and a 'competence' view. These two views may be appropriate in discussing current medical education curriculum trends. According to Bernstein (1996), a 'performance' view or model emphasises the importance of separate subject disciplines and does not draw much on real-life situations, while the 'competence' model is about integration of subjects with strong links between current learning and real-life issues. Bernstein also referred to 'integration'-type curricula which have weaker boundaries between subjects than the so-called collection-type curricula where there is an emphasis on keeping pockets of content apart. The trend in medical education curricula seems to be towards integrated and competence-based curricula versus the collection-type performance-based curricula of the past. Since there is often uncertainty about the difference between 'competence-based' and 'outcome-based' curricula, it is important to explore these two concepts.

There seem to be mixed messages in the literature, and especially in medical education literature, about the differences between OBE and CBE. In 1988, Spady defined OBE as a way of designing, delivering and documenting teaching in terms of its planned goals and outcomes (Harden, 1999). Outcomes can also be seen as specific learning results that students have to demonstrate by the end of a learning experience; it is having students go beyond just knowing, as they also need to demonstrate what they know by doing certain things (Gravett & Geyser, 2004).

A competency-based curriculum can be seen as a type of outcomes-based curriculum since it focuses on the end result and not on the pathways and processes followed to attain learning outcomes (Frank et al., 2010). Some authors use the terms 'outcomes' and 'competence' interchangeably (Harden, 1999; Smith, 1999), while other authors argue that there is a subtle difference between the two. Albanese, Mejicano, Mullan, Kokotailo and Gruppen (2008) argue that in the field of medical education the difference between OBE and CBE seems to be in the

words 'want' and 'need'; with an outcome defining what skills and qualities we want students to have whereas a competency refers to what skills and qualities graduates need to have in order to care for patients (Albanese et al., 2008). Cumming and Ross, who have a very similar view, state that objectives are set and described by teaching staff, while competencies belong to student (Cumming & Ross, 2007). Since the two terms (OBE and CBE) are closely related, I follow the lead of other authors (Frank et al., 2010; Hodges, 2010) in medical education literature and also use the terms 'competency-based' and 'outcomes-based' as synonyms in this study.

It is important, however, to point out that whilst authors imply that competency-based and outcomes-based curricula are essentially the same thing, Frank et al. (2010) highlighted four themes which characterise CBE, compared to only two aspects that Harden (1999) identified as being key to OBE. In an outcomes-based curriculum, learning outcomes are identified, made explicit and communicated to all the role players and these outcomes are seen as the most important issue for any decisions in the curriculum (Harden, 1999). According to the definition by Frank et al. (2010), OBE has four themes: (1) a focus on curriculum outcomes, (2) a focus on abilities, (3) a de-emphasis of time-based training and (4) a promotion of learner-centredness. The aspects that distinguish the two are that CBE seems to have a time factor linked to it and that students should be able to move on to another learning outcome once they are judged as being competent. Both these factors have major logistical implications for a programme, especially in a resource-constrained environment such as South African higher education, making a true CBE model difficult to implement in the South African context.

In order to clarify where OBE originates from and how it has found its place in medical curricula, Morcke, Dornan and Eika (2013) tracked it back to the behaviourist psychology of the 1940s. It was then implemented widely, but also heavily critiqued during the 1970s, mainly because in terms of assessment it was reducing values, insight and judgment to simple behavioural objectives. During the 1980s it was revived and advocated for to be used in medical education, where it is currently implemented extensively. The same critique that was voiced about assessment of attitudes then is currently rife, namely that personal and professional attributes that medical graduates require for effective therapeutic relationships cannot be tidied up and reduced to observable behaviours; therefore it seems to be more appropriate for some aspects of undergraduate medical education than for others (Morcke et al., 2013).

It is clear that the emphasis in both OBE and CBE is on the students' learning outcomes and not the processes followed in order to get there. From a teaching and learning perspective this approach could potentially be problematic, since it could encourage curriculum developers to pay little attention to the types of learning opportunities students are exposed to in a curriculum.

Since learning theories and the ways in which curricula are designed are closely linked, it is important to briefly explore the theories that have persisted and influenced medical curricula over the last few years.

2B.4.4   Current learning theories in medical education

Since the philosophical perspectives or learning theories that are adopted in designing a curriculum have an impact on the formulation of the objectives as well as the selection of the content of the curriculum, it is important to understand the essence of the theories (Walsh, 2013). Traditionally there has been a theory-practice gap, but if the theory that supports the educational practices is better understood, theory has the possibility to inform practice and be informed by it (Kaufman & Mann, 2010). Since medical education is socially constructed, its underpinning theories differ according to the social ideas that are dominant at the time and one could even find a situation where 'older' learning theories can reappear under new guises, for example, the situation where learning outcomes are now being defined as competencies instead of behavioural objectives (Walsh, 2013).

The field of medicine is complex, with educational processes that have different stages and multifaceted outcomes. Hence there is not a single theory that can describe the actual learning of students in this field. Patient-centredness comprises knowledge, skills and attitudes that have to be constructed differently for each patient encounter, both learning theories that refer to learning as an individual and social learning are equally relevant. Therefore, in this section a brief summary is provided of the main learning theories relevant to medical education and then the ones that may be more relevant to the teaching and learning of patient-centredness are highlighted.

The main learning paradigms and theories that have influenced the ways of describing and conceptualising medical curricula over the years and to the present, are behaviourism, cognitive theories, constructivism, social learning theory (Walsh, 2013) and transformative learning theory (Swanwick, 2011). The health behaviour theories, which have only recently started to find their way into HPE, can be used to plan interventions, to interpret and explain behaviours

and to evaluate interventions (Cilliers, Schuwirth, Adendorff, Herman & Van der Vleuten, 2010).

Behaviourism needs to be mentioned since some aspects of patient-centredness, such as communication skills training, are often approached by making use of behaviouristic principles. Communication in medicine is often seen as a series of learned skills rather than a matter of personality, and while some individuals have a predisposition to communicate well, others can learn to develop this skill very effectively. The use of both positive and negative reinforcement to shape behaviour is very much part of the teaching culture in medical education (Mann, 2011) and the very important role of feedback to students is one of the central aspects of behaviourism (Archer, 2010). The key proponents of behaviourism in the first half of the 20th century were researchers such as Skinner, Thorndike, Pavlov and Watson (Schunk, 1996). Considering curricula that follow a strict behavioural perspective would, for example, suggest that learning has only taken place when behavioural change can be observed and assessed. Such curricula would then typically consist of behavioural objectives that are stated in observable and measurable terms (Posner, 1995). The potential problem here is the difficulty to observe attitudinal and normative changes in student learning.

Researchers such as Piaget and Vygotsky had a major influence on thinking about learning in cognitive terms (Schunk, 1996; Walsh, 2013). Piaget was the first to argue that learning is a developmental cognitive process and that students do not 'receive' knowledge, but rather 'create' it themselves (Schunk, 1996). A cognitive approach to learning objectives focuses on the internal thought processes rather than on the performance resulting from learning, and often such changes in students' cognitive structures are not directly observable or measurable (Posner, 1995).

Constructivism was a further development of cognitive theory where learners are seen as actively constructing new concepts and ideas building on their prior knowledge. This perspective assumes that students are able to construct their own understanding independently of the teaching method and that scaffolding of knowledge is vital (Schunk, 1996). Vygotsky extended Piaget's theory to include the idea of social-cultural cognition, acknowledging that all learning occurs in cultural contexts and social interactions are involved. He then proposed the concept of the zone of proximal development which suggested that students learn better with assistance from a knowledgeable other (a teacher or peer) to bridge the distance between what they currently know to what they potentially can or should know (Schunk, 1996).

Social learning theory developed because theorists such as Bandura, Lave and Wenger and Vygotsky assumed that people learn through observation and that learning is more powerful as a social process (Walsh, 2013). Since learning is situated in practice with each situation providing a uniqueness which can lead to different learning experiences, the importance of role modelling cannot be under-estimated (Torre & Durning, 2015). Social cognitive learning theory includes aspects of behavioural, cognitivist and humanist perspectives (Mann, 2011), which implies that learning and performance are two distinct processes. This theory states that one can learn much from observing rather than by doing, and whether one performs what one learns by observing depends on factors such as motivation, interest, incentives, perceived need and social pressures. Furthermore, Bandura states that people can learn new actions by merely observing how others perform them. Observers do not have to perform the action at the time of learning and reinforcement is not necessary for learning to occur; in essence, by observing others, people can acquire knowledge, rules, skills, strategies, beliefs and attitudes (Schunk, 1996). The implication of this theory for the effective teaching and learning of patient-centredness is that there are five aspects in the learning process (Kaufman & Mann, 2010):

- the need for a clear objective (outcome);

- modelling or demonstration;

- provision of task-relevant knowledge;

- guided practice with feedback; and

- opportunities to reflect on learning.

This theory seems highly relevant to the teaching and learning of patient-centredness since a major component of patient-centredness is learnt when students observe how doctors interact with patients (role modelling). This learning theory also refers to self-efficacy, the beliefs that students have about their learning and their capability to organise and execute actions. Self-efficacy assists students in deciding how much time and effort they will invest in certain tasks as well as how long they will keep on doing these tasks (Bandura, 1986). While outcome-based curricula are focused on assisting students in acquiring the necessary knowledge, skills, attitudes and competencies, self-efficacy is often overlooked, yet it is critical in promoting student resilience (Van Dinther, Dochy & Segers, 2011).

Lave and Wenger's *theory of situated learning* forms part of the social cognitive theories. According to this theory, learning is a social, collaborative and interactive process and its core

components are communities of practice and legitimate peripheral participation (Schunk, 1996). These theorists argue that learning happens in a community of practice and that the members share their knowledge and develop relationships that lead to the bonding of the members. Within this community of practice some members are core members with vast experience, while others are newcomers and therefore more peripheral to the learning community. From this perspective learning does not only happen from observing, but the novices gain experience by doing things themselves, starting as peripheral members; as proficiency increases, more responsibility within the community is permitted (Torre & Durning, 2015). With regard to the learning of patient-centredness one may argue that students will typically start as novices by just watching the senior doctors, but will later acquire knowledge from their participation in medical encounters in the broader community (Kaufman & Mann, 2010).

Transformative learning theory, as suggested by Mezirow in the 1970s, was influenced by various scholars, of whom Habermas has to be recognised (Kitchenham, 2008). Transformative learning theory is built on constructivist learning principles such as questioning, examining, validating and revising of one's current thinking. Learning typically happens when an individual experiences an alternative perspective and previous habits of mind are questioned. This so-called disorienting dilemma could be a single dramatic event or a gradual cumulative process. Learning becomes transformative when a person responds to an alternative habit of mind by reconsidering and revising current beliefs. Mezirow identified six habits of mind or, as suggested by Cranton, six different types of perspectives (Cranton, 2006). A habit of mind is a way in which an individual sees and experiences the world and it is based on background, culture, experience and personality. Although the concept of reflection can be traced back to theorists as early as Dewey in 1933, it is one of the key aspects of transformative learning. Critical reflection consists of content reflection (what is happening here?), process reflection (how did this come to be?) and premise reflection (why something is important and what difference does it make?). It is the last question that has the potential to lead to transformation of the mind. Content and process reflection might lead to the transformation of a specific belief, but it is premise reflection that can make people think differently about the world and themselves. As discourse is critical in the learning process, people need to engage in conversation with others in order to consider alternative perspectives and determine the validity of their own views (Cranton, 2006). Since the teaching and learning of attitudes towards patient-centredness are complex and require more than knowledge and skills, one can argue that an

application of this learning theory can serve as a potentially effective vehicle for transformative learning to take place.

Behavioural science theories can be used effectively as a framework to explain some human behaviour as well as to plan interventions to change behaviour (Cilliers, Schuwirth, Herman, Adendorff & Van der Vleuten, 2012). The use of behavioural science theory to explain and influence health behaviour changes dates back as far as the 1950s, but it is only since the 2000s that researchers have started to use this theory in HPE (Cilliers, Schuwirth & Van der Vleuten, 2015). The *health behaviour theory* that is most often used in the context of HPE research is the Theory of Planned Behaviour (TPB) (Cleland, Francis, Watson, Inch & Bond, 2007), while a newer interpretation of this model, namely the Integrative Model of Behavioural Prediction (Fishbein & Yzer, 2003) has recently also been used quite a lot in HPE research (Rees & Knight, 2007). It is the latter model that was used in this study in order to understand the factors that potentially influence medical students' patient-centred behaviour. The reason for choosing this model will be explained in more depth in 2C.4.

The theories that have been described above are not the only ones that can or do play a role in medical education. They may, however, be the main ones that are relevant in offering explanations of how patient-centredness is or fails to be effectively learnt by undergraduate medical students.

Another curriculum factor that plays an important and prominent role in students' learning is the assessment of their learning. It is therefore appropriate to highlight some of the most pertinent influences that assessment could have on the teaching and learning of patient-centredness.

2B.4.5   The role of assessment

Assessment is viewed differently by lecturers and students, with lecturers often focusing on the content or teaching and the students mainly on the assessment in the curriculum (Gravett & Geyser, 2004). The importance of assessment for students and the way in which institutions can make use of this component in the curriculum to 'drive student learning' was well demonstrated by a study which showed that medical students' learning behaviour was influenced by factors such as appraising the impact of the assessment, appraising their learning response against demands from other dimensions of their lives, their perceived self-efficacy, and contextual factors such as the opinion of their lecturers and peers (Cilliers et al., 2010).

For assessment to be effective it seems important that it is integrated and holistic and that a number of outcomes are assessed together (i.e. capstone assessment). Furthermore, assessment needs to be authentic and contextualised, with the student having to perform real-life assessment activities and not fragmented assessment tasks (Gravett & Geyser, 2004; Morcke et al., 2013).

Now that the concept 'patient-centredness' has been described in sub-section Part A and some relevant curriculum aspects in sub-section Part B, this last section of the chapter (Part C) will explore how patient-centredness can potentially be embedded into medical curricula. This section will start with literature perspectives on current trends in the teaching and learning of patient-centredness, followed by the main barriers and enablers in acquiring this competence. Finally, Fishbein's (2000) Integrated Behaviour Model is introduced as a tool to potentially understand students' learning of patient-centredness.

PART C: PATIENT-CENTREDNESS IN MEDICAL CURRICULA

2C.1   INTRODUCTION

Internationally, medical schools have sought to foster patient-centredness in undergraduate medical students with different courses and experiences (Lévesque, Hovey & Bedos, 2013). Amongst these are communication skills courses (Bombeke et al., 2011; Smith et al., 2000), the use of simulated patients and problem-based learning (Claramita et al., 2011; Haidet et al., 2001), role play and group discussions (Ross & Haidet, 2011), community-based placements (Thistlethwaite & Jordan, 1999) and hospital clinical placements (Gaufberg, Hirsh, Krupat, Ogur, Pelletier, Reiff & Bor, 2014; Krupat et al., 2009). A brief discussion follows of the key teaching and learning strategies that are advocated to assist students in developing competence in patient-centredness. In addition, the barriers and enablers of the teaching and learning of patient-centredness are addressed, and lastly a behavioural model that potentially explains how students learn patient-centredness is introduced.

2C.2   CURRICULUM ACTIVITIES SUPPORTING THE DEVELOPMENT OF PATIENT-CENTREDNESS IN UNDERGRADUATE MEDICAL CURRICULA

Over the past number of decades there has been a shift from a paternalistic to a more patient-centred approach in the delivery of health care (Benbassat & Baumal, 2005; Bombeke et al., 2011; Dobie, 2007; Noble et al., 2007). However, a body of research shows a decline of medical students' attitudes towards patient-centredness as they progress through the undergraduate medical curriculum (Hojat et al., 2009; Krupat et al., 2009; Trotter, Evans, Jones, Ragain, Cook, Prabhu & Linton, 2010; Tsimtsiou et al., 2007), and medical schools have responded to this decline by developing various curriculum innovations (Lévesque et al., 2013). The teaching methods employed in curricula for the teaching and learning of patient-centredness vary substantially, with most curricula making use of more than one method. Prevalent examples are problem-based or case-based learning (Claramita et al., 2011), lectures, group discussions, role play and patient encounters (Haq, Steele, Marchand, Seibert & Brody, 2004; Ross & Haidet, 2011). Such teaching, which takes place in various clinical settings and at various stages of the curriculum (e.g. junior versus senior students), is further discussed below.

It may be important to look into the teaching and learning strategies that are currently used most frequently in medical curricula, and to consider the barriers and enablers that may inhibit or enhance the teaching and learning of patient-centredness.

2C.2.1   Communication skills training

Communication skills training has become a substantial component of most undergraduate medical curricula (Bombeke et al., 2012; De Villiers & Van Heusden, 2007) and since communication is viewed as a core component of the doctor-patient relationship and of being patient-centred (Rao et al., 2007; Street et al., 2009), this seems a reasonable strategy. Research of almost two decades ago has shown that communication skills as part of the doctor-patient relationship can be taught and learnt; however, these skills deteriorate if they are not maintained by practice (Aspegren, 1999). Current research confirms the belief that good communication skills can be learned through systematic, intentional and experiential training; it is not an innate value (Heaven, Clegg & Maguire, 2006; Kurtz et al., 2005; Rao et al., 2007). Communication skills training has also been shown to assist students in adopting more positive attitudes towards patient-centredness and communication (Smith, Hanson, Tewksbury, Christy, Talib, Harris,

Beck & Wolf, 2007; Yedidia, Gillespie, Kachur, Schwartz, Ockene, Chepaitis, Snyder, Lazare & Lipkin Jr, 2003). Research has also shown a positive correlation between students' attitudes towards patients and their self-efficacy (confidence in their own ability to communicate with patients), thus making it more likely that they will take a patient-centred approach if they are confident of their own ability to communicate (Noble et al., 2007). A study by Kaufman and Mann (2010) about various strategies to teach 'the breaking of bad news' highlighted that students wanted multiple sessions as well as opportunities for demonstration, reflection, practice, discussion and feedback. This study drew attention to the importance of allowing students opportunities to grow their self-efficacy and gain confidence in communicating with patients in a patient-centred manner.

A challenge with regard to communication skills training in a medical school is that different departments often make use of a variety of models (Kurtz et al., 2005; Stewart, 2003) to teach and assess these skills. This approach may cause confusion for both students and clinical trainers, and some authors advise that curriculum planners make use of the same framework to teach and assess such skills (Rider, Hinrichs & Lown, 2006). Whether accepting the same model across all the specialities is practical may be highly debatable, especially when one takes into account that the context in which the various specialities of medicine work is diverse. It must be acknowledged that the different specialities and work areas have an influence on the relevance of particular dimensions of patient-centredness (Mead & Bower, 2000a) and the applicability of the current patient-centred model to all disciplines can indeed be questioned (Bombeke et al., 2012).

The importance, however, of extending communication skills training to all fields of medicine cannot be over-emphasised since it signals the message that good clinical communication is desirable for patient care in any medical discipline (Perron, Sommer, Louis-Simonet & Nendaz, 2015). Such a curriculum-wide implementation of communication skills training may assist in changing the perception by some people that patient-centred communication is only required in Family Medicine (Wilson, 2008).

Despite the positive effects of communication skills training, some studies indicate a less than optimal transfer of the skills taught in simulation compared to clinical practice (Woloschuk et al., 2004). Training transfer, according to Perron et al. (2015), seems to be effective when the skills, knowledge and abilities that have been learned in the training can deliver the desired behavioural change in the context of the workplace. If the gap between communication skills

training and patient communication in medical practice is too wide, students risk forgetting all they have learned (Bombeke et al., 2012). While research on this issue is limited, some authors have recommended strategies to improve the transfer of communication skills training. One of the key recommendations is to adjust the work environment by ensuring consistency between the informal, formal and hidden curriculum, to formalise communication skills objectives and to integrate clinical communication in mainstream clinical activities (Perron et al., 2015). Bombeke et al. (2012) suggest that one strategy to enable students to bridge the gap between the learning of communication skills and practice is to provide students with sufficient information about the evidence-based foundations of communication skills. This might help them to experience communication skills training in the curriculum as a more 'academic' and 'credible' intervention. Another suggestion is to make communication skills training more realistic for students by integrating it with practical skills training and history-taking skills on simulated patients (Silverman, 2009).

For the purposes of this study, the details of simulated patients as part of communication skills training was not deemed necessary other than to acknowledge its potentially powerful impact. Simulated patients have been used in the teaching and learning of communication skills at many institutions over many years, and while research has confirmed that such a strategy is effective if used correctly, the costs need to be taken into account (Lane & Rollnick, 2007). The involvement of patients to assist students with the learning of a patient-centred approach has been advocated by Bleakley and Bligh (2008), who suggest that the patient should be given an active role in the educational activities initiated by the doctor. These authors argue that patient-centredness has traditionally been framed as a set of values and qualities that is learned by students via structured educational input in the curriculum as well as from doctors as role models. They emphasise: "Patient-centredness is then, paradoxically, not learned from patients" (Bleakley & Bligh, 2008:92). This proposition is a shift in how power and roles are viewed – from a relationship between the student (as a learner) and the doctor (as a teacher) with the patient only playing a supportive role, to a situation where the patient and the student collaborate and the doctor acts as a facilitator (Bleakley & Bligh, 2008). Some of the relevant documented benefits of increased patient involvement for students are a more prominent role for empathy, recognition of cultural diversity, and the development of professional skills and attitudes (Spencer & McKimm, 2010). The clinical education ward is an example of a relatively new educational model that directly involves patients and where students are supervised and guided by professionals. Students thus learn by taking part in a healthcare team that cares for

patients while they have real tasks and responsibilities and thus feel responsible for professional patient care (Scheffer et al., 2011). This innovative approach has the potential to be used effectively to include patients as active role players in the curriculum.

Finally, one may agree that it is critical to give communication skills training its fair space in any medical curriculum since patient-centred medicine is an important aim in health care where effective communication seems to be a vital tool by which to achieve this aim (Bensing, 2000).

2C.2.2   Longitudinal and hospital placements

Traditionally, clinical training in medical curricula has consisted of a sequence of relatively short rotations of 4-8 weeks through speciality disciplines such as internal medicine, surgery, paediatrics and obstetrics, and these are usually based in tertiary urban teaching hospitals. The patients in these hospitals have conditions that are usually more acute, with a high turnover, hence limiting students to brief experiences with a disease-based model of care (Puvanendran, Vasanwala, Kamei, Hock & Lie, 2012; Thistlethwaite, Bartle, Chong, Dick, King, Mahoney, Papinczak & Tucker, 2013). In such a setting patients are often seen in a system that is fragmented and they are handed over to various people, with the result that the medical students or doctors are seldom in a position to build relationships with their patients or to see the complete course of their illness (Glick & Moore, 2001; Pelzang, 2010). Students are also supervised by a range of clinicians with few opportunities for consistent support and role modelling (Bell, Krupat, Fazio, Roberts & Schwartzstein, 2008; Thistlethwaite et al., 2013). It was challenges such as these that prompted medical educators to realise that the traditional hospital setting may not be the optimal learning environment within which to conduct basic clinical education (Hauer, Hirsh, Ma, Hansen, Ogur, Poncelet, Alexander & O'Brien, 2012; Whitcomb, 2005). Students who work in longer rotations can build relationships with not only the patients, but also with the clinical educators they work with and thus seek guidance from them in a safe environment (Von Pressentin, Waggie & Conradie, 2016).

Longitudinal integrated clerkship (LIC) models of clinical medical education are being implemented worldwide (Strasser & Hirsh, 2011) with the purpose of improving various shortcomings that have been identified in medical schools. The LIC model is built on the concept of continuity and it may offer students and patients the 'centredness' that is sometimes missing in other medical curricula (Hirsh, Ogur, Thibault & Cox, 2007). In some countries with large rural populations such placements are often in rural hospitals or other community settings

and integrated across core clinical disciplines (Thistlethwaite et al., 2013). Rural LICs have been implemented by medical schools in the USA, Canada, Australia and South Africa (Heddle, Roberton, Mahoney, Walters, Strasser & Worley, 2014; Norris, Schaad, DeWitt, Ogur & Hunt, 2009) and they provide students with a completely different clinical learning environment to the traditional one in tertiary hospitals. Two LIC characteristics directly influence the teaching and learning of patient-centredness. One is that that students have more opportunities for longer follow-up of patients with the result that the patient is seen as a whole person and not only the disease, and the other is greater emphasis on the personal and professional development of students (Maley, Worley & Dent, 2009; Worley, Prideaux, Strasser, Magarey & March, 2006). Due to the wide variety of LIC placements, a recent article by the Consortium of Longitudinal Integrated Clerkships Research Collaborative has assisted to classify these various programs into three distinct clusters of LIC's namely Comprehensive, Blended and Amalgamative (Worley, Couper, Strasser, Graves, Cummings, Woodman, Stagg, and Hirsh, 2016).

To implement the rural LIC approach in tertiary hospitals has been a challenge, but it has been done successfully at Harvard University and Flinders Medical Centre (Heddle et al., 2014), amongst other institutions. The LIC approach in these contexts has been shown to foster patient-centredness and humanitarian values while it has also improved the learning and retention of science and clinical medicine. At the same time, this newer model of clinical curricula is relationship-centred and is characterised by the following three principles: medical students take part in the care of patients over an extended time, students develop continuing relationships with the patients and the patients' doctors (supervisors), and the students achieve most of their clinical competencies across multiple disciplines at the same time (Gaufberg et al., 2014; Hirsh et al., 2007).

The motivation for early clinical exposure as curriculum innovation has been happening for some time, with some of the community-based placements starting from as early as when the students are in their first year (Thistlethwaite & Jordan, 1999). In a study that explored the advantages and disadvantages of both hospital and community-based teaching, it seemed as if hospital-based teaching assisted with the learning of specialities, acute conditions and procedures and investigations. On the other hand, community placements with general practitioners gave students more insight into psychosocial issues and enhanced their communication skills (O'Sullivan, Martin & Murray, 2000). While the original purpose of the early clinical exposure in out-of-hospital settings was to recruit students to become primary

care practitioners, the focus has broadened over the years and benefits such as students developing positive attitudes towards their studies, themselves and their patients have also been recognised after such placements (Dornan & Bundy, 2004; Dornan, Littlewood, Margolis, Scherpbier, Spencer & Ypinazar, 2006; Littlewood, Ypinazar, Margolis, Scherpbier, Spencer & Dornan, 2005; Worley, Prideaux, Strasser, Silagy & Magarey, 2000; Yardley, Littlewood, Margolis, Scherpbier, Spencer, Ypinazar & Dornan, 2010).

Longitudinal placements have been shown to increase patient-centredness in undergraduate medical education. This educational pedagogy thus appears to provide for learning opportunities that every medical student should experience. The next aspect that to be discussed as potential curriculum renewal element is the inclusion of appropriate disciplines or knowledge from the humanities in medical curricula.

2C.2.3   Including the humanities in the curriculum

Since medical curricula traditionally have a scientific focus, there seems to be little room for training in concepts related to the humanities. Students may thus soon discover that the emphasis is on the teaching and assessment of medical sciences rather than on the social aspect of medical service provision (Gordon & Evans, 2010). This seems to be one of the major challenges that has hindered the adoption of patient-centredness in medical curricula and vital concepts have classically been labelled as 'soft skills' and often perceived as 'non-essential' (McGaghie, Mytko, Brown & Cameron, 2002). Attempts to incorporate aspects such as emotional skills training as part of communication skills training into medical curricula have thus been met with some resistance. However, a suggestion from some authors regarding the effectiveness and implementation of such training is that aspects such as the neurobiological and physiological bases of empathy should be emphasised (Riess, 2010). It was believed that such an approach might help students, lecturers and institutions to see the practice of empathy not as an application of 'soft skills', but rather as a science-based concept with demonstrated clinical, personal and professional benefits (Shapiro, Coulehan, Wear & Montello, 2009).

At the same time, the debate continues as to whether so-called soft skills (such as communication, ethics and human empathy) can be acquired or taught as part of a medical curriculum. Some educators are of the opinion that it is more appropriate to see these as the 'development' of attributes, including the promotion of teaching-learning activities such as role modelling, peer discussions, hands-on experience and various patient interactions acting as

stimuli for such development (Bergh, Van Staden, Joubert, Krüger, Pickworth, Roos, Schurink, Du Preez, Grey & Lindeque, 2006).

Curricula can introduce and expose students to various learning opportunities, but any change in a student's behaviour is dependent on that individual's preparedness and ability to change. In addition, the term 'soft skills' may also be a misnomer as it creates the idea that such skills are optional rather than 'hard core' and essential to medical education (Bergh et al., 2006).

2C.2.4   The use of role modelling

Role modelling has been recognised as a powerful teaching strategy in medical education (Cruess et al., 2008) and is often regarded as the primary strategy by which clinician teachers attempt to teach students the humane aspects of medical practice (Passi, Johnson, Peile, Wright, Hafferty & Johnson, 2013; Weissmann, Branch, Gracey, Haidet & Frankel, 2006). Other reasons for opting for this strategy are that students can see listening skills as well as non-verbal behaviours in action. It thus seems vital that humanistic and caring role models are available for students to observe (Sandhu, Rich, Magas & Walker, 2015). It has also been pointed out that role modelling as such is not teaching, since effective teaching involves lecturers making provision for learner needs as well as taking deliberate actions to facilitate learning experiences such as thinking aloud and questioning (Sandhu et al., 2015). The educational value of role modelling can thus be potentially enhanced by a two-sided approach: firstly by professional learning development, where clinician teachers are encouraged to develop a conscious awareness, and secondly where students are being made aware of their responsibility to be reflective and critical towards the clinical learning environment (Benbassat, 2014). By contrast, negative role models have the potential to promote cynicism, emotional detachment and other negative attitudes that are contradictory to being patient-centred (Burks & Kobus, 2012). Despite the acknowledgement of the importance of role modelling, its foundations are not clear and many assumptions reign about its effectiveness (Kenny, Mann & MacLeod, 2003).

2C.2.5   Creating a student-centred environment

It is recognised that attention to students' well-being and personal development is important (Bombeke et al., 2010), and that enhanced student-supervisor relationships and mentoring can increase students' patient-centredness (Krupat et al., 2009). Other parallels between these two views of being 'centred' are that students' individual learning needs should be embraced, their

psychological and social aspects should be supported, their self-learning skills should be developed, and a 'holistic' student approach should be adopted (McLean & Gibbs, 2010). While institutions are investing energy and resources in creating student-centred spaces for their students to develop in, this should also be creating a culture that makes it easier for students to learn about patient-centredness.

Initiatives to foster patient-centredness in medical undergraduate students such as those that have been discussed above are only a few of the options being implemented in institutions worldwide, but for the purpose of this study it was not deemed necessary to discuss others. The most important message from these initiatives seems that since patient-centredness is a multi-dimensional construct and a single intervention or strategy is not sufficient; students should intentionally be exposed to curriculum activities that can promote their knowledge, skills and attitudinal components with regard to this competency. However, within any curriculum there are certain barriers and enablers with regard to the teaching and learning of patient-centredness and these are discussed next.

2C.3   ASPECTS THAT INFLUENCE THE TEACHING AND LEARNING OF PATIENT-CENTREDNESS

It would seem as if some factors are more enabling than others in the teaching and learning of patient-centredness with some of these factors more difficult to change than others, but once they are recognised as barriers, they can be more easily addressed. The next section explores a number of factors that are often referred to in the literature.

2C.3.1   Gender and medical specialty

Female medical students appear to be more patient-centred and empathetic than their male counterparts (Quince, Parker, Wood & Benson, 2011; Wahlqvist et al., 2010) and although it is not clear why this is the case, it might be because females are generally more sensitive to emotional signals than men (Hojat, Gonnella, Mangione, Nasca, Veloski, Erdmann, Callahan & Magee, 2002). Studies conducted with qualified doctors have shown that female doctors were more patient-centred than male doctors, and even more so when they were interacting with a female patient (Law & Britten, 1995; Roter, Hall & Aoki, 2002). Although the amount of biomedical information shared during consultations was similar, the consultation time per patient was somewhat (an average of two minutes) longer when a female doctor was involved

(Roter et al., 2002). However, another study showed that gender is more important in undergraduate students' attitudes early in their training, while later in training specialty orientation seems to become more significant (Batenburg, Smal, Lodder & De Melker, 1999).

The specialty a medical student is keen on pursuing is a factor indicated as being influential in the patient-centredness of an individual. For instance, medical students preferring general practice as a career option showed more patient-centred attitudes than those wanting to specialise in surgery-related disciplines (Batenburg et al., 1999; Haidet, Dains, Paterniti, Hechtel, Chang,Tseng & Rogers, 2002a). This finding corresponds with studies conducted with qualified doctors where general practitioners tended to lean more towards patient-centredness than the doctors that chose other specialties such as surgery (Haidet et al., 2002a). Physician attitudes measured by the PPOS (Krupat et al., 2000) showed that amongst surgeons, general practitioners, oncologists and obstetricians and gynaecologists, surgeons were the least patient-centred (Chan & Ahmad, 2012), while the oncologists were the most patient-centred in this group. Reasons for the surgeons' doctor-centred attitudes can possibly be attributed to the nature of their practice and the fact that the conditions they deal with are often more acute than the oncologist who usually treats long-term cases. The literature suggests that the various disciplines in medicine have unique features with regard to their training and socialisation that have an impact on doctors' attitudes. It is even possible that certain personality types are more easily drawn to particular medical disciplines (Chan & Ahmad, 2012).

2C.3.2   Seniority of medical students

Whether age has an influence on being patient-centred is less clear. Medical students seem to become more cynical, less patient-centred and less empathetic as they progress through medical school (Colliver et al., 2010; Haidet et al., 2002a; Hojat et al., 2009; Neumann et al., 2011; Tsimtsiou et al., 2007). However, contrary to these results it was found that a group of students in Brazil scored higher on patient-centredness by the time they left medical school compared to their entrance (Ribeiro et al., 2007), while in another medical group in Sweden it was found that there was no deterioration in student attitudes (Wahlqvist et al., 2010). The latter study speculates that selecting older candidates for medical programmes could be a reason for the fact that students do not lose their patient-centredness, while the former study attributes the improvement of patient-centredness to the fact that their student placements are predominately in primary care where the doctor-patient relationship is emphasised and practised more than in tertiary settings (Ribeiro et al., 2007).

2C.3.3   The clinical learning environment

Except for communication skills training, structured strategies and activities to enhance patient-centredness are often absent in medical curricula. Other aspects of patient-centred care are not normally taught or assessed. Despite various attempts to incorporate principles of patient-centredness into formal curricula, there is evidence that such attempts are often undermined by social processes and messages that negatively influence the learning and practice of patient-centred care (Donetto, 2012; Haidet, Kelly, Bentley, Blatt, Chou, Fortin, Gordon, Gracey, Harrell, Hatem, Helmer, Paterniti, Wagner & Inui, 2006). It is acknowledged that the so-called hidden curriculum (Hafferty & Franks, 1994), which may be more observable in the practices and routines of healthcare provision in communities, has a greater impact on students' behaviour than organised educational interventions (Kaufman & Mann, 2010). What may confuse students is that they are often taught one approach to patients in medical school, while they observe another, less patient-centred approach in clinical practice (Donetto, 2012). It remains challenging to encourage the development of important skills such as the doctor-patient relationship in clinical areas where medical history-taking, clinical reasoning, examination skills and service delivery are still the only focus (Kurtz et al., 2005). Woloschuk et al. (2004) argue that the decline in patient-centred attitudes and behaviours of medical students could be due to a loss of idealism together with the adoption of a more realistic view of medicine. This change in the students' view is a result of the negative influence of the hidden curriculum as well as the predominantly biomedical clinical experience to which students are exposed in many institutions (Woloschuk et al., 2004). Another factor in the erosion of patient-centredness may be the context of hospitals and that patients do not often have a one-to-one consultation with the doctor (Wilson, 2008). About two decades ago Stewart alluded to the fact that tertiary-care teaching hospitals were not the ideal environments for learning about relationships and communication with patients (Stewart et al., 1995). This is mainly because other areas are now regarded as being more conducive to learning related to long-term relationships with patients. These areas include chronic care facilities, palliative care settings and doctors' consultation rooms in the community. It is evident therefore, why rural and longitudinal placements of students have become part of many medical curricula.

One of the constant challenges in health care remains the issue of limited time. Staff shortages and an extensive workload have been documented as major challenges in implementing patient-centred care in the clinical areas (Bombeke et al., 2010; Wilson, 2008). Communication with

patients suffers as a result of inadequate time available and heavy workloads. It is clear that while the clinical learning environment is very challenging to the teaching and learning of patient-centredness, it is also the most appropriate environment to foster this competence in doctors.

From the discussion in this chapter it has emerged that the learning of patient-centredness from a student perspective is not simple. However, the flipside of student learning is the teaching that takes place in the curriculum, which is equally challenging. Some literature perspectives underpinning the teaching and learning of patient-centredness have now been explored and as a final section of this chapter a behavioural model that was used in order to assist with the understanding of the learning process of the students is explained. The rationale for selecting this model was that the learning of patient-centredness in this study is ultimately understood as a desired behaviour – in this case patient-centred medical practice. According to the chosen model the factors that are taken in account in the teaching and learning of patient-centredness are student backgrounds and characteristics, attitudes, knowledge and skills as well as perceived norms, self-efficacy and the environment. The literature that was explored in Chapter 2 has highlighted exactly these components as integral to the development of patient-centredness. Next this model will be explained in more detail.

2C.4 USING A BEHAVIOURAL MODEL TOWARDS A PRELIMINARY UNDERSTANDING OF HOW MEDICAL STUDENTS LEARN PATIENT-CENTREDNESS

2C.4.1 Introduction

In order to understand the underlying theories involved in the teaching and learning of patient-centredness one has to start with how the concept of patient-centredness is interpreted in this study. Patient-centredness here is viewed as a multi-dimensional construct, consisting of attitudinal and cognitive aspects, as well as behavioural skills. Patient-centredness is further interpreted as a competence made up of various smaller competencies. Since patient-centredness is also entrenched in attitudes, it would often require students to transform some or much of their thinking and practices. While attitudes form a major part of patient-centredness it is challenging to evaluate whether a student is patient-centred or not. Since one does not have direct access to another person's thoughts and feelings, this study argues that one can only

observe how students' and doctors' attitudes or attributes result by looking at their behaviours and actions. Attitudes are thus mainly hidden and can only be inferred from observed behaviour.

2C.4.2   The Integrative Behaviour Model (IM)

The IM as suggested by Fishbein (2000) provides an integration of various theories of behavioural change. The development of this model stems from the Theory of Reasoned Action (TRA) that originated in the field of social psychology in the 1970s. According to this theory, intention is a very good predictor of behaviour. The TPB was subsequently developed around 1985 as an extension to the TRA, addressing the possibility of partial voluntary control by incorporating the additional construct of perceived behavioural control. According to the TPB, a person's intention to perform or not perform a specific behaviour is the most important immediate determinant of that action. Intention is a function of three determinants, namely attitudes, social influence and perceived behavioural control. The TPB further recognises that background factors can influence people's behavioural, normative and control beliefs and, in the end, their behaviour (Fishbein, 2000). The most recent exponent of these theories is the IM which takes into account that there are situations where one cannot act upon one's intentions, where the person needs the necessary skills and abilities to perform the behaviour and whether there are environmental constraints that may impede on behaviour (Fishbein, 2000). See Diagram 2.1 for a diagrammatic presentation of the model.
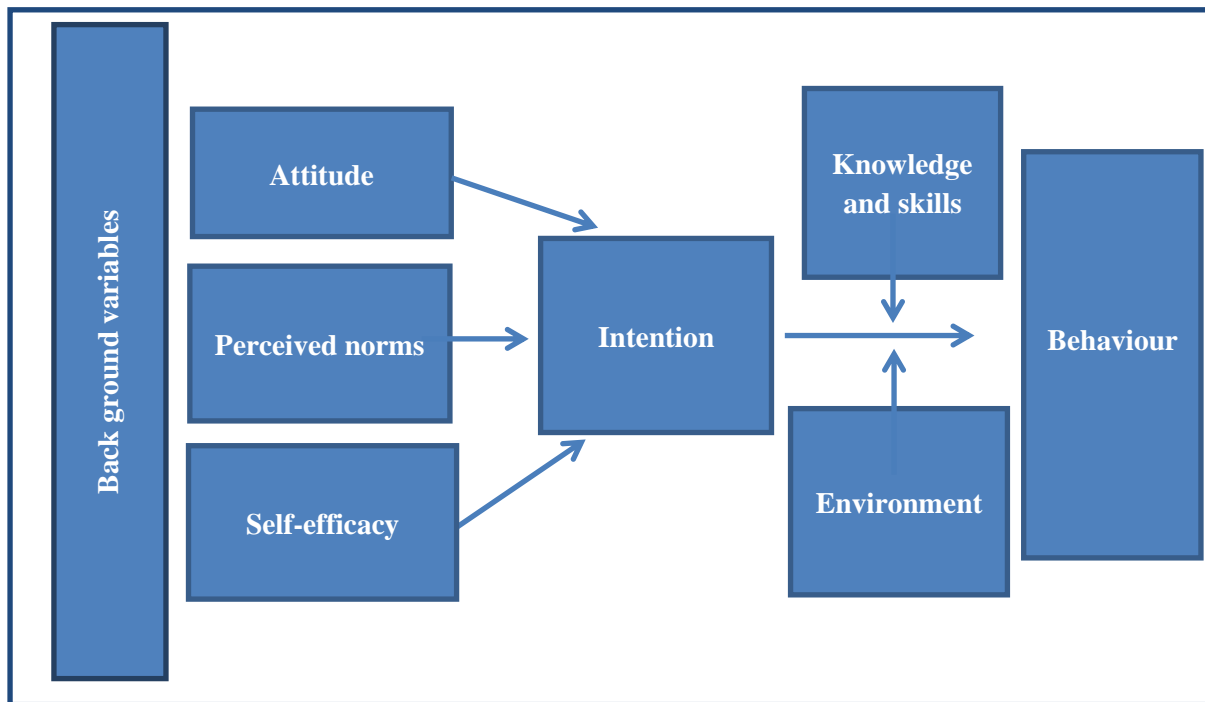
Diagram 2.1:   Conceptual understanding of how patient-centredness is taught and learnt (Fishbein's 2002 model (adapted))

According to the IM there are five determinants or factors that directly affect behaviour, with intention being the most important one. Behavioural intention is determined by attitude, subjective (perceived) norms, and self-efficacy (personal agency). Attitude is an individual's judgment of how favourable or unfavourable the performance of the behaviour would be, while perceived norm can be seen as the social pressure that is present regarding the performance of the behaviour. The third determinant towards intention is the extent to which an individual feels capable of performing the behaviour effectively; namely self-efficacy. Two further components that influence behaviour directly are the knowledge and the skills to carry out the behaviour and the environmental constraints that make performance of the behaviour either difficult or not difficult. Finally, it must be taken into account that people's beliefs are influenced by many background factors such as age, gender, socio-economic status, ethnicity, education, religious affiliation, personality, nationality, mood, emotion, general attitudes, intelligence, past experiences, social support, and coping skills. It is therefore important to realise that all of these factors can affect people's beliefs and in the end their intentions and behaviour (Fishbein, 2000).

The social cognitive theory as developed by Bandura and others (see 2B.4.4) can be recognised in the elements described above. Bandura discussed human behaviour within a framework of reciprocal interactions among behaviours, environmental variables and personal factors. What differentiates social cognitive theory from behaviourism is the notion that people can learn by merely observing others and that observers do not have to perform the actions at the time of learning (Schunk, 1996). A major focus of Bandura's theory is the element of perceived self-efficacy or beliefs concerning one's capabilities to organise and implement the actions that are necessary to learn or perform behaviours. Bandura suggested that the stronger an individual's beliefs or their self-efficacy, the greater their effort, perseverance and flexibility would be. Self-efficacy affects the choices people make; they choose those activities they feel capable of doing and avoid those that cause discomfort (Van Dinther et al., 2011). People with a weak belief of their self-efficacy tend to think that tasks are more difficult than what they really are, leading to feelings of failure and helplessness. On the contrary, people with a high sense of self-efficacy have more resilience and see tasks as challenging rather than overwhelming (Van Dinther et al., 2011). Social cognitive theory further suggests that learning happens either actively through doing or indirectly (vicariously) by observing others perform. Learning patient-centredness thus occurs through both action and observation. Students can observe patient-centredness via role modelling and demonstrate patient-centredness and when they practise it themselves.

Most of the principles from the various learning theories are included in the IM as important factors that determine behaviour – in this case whether medical students will behave or act in a patient-centred manner or not.

2C.5   SYNTHESIS OF THE CHAPTER

In an effort to generate theoretical perspectives on the teaching and learning of patient-centredness in an undergraduate medical curriculum, it was important to start with an understanding of what patient-centredness is. In this study patient-centredness is considered a competence that consists of particular components of knowledge, skills and attitudes that can be learned and developed. Since patient-centredness is a competence in which learning may be influenced by various factors related to both the doctor and the patient, it is important that the curriculum exposes students to learning opportunities that can assist students in developing patient-centredness. Some authors see longitudinal placements as potentially answering many of the problems related to students becoming less patient-centred during their medical training.

Learning of applicable communication skills is also seen as offering a partial solution if such learning is well planned and incorporated into the formal curriculum, and not only left to individual departments who value the importance of this aspect. The relevant literature emphasises that in order to build students' self-efficacy it is critical that they be afforded opportunities to observe and practise various applications of patient-centredness, and receive feedback with patients in the clinical areas.

Chapter 3 continues to provide the context to the study and ends by providing a conceptual framework as a preliminary theoretical understanding of how undergraduate medical students learn patient-centredness.

Chapter 3

CONTEXTUALISING THE STUDY

3.1   INTRODUCTION

In Chapter 2 the literature supporting the teaching and learning of patient-centredness in undergraduate medical curricula was explored in some depth. This chapter aims to explain the context, history and scope of the specific medical curriculum that was explored in the study. Since a case study was chosen as the appropriate design for this research study, a critical aspect of the study design is the context in which the study is conducted (Yin, 2013) (also see Chapter 4). In order to understand the uniqueness and intricacy of the specific case, it is essential that the relations among its embedded contexts are clear (Stake, 1995). In addition to its theoretical context (see Chapter 2), this chapter aims to explain the various contexts related to the actual phenomenon in focus for this study, namely the learning and teaching of patient-centredness in undergraduate medical curricula.

HPE worldwide, but especially in developing countries, is facing many challenges. These challenges include inadequate funding, insufficient numbers of staff, increasing numbers of students and infrastructural constraints. Decision-makers at medical schools find it increasingly challenging to decide what should be included in medical curricula in order to ensure that their graduates are ready to provide an appropriate and excellent service wherever they choose to work. Decisions about what should be included in the curriculum are often determined by aspects such as the burden of disease, the local circumstances as well as the needs of different populations and patients (Walsh, 2013). Good curricula appear to be those that are contextualised and rooted in their own cultures and conditions. Decisions about what medical students should learn, how they should learn it, what qualities they should develop, where the skills must be acquired and how long it should take are all embedded in contextual considerations (Grant et al., 2013; Swanwick, 2011).

For a proper exploration of the research questions in this study, it is important that the research context be considered in some detail. The theoretical, disciplinary, international and national, organisational and programmatic contexts are obviously important (Plowright, 2011). As a starting point, an exploration of the theoretical context was based on a review of the literature

relevant to the research topic (see Chapter 2). The remaining contexts mentioned are also important as they assisted in determining and indicating the boundaries for the study (Yin, 2013).

3.2   DISCIPLINARY CONTEXT

This study was undertaken at the CHPE in the FMHS at SU and focused on a specific aspect of the undergraduate medical curriculum, namely the teaching and learning of patient-centredness. The field of HPE spans the areas of undergraduate and postgraduate education as well as continuing professional development of already qualified clinicians (Swanwick, 2011). Furthermore, the study falls within the field of higher education research and more specifically within curriculum inquiry. Curriculum inquiry is a form of educational research that focuses on various types of research questions to solve current educational problems, formulate policies and redevelop or develop new programmes (Bitzer & Botha, 2011). Although much has been written in the field of higher education studies and research, the three themes that were highlighted as the main research areas are course design, students' learning experiences and teaching and learning in higher education (Bitzer & Botha, 2011). Since this study is about how students learn as well as how teachers teach a specific aspect in an undergraduate medical curriculum, it is strongly linked to the three themes mentioned above.

3.3   INTERNATIONAL CONTEXT

With regard to HPE and more specifically medical education, there are a number of international trends and requirements that are of importance concerning the context of this study. These trends are discussed next.

3.3.1   Social accountability

The World Health Organization has defined social accountability as the obligation medical schools have to direct their education, research and service activities towards addressing the priority health concerns of the communities, regions and nations that they have the mandate to serve (Woollard, 2006). Although it is recognised that medical schools face serious challenges in striving for and demonstrating a greater impact on health through their connections with society, this obligation is considered a priority (Woollard & Boelen, 2012). One of the more recent seminal articles in the field of HPE, calling on health professionals to transform

education to strengthen health systems in an interdependent world (Frenk et al., 2010), was published in The Lancet (Frenk et al., 2010). What stood out from this study was the allegation that all is not well in health delivery and health education. Problems include health systems that are faltering and becoming more costly and complex, as well as the additional demands that are put on health workers. Furthermore, it was pointed out that professional education has not kept up with the health needs of populations and that health systems need curricula that deliver graduates who are better equipped to deliver the health services required. Frenk et al. (2010) therefore call for a redesign of health professionals' education and new instructional designs linked to transformative learning.

3.3.2   Patient-centredness as an international trend in curricula

Patient-centredness has become part of medical curricula for various reasons (as discussed in Chapter 2), with one of the main drivers being a change in the public's expectations of doctors over the last few decades. Many patients expect that their concerns should be addressed; they want to be fully informed about their conditions, be involved in relevant decisions and ultimately become educated and supported to manage their own medical conditions (Coulter & Ellins, 2007). With this greater appreciation of the psychological and social consequences of ill-health and healthcare treatments, the need was created for practice approaches that put the patients' priorities and perspectives at the centre – for example, through the biopsychosocial (Engel, 1989) and patient-centred approaches (Stewart, 1995). However, the ability to equip medical graduates with the necessary knowledge, skills and attitudes to engage with their patients in this desired manner is not without its challenges, and educators are bound to seek the most appropriate methods to structure curricula in ways that may develop this competence.

3.3.3   Graduate attributes and core competencies

Educators at universities worldwide are becoming increasingly aware of the need to equip their graduates with the necessary attributes to fulfil their roles optimally in the workplace and as members of society. The impetus for this drive has been the job market and rapidly changing societies amidst increased globalisation, new technologies and the need for flexible, skilled employees who are willing and able to continue their learning (De La Harpe, Radloff & Wyber, 2000). Various terms are used in the literature to describe the notion of graduate attributes. These include terms that are often used as synonyms and are referred to as 'generic', 'core' or 'key' competencies or skills, 'personal' or 'transferable' skills, and 'generic' attributes of

graduates. Bowden et al. (2000, cited in Barrie, 2007) state that graduate attributes are those attributes that go beyond disciplinary proficiency that has traditionally been the focus of most university courses. These qualities ensure that the graduates that universities deliver are agents of social good for the future.

The focus of graduate attributes therefore seems to involve a developmental process for students as they progress through their university education, ultimately preparing them to be employable with skills that go beyond their disciplinary knowledge and skills (Leibowitz, 2012).

While medical schools worldwide have gone through some processes of defining core areas of competence for their graduates, it would seem that most medical schools in the Western world currently make use of either the competency framework (CanMEDS) of the Royal College of Physicians and Surgeons of Canada or the Scottish doctor frameworks (Frank et al., 2010). These core competency frameworks mainly stem from reports that have been calling for change in medical education over the last 10 years and their themes derive from regulatory issues, as well as social and economic development. The CanMEDS framework originated as an initiative of the Fellows of the Royal College of Physicians and Surgeons of Canada (RCPSC) during the beginning of the 1990s with the desire to reform medical education in order to ensure that physicians are adequately prepared to deliver quality health care that is safe for their patients. CanMEDS reflects the work of hundreds of fellows, work that is based on empirical research, evidence of societal need, fellows' expertise, college consensus and educational design, and since its approval by the RCPCS's governing council in 1996 it has been adopted by numerous institutions around the world (Frank, 2005). While these frameworks have influenced the construction of many medical curricula worldwide, it is important for institutions to keep their own values and intentions in mind when designing their curricula (Grant et al., 2013; Walsh, 2013).

These international trends are equally relevant to the South African context, but one needs to be aware that the local (South African) context differs significantly from the countries where the aforementioned frameworks originated and that some of the criteria and expectations should probably be adjusted when such frameworks are implemented.

3.4 THE NATIONAL HEALTH SYSTEM AND THE HIGHER EDUCATION SYSTEMIC CONTEXT

Based on the latest statistics (2011) of the Organisation for Economic Cooperation and Development (OECD), South Africa has a critical shortage of doctors, namely 0.7 doctors for every 1 000 people, compared to 1.8 in Brazil and 3.0 in Australia (Health at a glance 2015). These statistics are even worse in some rural areas in South Africa. Currently there are nine medical schools in South Africa, but not all are in a position to meet the country's demand for medical doctors even though most of them have increased their student intake in response to requests from the government to stretch the limits of their capabilities and resources. The continuing demand on medical schools to graduate more doctors puts them under pressure in terms of resources and the way their curricula are structured and taught. Since the situation in South-Africa is of such that the amount and type of graduates we produce does not meet the needs of the country and has been suggested that a shift is required with regards the admission processes and criteria, health systems skills, sites of training and accountability of students and graduates (Michaels, Reid & Naidu, 2014). These same authors that represent nine South African Faculty of Health Sciences, established the Collaboration for Health Equity through Education and Research (CHEER) in 2003 as a health equity and human resource research interest group. Their aim has been to determine the most appropriate educational strategies that would support health science graduates to choose to practice in rural and underserved areas in South Africa once they had qualified.

A number of influential policy and publication initiatives related to higher education and curriculum development have been published over the last two decades in South Africa. The South African Higher Education Act (1997) delegated quality assurance in higher education to the Council on Higher Education (CHE), making it the responsibility of this body to ensure quality. This responsibility is then discharged to the permanent committee of the CHE, namely the Higher Education Quality Committee (HEQC), whose mandate is quality promotion, institutional audits and programme accreditation. Statutory bodies such the Health Professions Council of South Africa (HPCSA), which oversees medical education, have an agreement (memorandum of understanding) with the HEQC to regulate their own programmes as far as accreditation and the enforcement of criteria for programmes are concerned (CHE, 2004).

Furthermore, the South African Qualifications Authority (SAQA) provides educational institutions with generic outcomes. The South African Qualifications Act No. 58 of 1995)

stipulates that critical cross-field or generic outcomes should be incorporated in all qualifications. These generic outcomes are defined by SAQA as generic outcomes that enlighten all teaching and learning and it is vital for the development of a lifelong learning ability in students. Higher education institutions are even further guided by the Programme for Higher Education Transformation which, amongst various educational goals for institutions, also suggested that graduates should be socially responsible, have the competencies to be lifelong learners and be able to deal with change and diversity (CHE, 2004).

Most countries have some form of guidance in relation to medical curricula while some, including South Africa, has distinct standards from either the regulatory and/or professional bodies, which at least set minimum standards for the training of medical doctors. Some academics might perceive and experience that the professional accreditation and standards being set by all these statutory bodies pose a threat to their academic freedom and to institutional autonomy (Bitzer & Botha, 2011). However, these rules and regulations determined by, for example, the HPCSA should be viewed in the light of the end goal, which is to ensure competent healthcare practitioners who deliver safe patient care. In order to ensure that medical schools maintain the necessary standards, the HPCSA accredits medical schools and their curricula at least every five years. The document that currently guides the accreditation criteria of the Medical and Dental Professions Board of the HPCSA is the 'Questionnaire for self-assessment: Faculties/schools of medicine/dentistry'. It is clear from the content of this document that it was compiled according to the criteria for programme input as proposed by the CHE. The CHE (2004) proposes eight criteria and all of them, except one, are applicable to undergraduate programmes. The seven criteria for programme input suggested by the CHE are as follows:

- Programme design
- Student recruitment, admission and selection
- Staffing
- Teaching and learning strategy
- Student assessment policies and procedures
- Infrastructure and library resources
- Programme administrative services

The HPCSA's questions related to self-evaluation are built extensively around these criteria and this document has to be completed by the dean or chairperson of the respective programme prior to a visit by the HPCSA's evaluation panel.

It is against the background of these policies and publications and in order to address the necessary skills required of our graduates that the HPCSA accepted a slightly adapted version of the CanMEDS framework in 2011 as a guideline for core competencies (Van Heerden, 2013). Although this framework was initially set up for postgraduate specialists, it has been adapted by medical educationalists in South African to make it applicable to the local context and for undergraduate education. The CanMEDS framework is built around seven roles, namely the medical expert, communicator, collaborator, manager, health advocate, scholar and professional. It was then decided that this adapted CanMEDS framework would have to inform many of the accreditation processes of the subcommittee for Undergraduate Education and Training of the Medical and Dental Professions Board of the HPCSA (Van Heerden, 2013). It has perhaps not been emphasised sufficiently that the adoption of such a framework does not only influence the vision an organisation has of its graduates, but also has a significant impact on the style and content of how a curriculum is structured (Grant et al., 2013). While the FMHS has started to incorporate aspects of the CanMEDS framework in some areas, the process to align the current curriculum with CanMEDS is not a simple one and the graduates who took part in this study had not been exposed as yet to the CanMEDS framework as a formal part of their curriculum.

3.5   ORGANISATIONAL CONTEXT

The institutional context for the study was Stellenbosch University, with its main campus situated in the town of Stellenbosch, approximately 30 km northeast of Cape Town. One of the drives at SU relevant to this study was that institutions had to identify their own graduate attributes. According to the University's Strategy for Teaching and Learning (2014-2018) there are four graduate attributes that the university wishes all its graduates to develop, namely (1) an enquiring mind, (2) an engaged citizen, (3) a dynamic professional and (4) a well-rounded individual. The 10 faculties at SU were given the opportunity to decide whether they want to adhere to the institution's graduate attributes or whether they would like to develop their own (University of Stellenbosch, 2016).

The Faculty of Medicine and Health Sciences of SU is located next to the Tygerberg Academic Hospital in the northern suburbs of Cape Town and is one of three SU satellite campuses. There are five under-graduate health professions programmes offered by the FMHS, namely the Bachelor of Medicine and Bachelor of Surgery (MB,ChB), Bachelor of Speech-Language and

Hearing Therapy, Bachelor of Science in Physiotherapy, Bachelor of Science in Dietetics, and Bachelor of Occupational Therapy. Various postgraduate programmes are also on offer, the details of which are not relevant to this study. The curriculum that provided the context for this study is the MB,ChB programme wherein the FMHS has agreed to incorporate the CanMEDS framework as advocated by the Undergraduate Education and Training subcommittee of the Medical and Dental Professions Board, hence the seven roles of the CanMEDS include the four graduate attributes as recommended by the university.

3.6   PROGRAMMATIC CONTEXT

The MB,ChB programme committee has been given the overall responsibility of managing the MB,ChB programme since 2001. All the undergraduate programme committees, including the MB,ChB programme committee, report directly to the faculty's Committee for Undergraduate Education (CUE). The CUE is one of the standing committees of the faculty board and the deputy dean of Learning and Teaching is the chairperson of the CUE. The CUE reports to the faculty board, which is the supreme academic decision-making structure of the faculty. The faculty board reports to the senate of the university through the executive committee of the senate. The senate reports to the council of the university through the executive committee of the council.

The MB,ChB programme at US was established in 1956 with a few curriculum reviews since the first curriculum was implemented. The latest revision was implemented in 2008, which meant that the students that took part in the focus group interviews as part of the data collection for this study were first–year students in 2009 and thus products of this revised curriculum. At the time this group of students were admitted as first–year student (2009), about 220 students were accepted into the programme, and 183 graduated by the end of 2014 (six years later). The duration of the programme is six years and after graduation, the newly qualified doctors have to complete two years of compulsory and supervised internship training. Only after the internship and after completing a further year of compulsory community service, the graduates will be eligible for registration with the HPCSA as independent practitioners. After these three years a doctor can decide either to go into the private sector or to continue working in the state sector.

In order to understand the context of the study it is vital that the logistics and structure of the curriculum of the MB,ChB programme at SU be discussed in detail. The sources for the rest

of 3.6 was obtained from various documents in the faculty, mainly from reports for self-accreditation (which do not have specific references) and a few websites which are stipulated.

3.6.1   Programme admission requirements

In order to be selected for the programme, applicants have to complete a structured selection process (Selection guidelines, 2017). This is not a graduate entry programme, so students that have completed their secondary (high school) education can apply to enter the programme, and in fact most of the students in the programme are from this particular group. The selection process takes into account both the academic and the non-academic merit of applicants. This process restricts student numbers, which are largely determined by the available infrastructure and budget of the institution. The programme's enrolment targets are determined annually and these are aligned with the guidelines of the National Department of Higher Education and Training, as well as with the university's commitment to inclusivity and diversity (University of Stellenbosch, 2012).

3.6.2   The purpose of the medical programme

The doctors that graduate from SU have to possess the necessary knowledge, skills and attitudes to optimally utilise the opportunities available during the internship. They have to be able to function autonomously in the primary healthcare sector after the internship and by then they should be equipped with the necessary ability and insight to develop further, both personally and professionally. The exit-level outcomes for the programme as contained in the Profile of the Stellenbosch Doctor (Addendum 1) are made known to all the students and staff and should serve as a cornerstone in the design of modules and the curriculum as a whole.

3.6.3   Programme level and credits

The programme is at Level 8 on the National Qualification Framework and entails a total of about 9 190 notional hours over the six years. The curriculum is divided into three phases as explained in the section below. It is important to mention that since the study was conducted minimal changes have been made to the curriculum, therefore the structure that is explained below is applicable to the current situation.

Phase 1 is presented during the first 30 academic weeks of the first year and is called the Pre-Clinical Theory Phase. Phase 2 is more clinically oriented and used to start in the last four

weeks of the first year with the module Digestive System, ending in the middle of the fifth year. Phase 3 is comprised of the Late Clinical Rotations and stretches from the middle of the fifth year until the end of the sixth year. These final 18 months involve no formal classes, just workplace-based learning with tutorials as required. See Diagram 3.1 for a graphic representation of the curriculum that was adopted in 2009.
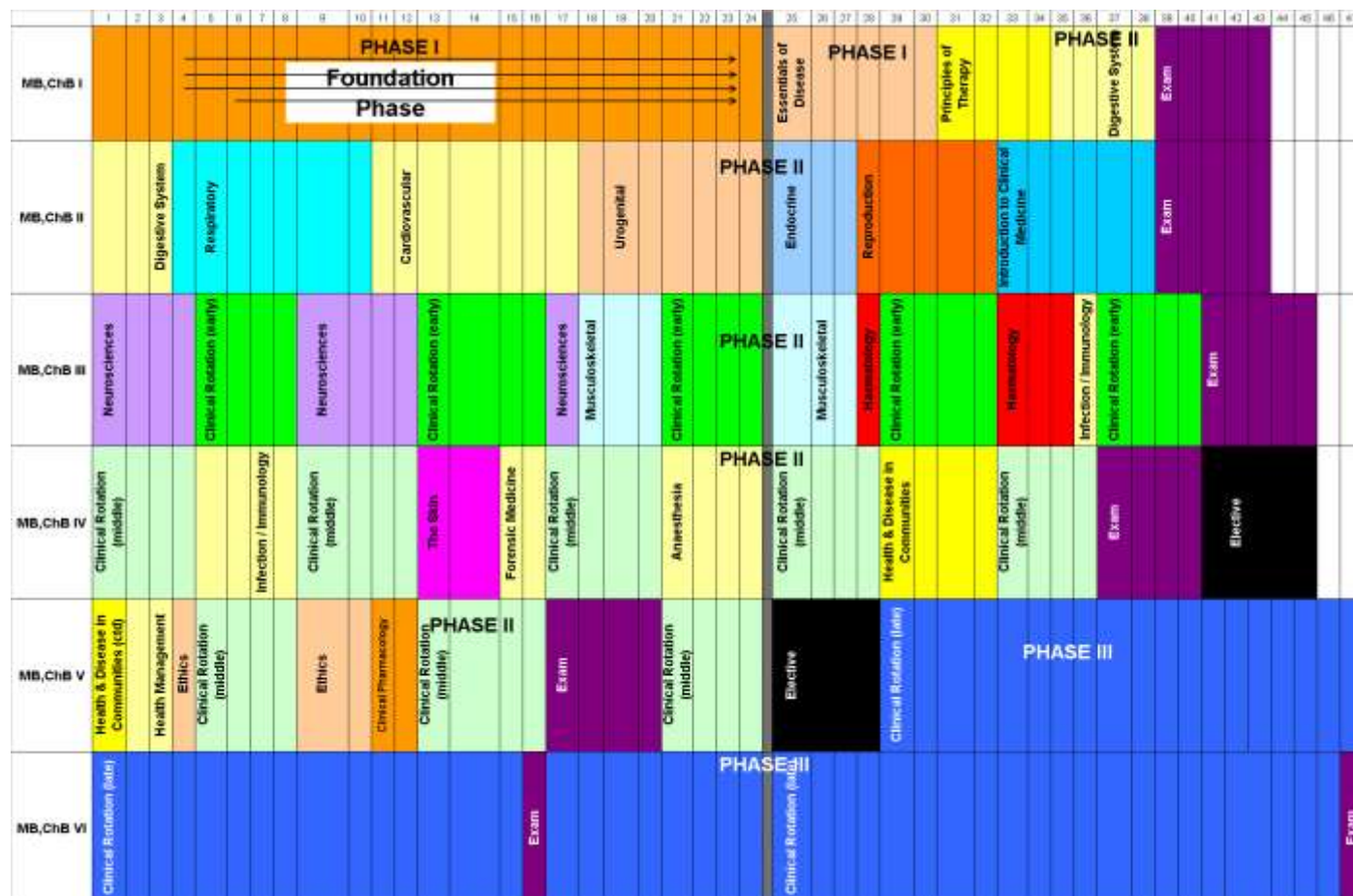
Diagram 3.1:   Outline of the curriculum in 2009

3.6.4   Nature of the programme

The entire curriculum is outcomes-based and modular in nature. An integrated, organ system-based approach (Swanwick, 2011) is followed in the presentation of most of the theoretical components of the curriculum. The introduction of integrated organ system-based theory modules, combining the pre-clinical and clinical sciences into a single module, was seen as a major step forward in terms of so-called vertical integration. Horizontal integration (Swanwick, 2011) is ensured by the integrated participation of various disciplines in these organ system-based modules.

The students spend their time divided into blocks of time learning in the clinical environment and alternatively theoretical blocks. The 'checkerboard' design of the academic programme during phase II of the curriculum with alternating theoretical and clinical modules (see Diagram 3.1) allows for continuous placement of students on the clinical teaching platform while other groups of students have theoretical classes. This structure ensures that not too many students are on the clinical teaching platform at once, with as little overlap as possible between the early, middle and late clinical rotations. The clinical rotations in the curriculum are discipline-based with almost no horizontal integration.

The Inter-professional Foundation Phase (first semester of the first year) is viewed as a significant curricular innovation. This foundation phase presents significant opportunities for interdisciplinary teaching and learning in the sense that students from more than one undergraduate programme in the health sciences participate simultaneously in these modules. Various health (and other) professions are furthermore involved in teaching these modules (and other modules) of the programme. This creates opportunities for the learning of a number of essential graduate attributes, especially in the modules Personal and Professional Development and Health in Context.

Another innovative aspect of the curriculum is the presence of two elective modules during the six years. Provision is made for students to develop and/or expand their own interests in the form of two month-long elective modules – one in the fourth year, and another in the fifth year. For this the students have to compile their own outcomes, guided by external and internal supervisors. These outcomes should take the exit-level outcomes of the programme, Profile of the Stellenbosch Doctor (Addendum A) into account and at the completion of the elective a learning portfolio, providing evidence that these outcomes have been reached, has to be submitted followed by an individual interview between the student and the internal supervisor.

3.6.5   Personnel situation

During the time the students spend in the clinical environment they have the opportunity to learn from specialists, registrars (specialists in training), medical officers and allied healthcare workers. Personnel are appointed as joint personnel, either of the university establishment or that of the Provincial Government of the Western Cape or other partner employers, such as the National Health Laboratory Service and the Medical Research Council. According to a previous

accreditation report for the FMHS, the staff on the joint appointments estimated their time spent as follows:

- Classroom teaching: 5%
- Clinical teaching: 25%
- Research: 10%
- Service: 60%

These percentages are testimony to the complaints often heard from clinicians with regard to their working demands and the clinical services load they have to manage. This situation poses a constant threat of having a negative impact on the teaching role of the faculty. However, the dedication, commitment and loyalty of these staff members have enabled the faculty to maintain high standards in their three key focus areas, namely teaching and learning, community service and interaction, and research.

The teacher:student ratios differ depending on the outcomes being taught as well as the year group the students are in. The sizes of the groups vary according to the clinical rotation (Early, Middle and Late) as well as the disciplines involved and the specific training activity (for instance, outpatient consultations, teaching ward rounds, seminars, case presentations). The average class size in the clinical years (based on the 2010 figures for student numbers) was about 180 students per class group. For the Early clinical rotation the third-year class is divided into five groups, as five domains are involved (see Figure 3.1). Each of these groups consisted of approximately 36 students at the time when the cohort studied for this project was in the third year. These groups are further subdivided in the departments; for example in Internal Medicine the group of 36 would have been further subdivided into at least five groups (for each of the five firms). In the Late clinical rotations (second semester of both the fifth year and the sixth year) group sizes vary between 10 and 20 students per group. The calculation of the exact teacher:student ratios is further complicated by the fact that the students of different clinical rotations, or the same rotation but different year groups (e.g. the fifth years and sixth years late clinical rotation in the second semester) can sometimes be on the clinical teaching platform simultaneously. It must, however, be stressed that the number of students selected for the programme has increased significantly over the last few years and currently the groups are substantially bigger than they were when the study was conducted.

3.6.6   Nature of the workplace-based learning

Students spend a substantial amount of their time in the Tygerberg Academic Hospital), a tertiary-care hospital which is one of the country's major teaching hospitals and which is located in the northern suburbs of Cape Town (adjacent to the FMHS of SU). They also spend time in smaller (regional) secondary hospitals and primary healthcare facilities which include facilities such as district hospitals, community health centres and healthcare clinics. While the current curriculum focuses on primary and secondary healthcare delivery, the placements are unfortunately mostly in a tertiary care hospital; however, the faculty undertakes to place the students for longer times in some of the secondary and primary healthcare facilities as part of their clinical training in the future.

As mentioned earlier, clinical training has been structured as uninterrupted four-week-long periods of clinical exposure in the Early and Middle clinical rotations and for much longer periods during the Late clinical rotations (student internship) (see Diagram 3.1). During these times students have the opportunity to fully integrate into the healthcare team at the site of the rotation and they can devote their time and energy completely to their clinical training. Since these are uninterrupted placements, students can be placed at peripheral training sites, in other words, that are not on campus.

Much of what students learn in the clinical environment is due to the fact that they are able to observe other doctors while they are working and interacting with patients and colleagues. Furthermore, the unwritten rules of the environment also have an impact on the behaviour of students. This hidden curriculum remains a concern in the medical training programme and the faculty is aware of the possibility of unintended outcomes that might be the result of poor role modelling. It is expected from all staff involved in the clinical training of the students to serve as positive role models for them. This is obviously not a matter that can be directly monitored by the faculty, yet the expectation is that the institutional culture is of such a nature that the vast majority of the personnel meet the expectation of being positive role models for the students.

3.6.7   The Rural Clinical School initiative

UKWANDA, the FMHS's Centre for Rural Health, was established in 2002 in Worcester, a town about 100 km from the Tygerberg Campus. This rural teaching platform has the Worcester Regional (secondary level) hospital as its hub with district hospitals (Ceres and Hermanus) and

primary healthcare clinics attached to it. These hospitals serve as training facilities for medical and health sciences students at both undergraduate and postgraduate level. An integral component of training on the UKWANDA platform includes structured and well-planned interdisciplinary teaching and learning opportunities.

The Rural Clinical School (RCS) of the UKWANDA Centre for Rural Health was founded in January 2010 (Van Schalkwyk, Kok, Conradie, and Van Heerden, 2015). The aim of the RCS is to train a group of selected final-year undergraduate students for one year continuously on a secondary and/or primary health service platform in a rural setting, which will hopefully motivate students to practise medicine in rural areas after completion of their studies. The first group of medical students commenced their RCS training in January 2011. The RCS utilises two clinical training models which are briefly explained next.

3.6.7.1 *The Worcester Model*

This model is based on the traditional clinical training curriculum followed at Tygerberg Campus, which means that it is discipline-oriented. This implies that students rotate through various departments, for example, Internal Medicine (7 weeks), Orthopaedics (5 weeks), and so forth.

3.6.7.2 *The District Model (longitudinal model)*

In this model students spend one year at selected district hospitals with a maximum of three students per hospital. This is a new initiative and by the time the study was undertaken only a small number of students had experienced this model. During 2014 there were two students involved in this model at Ceres and two in the Hermanus district hospital. The nature of the training in this model is in the form of a true LIC which is not discipline-based. The students are exposed to 'undifferentiated' patients and experience continuity of care and continuity of supervision by Family Medicine specialists at the respective district hospitals. This model is now referred to as the Comprehensive LIC (Worley, Couper, Strasser, Graves, Cummings, Woodman, Stagg, & Hirsh, 2016).

3.6.8 The emphasis on patient-centredness within the curriculum

The medical programme as it has been explained in this section has the potential to create opportunities for the teaching and learning of patient-centredness since there are theoretical

blocks followed by plenty of patient contact in the clinical blocks as well as a wide variety of disciplines to which the students are exposed. If incorporated into the programme, students have the opportunity to be exposed to the various components of patient-centredness through theoretical, attitudinal as well as practice opportunities. The challenge, however, lies in the fact that the students are taught by many lecturers on many platforms with different expectations of the students. Furthermore, the advantage of the modified CanMEDS framework that has been accepted for the faculty and the medical programme, is that patient-centredness is specifically incorporated in the seven roles (note, however, that this framework was not yet implemented by the time the student cohort who studied for this research graduated). The next section is a summary of reference made to patient-centredness in the outcomes per module as indicated in the students' study guides.

3.7   STUDENT STUDY GUIDES

For the purposes of providing a suitable context for the study it was important to get a detailed picture of the intended curriculum regarding patient-centredness. In order to determine how much reference is made to patient-centredness in the study guides of the MB,ChB programme, these documents were analysed (see 3.7.2 for the findings). Each module in the MB,ChB curriculum has a study guide which students receive at the start of the module and which indicates the outcomes that the students need to achieve as well as the activities and assessment that form part of the module.

The students who graduated at the end of 2014 and who were involved in this research started their first year as medical students in 2009 and therefore all the study guides related to their specific curriculum had to be studied. It must be noted that since they entered the programme several curriculum innovations have been implemented. This implies that there have been a number of adaptations to the current study guides, but for the purpose of this research only the study guides of the 2014 final-year medical students were inspected.

It is important to clarify some terminology before the findings from the study guides are presented:

- The students rotate through the various clinical disciplines during their clinical rotations and within the curriculum this is called rotation-domains. Therefore, the term that is used in the findings for the clinical rotations is *domains*.

- With regard to the names of the various domains; in most cases it is fairly easy to understand what each entails; however, there is one domain that is a combination between three disciplines and this need to be flagged. The domain Health and Disease in Communities is co-presented by the disciplines of Family Medicine, Community Health and Rehabilitation Studies. Students tend to refer to this rotation simply as 'Family Medicine'. This domain will therefore also be referred to as Family Medicine in this dissertation.

3.7.1   Analysis of the student study guides

A document analysis of the study guides was an important activity for this study for two reasons: firstly, it was a method by which to determine what the intended curriculum with regard to patient-centredness was, and secondly, it assisted in understanding the MB,ChB curriculum better. Although the findings of this word search were intended to form part of the data-gathering of this study, it was decided to present them as part of this context chapter since some boundaries and context could thus be provided for the study. Furthermore, it was decided that the presentation of these results as a stand-alone dataset/chapter would have been insufficient and very short, so adding it to this chapter was partly a strategic decision.

In terms of the analytical process that was chosen for this study (see Diagram 4.4), the document analysis of the study guides as it is presented in this section was both a level one and a level two activity. What simplified the level one activity was the fact that the study guides were already in a Word format and an electronic word search was easy to perform. The method that was followed was a word search for all study guides to detect the frequency of the terms 'patient-centredness' and 'patient-centred'. The first word search resulted in very few references and it was then decided that additional terms should be added to the word search, since patient-centredness is such a vague and complex concept and modules could perhaps refer to certain of its components. The study guides were then searched for any of the following terms:

patient-centred / patient-centredness / person-centred / caring /empathy / compassion / sharing information / advice / sharing / explain, shared decision-making / communication skills / biopsychosocial / holistic approach

After the word search the findings were displayed in graphs as a level two activity. This assisted in identifying gaps and emphases in the data. It is however important to note that higher counts

of some terms could be due to the way in which the study guides were written (repetition) rather than a real increase in the emphasis on these components. The respective graphs are presented in the following section.

3.7.2   Findings from the student study guides

The results from the word search in study guides are presented below in relation to the three phases of the MB,ChB curriculum.

3.7.2.1   Findings from the word search in the study guides: Phase 1

During the first semester of the first year of training the medical students take part in an integrated curriculum with other programmes such as BSc Physiotherapy and BSc Dietetics. However, from the second semester onwards the students of the various undergraduate programmes follow separate, programme-specific curricula. The theoretical modules that form part of Phase 1 of the MB,ChB curriculum are:

- Personal and Professional Development

- Life Forms and Functions of Clinical Importance

- Chemistry for the Health Sciences

- Health in Context

- Essentials of Disease Processes

- Principles of Therapy

None of the terms used for the word search related to patient-centredness were found in any of the study guides for these theoretical modules.

3.7.2.2   Findings from the word search in the study guides: Phase 2

Phase 2 of the curriculum runs from the last four weeks of the first year until the middle of the fifth year. For the purpose of the discussion, the modules that are presented during this phase are divided into theoretical and clinical modules (Table 3.1).

Table 3.1:   Summary of theoretical modules and clinical modules of Phase 2

Theoretical modules	Clinical rotation domains
• Digestive System • Respiratory System • Cardiovascular System • Urogenital System • Endocrine System • Reproductive System • Introduction to Clinical Medicine • Neurosciences • Musculoskeletal System • Haematological System • Infections and Clinical Immunology • The Skin • Forensic Medicine • Anaesthesiology • Health and Disease in Communities (Theory module) • Ethics • Clinical Pharmacology • Health Management	• ECR: Internal Medicine • ECR: Obstetrics and Gynaecology • ECR: Paediatrics and Child Health • ECR: Surgery • ECR: Health and Disease in Communities (Clinical) • ECR: Clinical Skills • MCR: Neonatology • MCR: Pathology • MCR: Forensic Medicine • MCR: Clinical Skills • MCR: Surgery: Paediatric / Head, Neck and Breast Surgery • MCR: Dermatology • MCR: Gynaecology • MCR: Imaging and Radiation • MCR: Health and Disease in Communities (Clinical) • MCR: Psychiatry • MCR: Paediatrics and Child Health • MCR: Internal Medicine

Early Clinical Rotation (ECR) and Middle Clinical Rotation (MCR)

Ten of the study guides from the 18 theoretical modules (Table 3.1) had no reference to the word 'patient-centredness' or one of the related terms, while the rest had some mention of it. Diagram 3.2 below presents the number of times the term 'patient-centredness' or related terms were referred to in the other eight theoretical study guides.
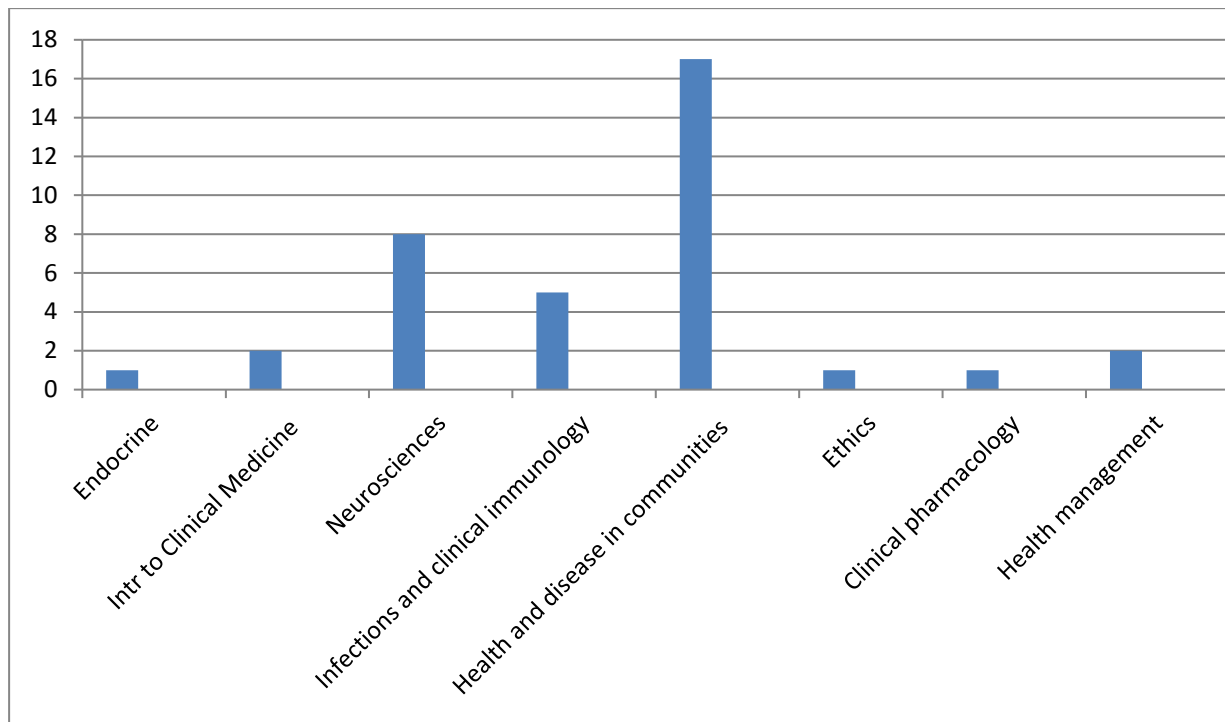
Diagram 3.2:   Theoretical modules in Phase 2 that had reference to patient-centredness or related terms

Of these eight modules that mentioned terms related to patient-centredness, more than half only mentioned it once or twice. It was only in the study guide of the theory module in Health and Disease in Communities where frequent reference was made to these concepts as part of the teaching activities and intended outcomes. In the instances where patient-centredness was mentioned in some or other way, there was no mention of how these would be taught or assessed.

The clinical modules of Phase 2 of the curriculum consist of an Early Clinical Rotation (ECR) with six domains and the Middle Clinical Rotation (MCR) that has twelve. When searching for the mentioned terms in these study guides, about half of them (n=10) had references made to one or more of the patient-centred terms. Diagram 3.3 is a diagrammatic representation of the occurrence of the terms.
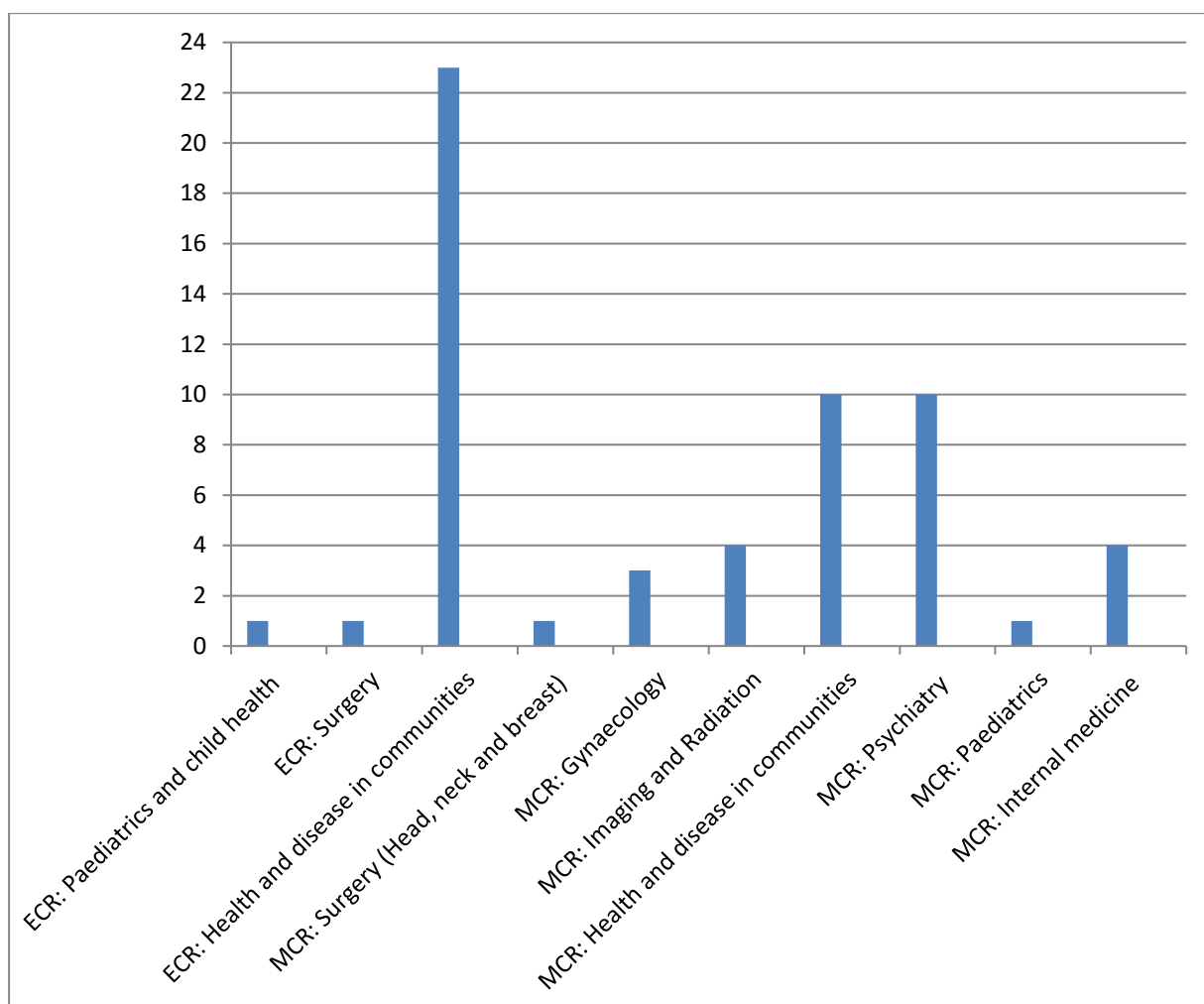
Early Clinical Rotation (ECR) and Middle Clinical Rotation (MCR)

Diagram 3.3:   Clinical domains in Phase 2 that had reference to patient-centredness or related terms

From Diagram 3.3 it would seem that substantial emphasis on a patient-centred approach is placed in the Health and Disease in Communities rotation domain and since many of the terms were referred to in the study guide for this domain. The other domain for which patient-centredness (or terms related to it) was mentioned several times in the study guides was Psychiatry. For the rest there were few or no references to these terms. Again, as in the case of the theoretical modules, when patient-centredness or related terms were mentioned, none of them indicated how this would be taught or assessed.

3.7.2.3   Findings from the word search in the study guides: Phase 3

This phase of the MB,ChB programme is the student intern period which extends over approximately 18 months, starting in the middle of the fifth year and continues to the end of the

sixth year. During this period students do not have any formal classes (lectures) but work in the clinical areas and have tutorials as arranged by the various disciplines. As mentioned before, final-year students may voluntarily complete their final year (only the sixth year) at the RCS at Worcester or at a district hospital in the longitudinal clerkship, but they still have to do the last six months of their fifth year at Tygerberg Hospital. The results of these options are displayed separately in the section that follows (Diagram 3.4 and 3.5).

The word search of the study guides for the four domains at Tygerberg Hospital that are followed by all students (RCS and Tygerberg students) yielded only one reference to patient-centredness or related terms. This reference was found in the study guide for the Ophthalmology rotation. The other three domains are Anaesthesiology, Urology, and Ear, Nose and Throat Surgery.

With regard to the cohort of students who were placed at the Tygerberg campus for the last year of their studies, the search for the patient-centred-related terms generated the following results (also see Diagram 3.4): All seven domains where the students were placed mentioned patient-centredness or some of its related terms. Again it was the Health and Disease in Communities domain that mentioned it the most with Psychiatry in the second place. The other five that mentioned terms related to this concept had only two or less than two references. However, in the instances where patient-centredness was mentioned in some way or another, there was no mention of how these would be taught or assessed. It is important to mention that although these students were based at the Tygerberg campus, they did not work only in the Tygerberg Hospital.
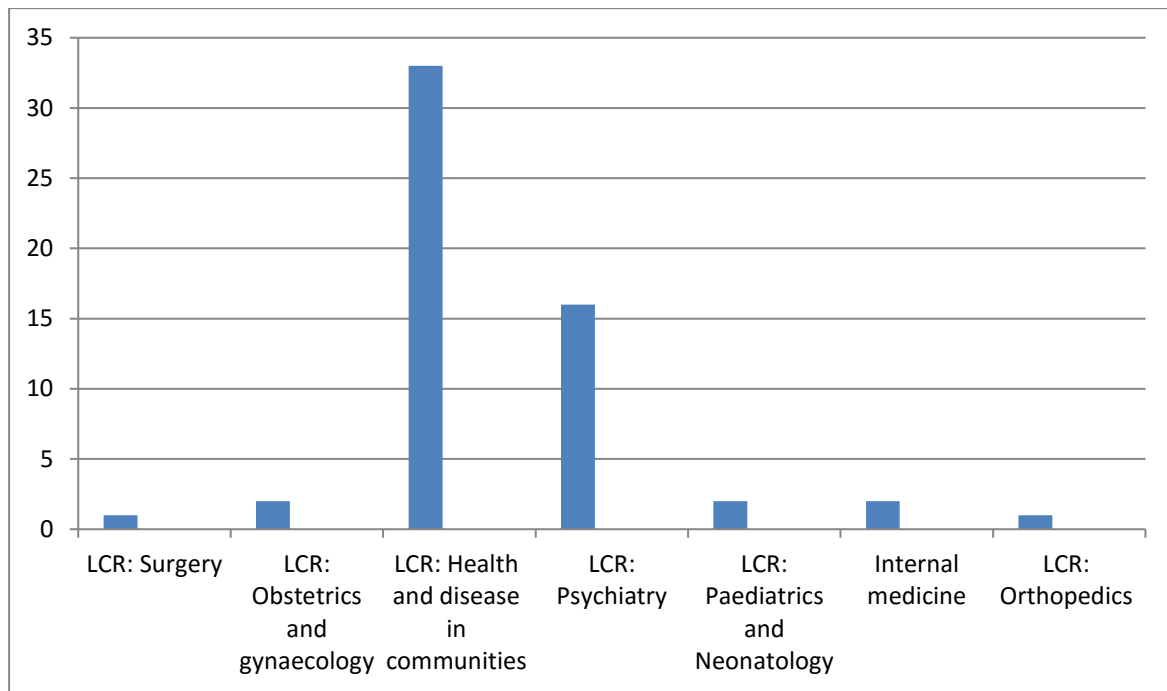
Diagram 3.4:   Results of Phase 3 domains at Tygerberg Hospital that had reference to patient-centredness or related terms

With regard to the two groups of students who were placed at the RCS, the domains make use of an assessment grid aimed at graduate attributes and it forms part of every study guide. The specific part of the grid that relates to patient-centredness is called the 'communicator' and the assessment aims are phrased as follows:

> **"COMMUNICATOR:** Interacts professionally, ethically and compassionately with patients, staff and students."

At the Worcester Hospital the study guides of Surgery, Obstetrics and Gynaecology, Internal Medicine and Orthopaedics only have the sentence quoted above related to patient-centred outcomes in the assessment grid. Psychiatry and Paediatrics and Neonatology had one other reference to a patient-centred outcome in their study guide while Health and Disease in Communities showed an explicit focus on patient-centredness throughout (Diagram 3.5).
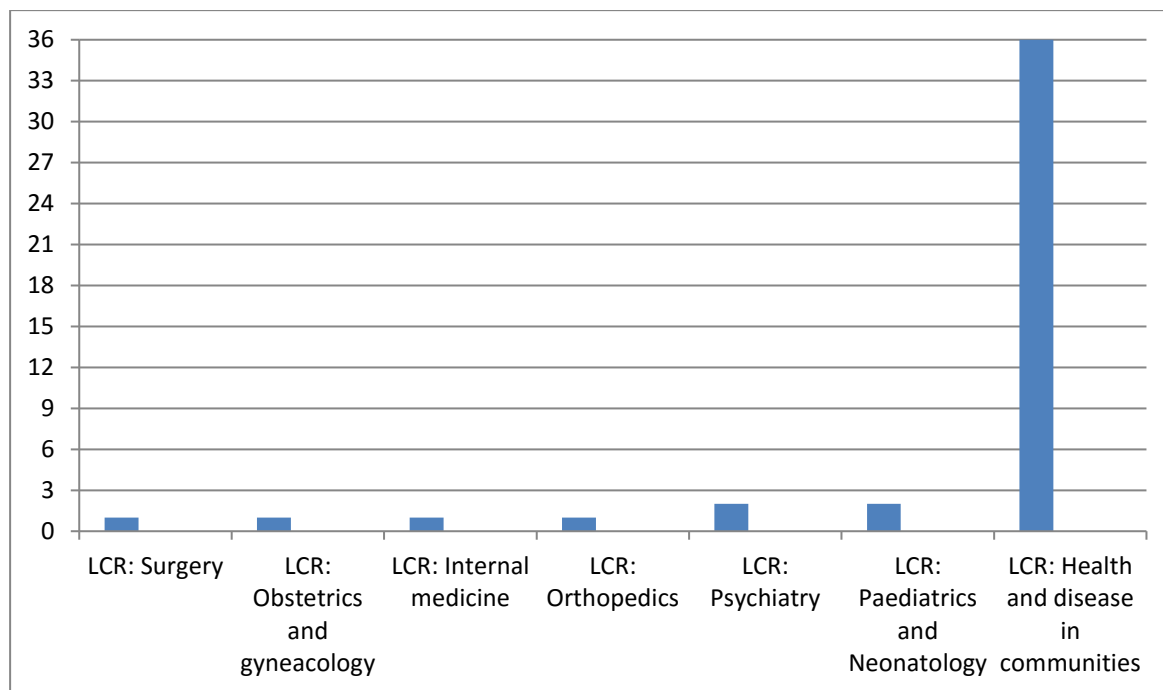
Diagram 3.5:   Results of Phase 3 domains followed by the final-year students at Worcester Hospital that had reference to patient-centredness or related terms

With regard to the LIC at the district hospital placements, students only have one study guide since their clerkship is integrated and longitudinal in nature. Within this study guide there were five references to terms related to patient-centredness - over and above the assessment grid that also forms part of the study guide, thus six references in total.

3.7.3   Summary of the findings from the student study guides

The findings of the search for the frequency of the term 'patient-centredness' or related terms in the various study guides showed that most of the modules/domains did not include any outcomes related to patient-centredness. In the case where there were references, they were limited and vague, or in some cases even used out of context. For example: "Theoretical Modules are student-centred; Clinical rotations are patient-centred."

The only modules/domains that had longitudinal outcomes related to patient-centredness were the Health and Disease in Communities theoretical module and these same clinical domains in the early, middle and late rotations. Furthermore, it was only the study guides of the Rural Clinical School that clearly indicated how the assessment of the domain would focus on components of patient-centredness.

The analysis of the MB,ChB study guides assisted in contextualising the study by providing an overview of the intended curriculum for patient-centredness. It would seem as if it is extremely complicated to coordinate the various theoretical and clinical modules of the MB,ChB programme as a whole, since each module is coordinated by a different person. The effect of the departments coordinating their own modules with regard to the outcomes and assessments is that some were operating in almost a 'silo'; not paying attention to the big picture and generic cross-cutting competencies that are required at graduation.

3.8   SUMMARY

In this chapter I have discussed the context of the MB,ChB curriculum in relation to a number of national and international trends in medical education. I also gave details of how the MB,ChB programme is constructed and operationalised. This information is essential in order to better understand a very specific component of the curriculum (the teaching and learning of patient-centredness) within a programme that is complex and multi-layered.

By now the theoretical perspectives (Chapter 2) and the role of context (Chapter 3) have been considered with regards to the teaching and learning of patient-centredness. What I shall discuss next is how the teaching and learning of patient-centredness as a competence, in relation to the integrated model (IM) of Fishbein (2000), may be understood. Diagram 3.6 represents my current understanding of the factors that influence students' learning about patient-centredness.
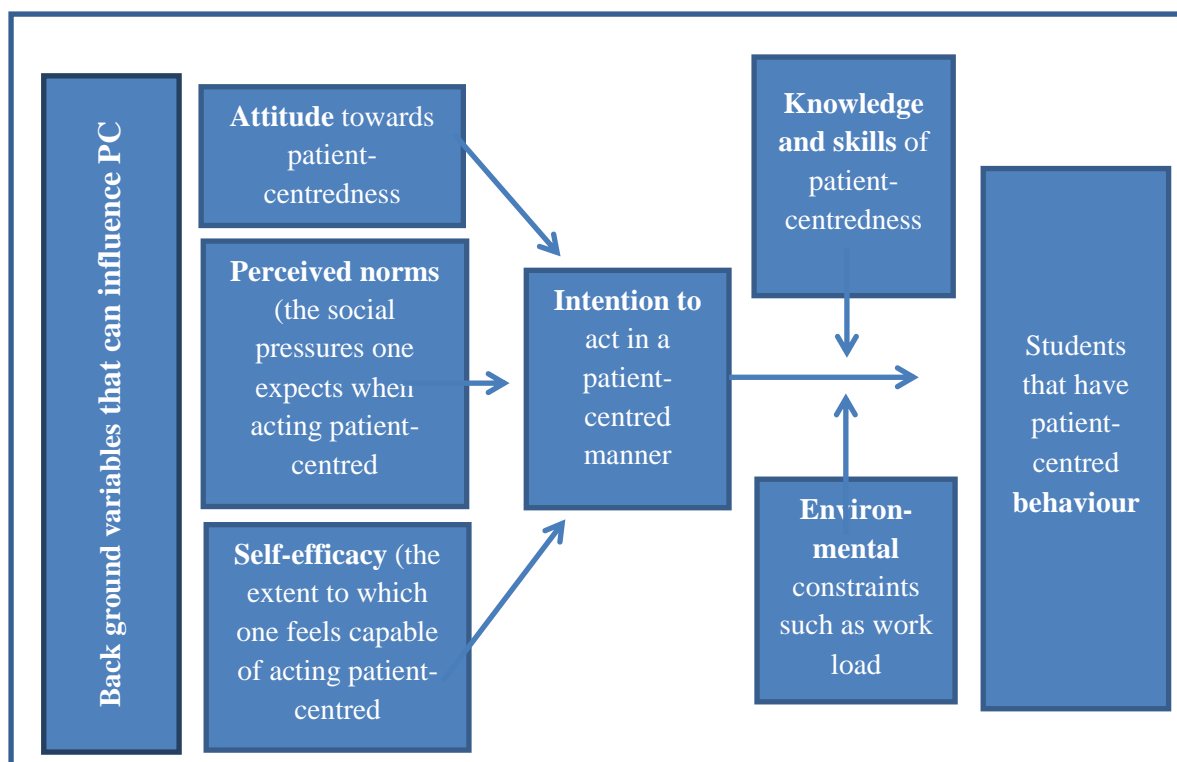
Diagram 3.6:   *Conceptual understanding of how patient-centredness is taught and learnt (Fishbein's 2002 model adapted)*

Diagram 3.6 attempts to explain my understanding of how patient-centredness is taught and learned. Students come into the programme with different background factors (see 2C.3) and they have certain beliefs that influence their attitudes (see 2C.3.3), social norms (see 2C.2.4) and self-efficacy (see 2B.4.4) with regard to patient-centredness. Two vital elements that further determine whether students display patient-centred behaviour are their knowledge and skills (2C.2.1) as well as the constraints or enablers in the environment in which they have to work (see 2C.3.3). All of this takes place within the context of the MB,ChB programme curriculum represented by the box enclosing the figure.

The next chapter reports on the methodology that was followed to conduct the empirical part of this research and then at the end of the study in Chapter 8, the conceptual framework is revisited in order to determine how, if at all, the understanding of the factors involved in the teaching and learning of patient-centredness in the medical programme at SU has evolved.

Chapter 4

RESEARCH METHODOLOGY

4.1   INTRODUCTION

The aim of this study was to explore teaching and learning experiences in the final year of medical education students in the MB,ChB programme at SU in order to explore how undergraduate medical students learn (or do not learn) patient-centredness. The previous two chapters dealt with relevant theoretical perspectives and the contextualisation of the study, while this chapter aims to focus briefly on the research problem and to explain the methodology that was used to achieve the research goals.

4.2   THE PROBLEM INVESTIGATED

There is a substantial body of literature indicating that the attitudes of undergraduate medical students towards patient-centredness seem to decline during the course of their undergraduate education. It has been reported that students develop more doctor-centred and disease-centred attitudes as they progress through the undergraduate curriculum (Bombeke et al., 2010; Haidet et al., 2002a; Lee et al., 2008; Tsimtsiou et al., 2007). Several studies have dealt with the issue of attitude change (Batenburg & Smal, 1997; Haidet et al., 2001; Krupat et al., 2009; Wahlqvist et al., 2010) and some indicate a trend away from patient-centredness despite educational interventions to improve this competence in medical students (Bell et al., 2008; Noble et al., 2007; Ogur et al., 2007; Vivian, McLaughlin, Swanepoel & Burch, 2010). Fewer studies have explored the factors that enhance or inhibit the development of patient-centredness (Bombeke et al., 2012). Gaining insights into the enablers and barriers in developing or promoting patient-centredness of medical students can be vital in order to make useful educational and programmatic changes aimed at enhancing this key competence in future doctors, based on the assumption that patient-centredness is a desired graduate outcome. South African research on the development of 'soft skills' such as professionalism (Joubert, Krüger, Bergh, Pickworth, Van Staden, Roos, Schurink, Du Preez, Grey & Lindeque, 2006), communication skills (De Villiers & Van Heusden, 2007) and patient-centredness (Archer et al., 2014) is rather limited. In addition, it is also less clear as to how international challenges and initiatives to improve

patient-centredness can be applied in local (South African) contexts. A study that adds some light onto the issues mentioned above is THEnet; a group of diverse medical schools from Cuba, Venezuela, Canada, South Africa, Australia and the Philippines that have formed an alliance to support one another in the implementation and evaluation of social accountability in relation to the education that they deliver (Leinster, 2011). This group recon that at the individual level, there is significant overlap between the concepts of 'social accountability' and 'professionalism'. The factors that they acknowledge as having an effect on a doctor's behaviour and practice are innate attitudes, available resources and the structure of the health services. These factors again are influenced by the dominant economic and political climate of the region/nation where the medical school is situated. So while a medical school that is socially accountable will seek to engage with these issues, the amount of influence it can have on these factors is outside of its direct control. Even admissions policies and curriculum design may in some cases be determined at a national level and lie completely outside of the control of the individual school (Leinster, 2011).

A logical starting point for this study was to gain insights into how the undergraduate medical curriculum at SU as a programmatic case in time is currently structured in order to understand how patient-centredness is potentially developed or fails to be developed. Only after such an understanding may one attempt to point out possible educational and programmatic changes implications aimed at enhancing the learning and teaching of patient-centredness in the MB,ChB curriculum.

In the next section the research questions that guided this study are restated, followed by an explanation of the selected methodology to answer the questions posed. The underlying philosophical considerations, research approach and the sampling decisions as well as the data source management and quality measures are then discussed. The chapter concludes with a description of data analysis measures and ethical considerations.

4.3   RESEARCH QUESTIONS

The main research question for this study was posed as follows:

How, if at all, do students in an undergraduate medical curriculum learn to be patient-centred?

In order to answer the main research question, the following sub-questions were explored:

- What constitutes 'patient-centredness' in an undergraduate medical curriculum?

- What factors enhance or inhibit the learning of patient-centredness by undergraduate medical students?

- What learning opportunities for patient-centredness are created, or failed to be created, by the clinician teachers involved in the teaching of undergraduate medical students?

4.4   THE DESIGN OF THE STUDY

4.4.1   Research paradigm

A research paradigm refers to the way one chooses to view one's research material (De Vos et al., 2011) and it is influenced by a researcher's expertise, beliefs and past experiences (Creswell, 2013). A paradigm or philosophical point of departure is seen as consisting of three important dimensions, namely the epistemological, ontological and methodological (Denzin & Lincoln, 1994). It is thus important for any researcher to state the chosen epistemology (how social phenomena can be known), ontology (belief of what social reality is) and methodology (how one gains knowledge about the world). Since the aim of this study was to understand and reconstruct the knowledge constructions of people and non-numerical data were predominantly used, an interpretive constructivist philosophical approach to reality was taken. In this approach, reality is interpreted through the meaning that the research participants give to their world and therefore such meaning is discovered through narrative and observational data (De Vos et al., 2011). According to Creswell (2013), there are certain assumptions when a constructivist philosophical lens on knowledge is used, namely that human beings construct meaning as they engage with their world, that the sense they make is based on their own historical and social perspectives, and finally, that the researcher has to make meaning from the narrative or observational data collected in the research. The constructivist paradigm has two distinct elements: firstly, it makes use of an epistemology which expects various and different interpretations of reality rather than looking for singular 'truths' and, secondly, it assumes an interpretive effort of how a specific phenomenon is experienced by those who are personally involved in or influenced by it (Bunniss & Kelly, 2010).

It is important to acknowledge that case study research (the design chosen for this study) could be executed with more than one philosophical assumption in mind (Maree, 2007). Researchers can, for example, do case studies from a positivistic, interpretivist or a critical stance. From an

interpretivist view, however, a case study can be seen as research where the aim is to foster a holistic understanding of how participants relate with the phenomenon, with each other and how they make meaning of the phenomenon under scrutiny (Maree, 2007). In this study an interpretivist stance was taken, since the focus was on how the respondents experienced a specific teaching and learning programme and its context.

4.4.2   Research design

A research design can be explained as the logical flow that connects the study's research question and empirical data to the conclusions (Yin, 2013). In this study a case study design was selected since the aim was to better understand how students learn or fail to learn patient-centredness within a particular real-life context. Creswell (2013) describes a case study as an in-depth analysis or exploration of a 'bounded system', which can be a single or even multiple cases, making use of more than one data-collection procedure over a continued period of time. This type of design allows researchers to immerse themselves in the activities of a small number of people in order to understand their social world while looking for patterns in the participants' lives, words and actions in the context of the case (De Vos et al., 2011). It seems vital that case studies build on knowledge of relevant literature and, most importantly, the context in which they appear (deductive logic) which differs from, for instance, grounded theory designs where theory is derived from the views of the research participants (inductive logic) (Creswell, 2013). Yin (2013) describes five components that are important when case study designs are considered:

- The central research question;
- Its propositions (if any);
- Its unit(s) of analysis;
- The logic which links the data to the propositions; and
- The criteria for interpreting the findings.

In defining the case the researcher has to clearly indicate the unit of analysis within a specific context (Miles & Huberman, 1994). In this study the unit of analysis was the teaching and learning of patient-centredness within the MB,ChB programme at SU. This programme also formed the boundaries of the case. Determining the boundaries of a case assists the researcher in staying within a specific scope and thereby answering the related research questions (Creswell, 2013).

Since the study was aimed at determining how patient-centredness is taught and learned (or fails to be taught or learnt) in a specific medical curriculum, it can be classified as a programmatic case study (Stake, 1995). Yin (2013) further classifies this type of study as an explanatory case study since the purpose is to explain how or why some condition – in this case the teaching and learning of patient-centredness that was (or was not) happening.

Case study research relies on triangulation since this assists with the validity of the data process (Yin, 2013). This study used various data sources and multiple perspectives for interpretation, comprising students and clinician teachers as interview respondents, observations of clinical teaching situations by the researcher as well as curriculum documents as artefacts (Patton, 2002). Some authors are of the opinion that triangulation is an effective measure to improve the validity and reliability of research, while others (Plowright, 2011) indicate that it is more appropriate to refer to ecological validity, which indicates the 'closeness' to or 'naturalness' of the real-life situation(s) investigated.

4.4.3   Generalisation in case study research

Models of generalisability that provide a useful framework to consider when one aims to make generalisations from research are statistical, analytic and case-to-case (Firestone, 1993). Generalisability is also referred to as transferability and for it to be possible researchers have to provide a detailed, thick description of the case (see Chapter 3) so that other researchers are able to judge the applicability of the current study for their own research (Firestone, 1993). Case study research (Stake, 1995) is a poor basis for generalisation since only one or a few cases will be studied and every case study inevitably has its own unique characteristics (Plowright, 2011). The intention of case study research is thus not to generalise, but rather to understand the dynamics of a specific state of affairs within a particular context – for the particular research (Maree, 2007).

4.4.4   Validity

Two criteria have been proposed to judge the quality of qualitative data, namely trustworthiness and authenticity. Trustworthiness refers to credibility while authenticity implies fairness (Denzin & Lincoln, 1994). Credibility is about the focus of the research and how well the subject has been identified and described, and one can attempt to set boundaries around the study by describing the setting, population and theoretical framework in great detail (De Vos et

al., 2011). Choosing research participants that have different experiences of the phenomenon under scrutiny increases the possibility of informing the research question from a variety of perspectives – and thus its trustworthiness (Patton, 2002). Credibility of findings further implies that categories and themes in the data-analysing process cover the data adequately (Graneheim & Lundman, 2004). Fairness implies balance, meaning that all participants' views, perspectives and voices should be apparent in the text. The omission of participants' voices is therefore seen as a form of bias (Denzin & Lincoln, 1994).

According to (Creswell, 2013), there are various strategies that can be implemented in order to assess the accuracy of findings and at the same time convince the reader of its value. Table 4.1 suggests the strategies and measures taken to enhance validity in this study.

Table 4.1: Strategies employed in this study to enhance validity (adapted from Creswell, 2013)

Research strategy	Measures to enhance validity
Triangulation	Different sources were used for data collection, namely focus group interviews, individual interviews, document analysis and observations.
Rich, thick description	A detailed and comprehensive description of the institutional and programmatic contexts were provided in Chapter 3
Bias	The researcher engaged in extensive self-reflection to clarify the bias she might bring to the study. Member checks of the analysis were done with some of the students and clinician teachers, but this was less satisfactory as it could not cover all participants because of practical concerns.
Spend prolonged time in the field	The researcher spent extensive time with students, clinician teachers and observations in attempting to understand the phenomenon under study.

4.4.5   The position of the researcher

When generating and interpreting qualitative data in case study research it is vital for the researcher to clarify his/her position or specific role in the research project. The interpretation of the researcher cannot be separated from aspects such as background, context and prior understanding or the person; it is thus important to highlight the position of the researcher (Creswell, 2013).

The researcher in this case study is a professional nurse by training and currently a clinical skills lecturer and manager of the Clinical Skills Centre at the FMHS of SU, teaching medical students clinical skills in simulation. The initial degree that was obtained is a BSocSc (Nursing) degree which had a significant emphasis on holistic care and caring for patients by taking into account their physical as well as psychological aspects. While working in the clinical area years ago an interest in teaching and learning developed and a postgraduate Diploma in Nursing Education was completed.

Given the researcher's background in nursing and psychology, she developed an interest in the teaching and learning of communication skills in the undergraduate medical curriculum soon after becoming a clinical lecturer in the Clinical Skills Centre. Being part of the FMHS committee that was tasked with integrating the so-called 'Golden Threads' (which later became the Graduate Attributes Working Group), caused this interest to grow into the bigger issue of how the undergraduate curriculum supports or fails to support the development of patient-centredness in medical students.

It is important, however, to acknowledge that at the time of the research the researcher was working in the FMHS where the research was done and knew the medical students personally therefore, some steps had to be taken to retain neutrality. These students have had clinical skills sessions in the Centre where the researcher was working from their second to their sixth year, however these sessions were presented to the students by various lecturers and not only by the researcher. The clinical teachers that took part in the study was also known to the researcher, however the researcher had a strict professional and quite distant relationship with all of these individuals.

In an attempt to retrain neutrality it was important as a first step not to set out to prove a particular perspective or truth, but to be committed to understand the case being studied as it unfolded. Choosing a paradigm where the 'how' question in research could be answered thus seemed to be appropriate. Other strategies that were used to assist with the process of neutrality were systematic data-collection procedures and multiple data sources (Patton, 2002), as well as attempting as far as possible to understand the phenomenon under study in its natural learning and teaching environment (Plowright, 2011). The population of and sampling for the study is discussed next.

4.5   POPULATION OF THE STUDY

The study population were the final-year medical students (2014) at SU as well as the clinician teachers involved in the teaching of these students. The reason why final-year medical students were selected as participants was that they had almost completed the undergraduate curriculum and constituted an appropriate data source of what teaching and learning opportunities they had been exposed to in order to develop or not develop patient-centredness.

The population for the clinician teachers consisted of the academic personnel of the five larger departments through which the students rotate in their third to sixth years of study.

4.6   SAMPLING

4.6.1   Sampling for the focus group interviews (students)

Since there is evidence in the literature that factors such as gender and culture have the potential to influence the attitudes of students towards patient-centredness (see Chapter 2), there were attempts to take these two aspects into account when setting up the focus group interviews. What complicated the sampling, however, was the fact that while all students were invited to take part, it was finally their own choice whether they wanted to participate in the study or not.

Three sets of focus groups were conducted: (1) the students placed at the RCS in Worcester, (2) the students who were part of the LIC at Ceres and Hermanus and (3) the biggest group of students who were placed at the Tygerberg campus. At the RCS, the population was small and only one focus group interview was conducted for all these students. Due to logistical issues, the four students from the LIC could not get together for a focus group interview, so the two from each site (Ceres and Hermanus respectively) were interviewed separately. For the rest of the students that were placed at the tertiary hospital, Tygerberg, convenience sampling was done since it was voluntary to take part in the research (Maree, 2007). Interestingly, the students that volunteered were a fair representation of the overall class demographics and in the end the group that took part in the study represented a profile similar to a proportional quota sampling profile (De Vos et al., 2011). In order to potentially achieve data saturation (Creswell, 2013), a total of seven focus group interviews were conducted with the Tygerberg group during their last semester of training (August and September 2014). Altogether 10 focus group interviews (Tygerberg x7, RCS x1 and LIC x2) were conducted, involving 60 students out of the total class

of 208 students (thus almost 29%). Diagrams 4.1-4.3 below indicate the demographic information of the students that took part in the interviews versus the total number of students per site. Diagram 4.1 displays the information of the students placed at Tygerberg Hospital.
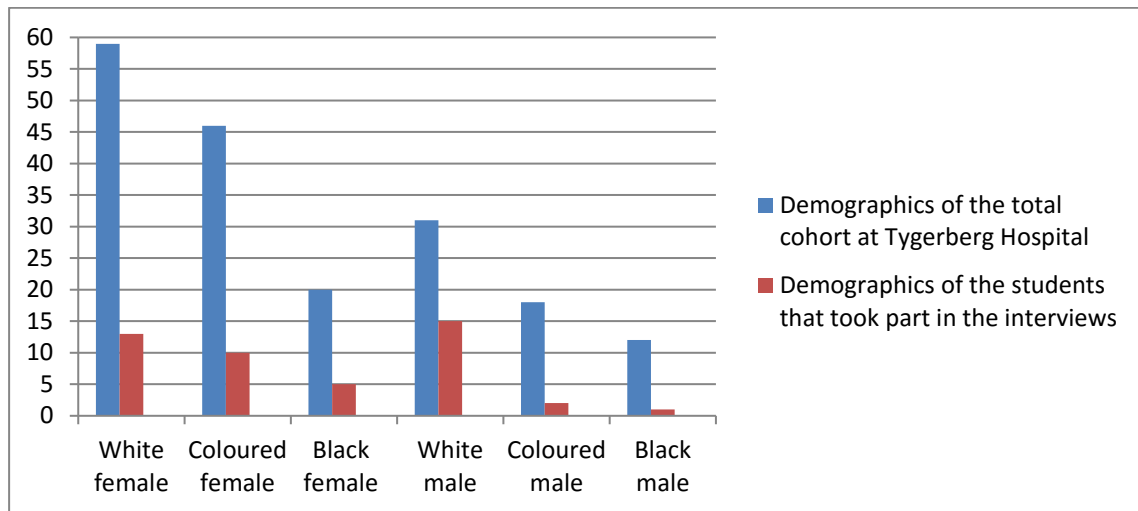
Diagram 4.1:   Demographics of the sample group compared to the population: Tygerberg Hospital (n=48)

Diagram 4.2 represents the group of students that were placed at the RCS in Worcester.
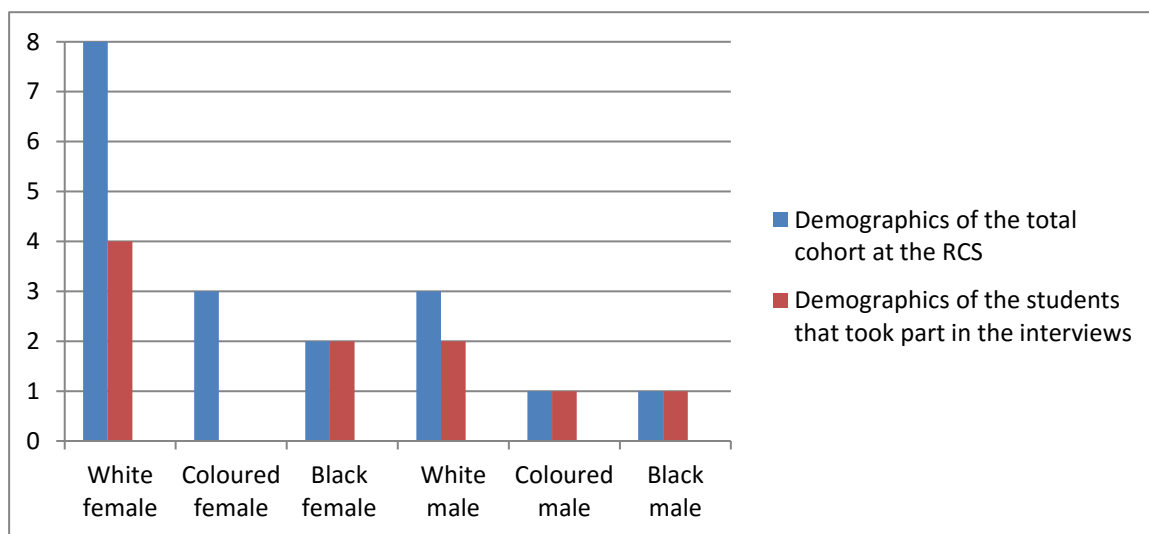
Diagram 4.2:   Demographics of the sample group compared to the population: Rural Clinical School Worcester (n=10)

Diagram 4.3 represents the small group of students that were placed in the LIC.
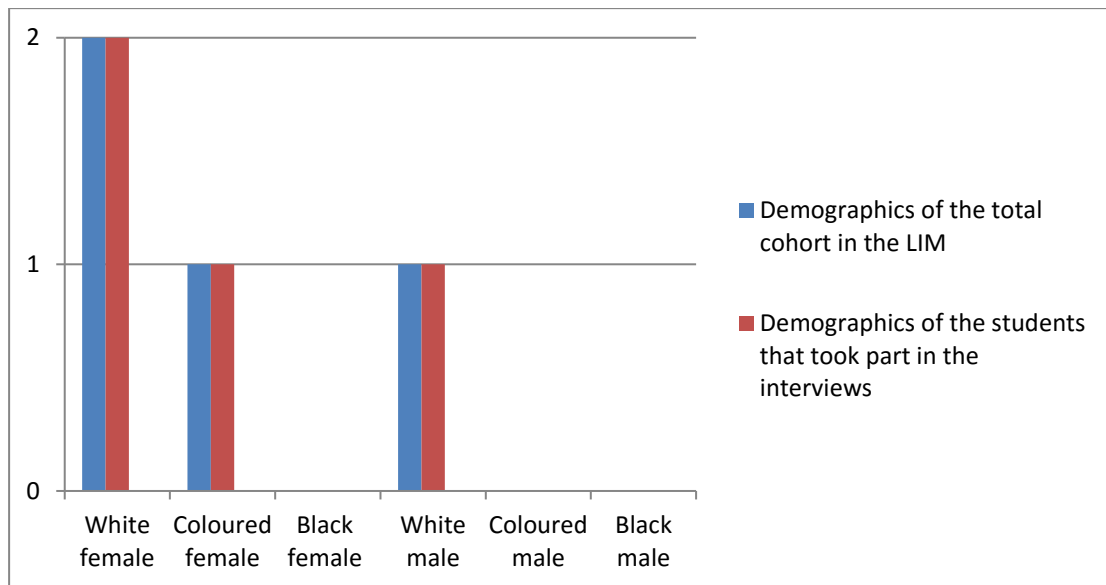
Diagram 4.3:   Demographics of the sample group compared to the population: Longitudinal Integrated Module (LIM) (n=4)

A total of 60 students took part in the interviews and the demographics of the sample group were as follows: 19 white female, 11 coloured female, 7 black female, 18 white male, 3 coloured male and 2 black male students. These numbers matched the actual demographics with regard to gender in the class (see Table 4.2).

Table 4.2:   Percentages of respondents with regard to gender

Participation: Gender	Percentage
Female students taking part in interviews	62%
Female students in the total population (class of 2014)	67%
Male students taking part in interviews	38%
Male students in the total population (class of 2014)	33%

4.6.2   Sampling for observation sessions and individual interviews (clinician teachers)

One clinician teacher was sampled from each of the disciplines that students rotate through during their third, fourth, fifth and sixth year. Disciplines where students spend most of their time were chosen, namely Family Medicine/Community Health/Rehabilitation (also called Health and Disease in Communities), Internal Medicine, Obstetrics and Gynaecology,

Paediatrics and Child Health, and Surgery. Within each discipline the purposive sampling technique (De Vos et al., 2011) was used to select only one clinician teacher to be part of the study. Either the departmental head of each of the five previously mentioned departments or their undergraduate teaching coordinator was asked to identify any clinician teacher considered as a suitable teacher for the facilitation of patient-centredness to undergraduate medical students. These five individuals were then approached and permission was asked to observe them in the clinical area while they were interacting with students. The observed clinical teaching encounter was followed by an individual semi-structured interview to clarify some issues that were unclear or about which the researcher was uncertain. This process is described in more detail in Chapter 6. The fact that no clinician at the Rural Clinical School (RCS) was selected by the Department Heads/undergraduate teaching coordinator could possibly have been due to fact that the clinician teachers at the RCS are not so involved with the undergraduate medical students as some of the clinicians at the hospitals where students were placed more often.

4.7   METHODS TO GENERATE DATA

In selecting the methods to generate data for this case study, the following aspects played a role. Firstly, study guides were useful data sources as they provided the focus for programmatic learning and were used by both the students and the clinician teachers. Secondly, focus-group interviews were seen as useful in generating information from the students since patient-centredness could not be observed directly and the students were able to provide historical and experiential information, such as how they perceived themselves to have developed over six years of study. Thirdly, by making use of observations in conjunction with individual interviews, the clinician teachers could be observed; these were followed by individual semi-structured interviews to clarify any uncertainties. These methods are discussed in sections 4.7.1 to 4.7.4.

4.7.1   Document analysis

Document analysis is the study of existing documents in order to understand their content although these documents were not initially written with a view to research (De Vos et al., 2011). In this case a document analysis was done of official documents (De Vos et al., 2011), namely all the study guides used by the sixth-year students of 2014 (from 2009 to 2014). The written data source was used as a primary source (Maree, 2007) and since they were available

in electronic format, a word search could be done for specific words. The frequency of the words was documented in order to determine the intended curriculum with regard to patient-centredness (see 3.7.2).

4.7.2   Focus group interviews with students

According to Yin (2013), conducting interviews is one of the most important ways by which to source data in case study research. However, researchers need to be aware that poor interviewing techniques can damage the credibility of this useful data-collection method (Patton, 2002). With well-designed interviews it is possible to understand what individuals think, feel and do since they provide information on their experienced personal realities (Henning et al., 2004).

A focus group interview can be explained as a small-group interview that is centred on a specific topic (Patton, 2002). It is assumed that by making use of focus group interviews there is a wider range of responses, and forgotten details of experiences are activated among the participants (Maree, 2007). For this reason focus group interviews were considered to be the ideal forum in which students would be able to remind one another of their experiences with regard to the teaching and learning of patient-centredness during their six years of study.

Focus group interviews were conducted with final-year medical students to encourage discussions about how and where they were taught about patient-centredness as well as which are factors that either enhance or inhibit the learning thereof (Brink et al., 2006). Bearing in mind that the focus group setting could perhaps be intimidating to some students, the group was observed carefully throughout. In general, students spoke openly in the groups as they had known one another for the last six years and were fairly comfortable with each other.

Participants were able to build on one another's ideas and comments in order to produce an in-depth view that could not have been attainable from individual comments (Maree, 2007).

Seven of the focus groups comprised between eight and ten participants at a time (Krueger & Casey, 2002), which worked well and made it possible for plenty of discussion to take place. Since some students did not attend despite their initial undertaking to participate, two of the groups had only four students. However, this was not a problem as participants still took part in the discussions and interviews did not last as long as the others with more participants.

The students were invited to take part in the focus group interviews in the groups that they had attended in the clinical areas since their third year of study. These groups typically consisted of between 12 and 24 students, and the students were randomly placed in these groups during their third year of studies. The chairpersons of the various clinical modules that agreed to dedicate time to the students were from Paediatrics, Orthopaedics, Obstetrics, Anaesthetics, Family Medicine and Internal Medicine. Finally, the students that were in these rotations were invited to attend the focus groups. During a verbal invitation the researcher provided a two-page document explaining the purpose of the research as well as a section where they had to sign informed consent for taking part in the discussion. The researcher then negotiated a time that suited the students best, which was over their lunch hour. The students who were willing to take part arrived at the scheduled times. No group had more than ten participants and the average size was eight.

The researcher conducted all the focus group interviews herself, making use of a discussion guide (see Addendum 2). Students were assured that whatever they said would be kept anonymous and they were allowed to withdraw from the study at any time they wanted to. The discussion was started with a brief overview of their knowledge of what patient-centredness is and only after that, in order to shape the rest of the conversation, participants were given the interpretation of patient-centredness as used in this study. In an attempt to assist them to reflect on their experiences, participants were requested to think of two encounters in the past: one where patient-centred behaviour was demonstrated by a doctor in the clinical areas, and the other an incident where this behaviour was absent. Only after making sure that most of the participants took part in the discussion, the group proceeded to a next area of discussion. A fieldworker was present in the first interview, but from there on additional field notes were taken by the researcher to inform the recorded interviews if and where needed. The discussions were all between 45 minutes and one hour in duration and all the focus group discussions were audiotaped and transcribed verbatim by a transcriber who was not part of the study.

4.7.3   Observation encounters

Direct observation occurs when a field visit is conducted during the case study and has proved to be useful for providing additional information about the topic being studied (Yin, 2014). Non-participatory observation, as it was done in this case, provided an understanding of the natural context without the influence of the observer (Patton, 2002). A long-standing concern about the reliability and validity of observation data has been the effect that the observer can

potentially have on those that are observed, since people may behave in a different way when they know they are being watched. However, due to ethical considerations it was not possible to observe the people and clinical incidents without their being aware of it (Patton, 2002)

Over a course of one month arrangements were made to observe and interview the five clinician teachers that consented to be part of the study. The number of medical students per observation opportunity varied from one to twelve, depending on the specific incident that was observed. The observations that took place were direct in the sense that the researcher was present at the time, was not concealed but rather known, and the researcher's role was that of a non-participant (Cohen, Manion & Morrison, 2007). In order to observe a teaching and learning session of the students in the clinical area, the researcher had to be physically present at the time and all the attendees in the ward round were aware of the research study. Since everybody was aware of the fact that the researcher was a registered nurse by background, it was relatively easy to blend into the environment. Field notes of all aspects related to the teaching and learning of patient-centredness were taken during the observations. To blend into the group and environment while also observing, and taking notes at the same time is a challenge and one constantly has to be aware of the purpose of the observation (Denscombe, 2007). The clinician teachers had been assured beforehand that the focus of the observation was on the teaching and learning of patient-centredness and not the subject or skills they were teaching the students. These measures seemed to put all the participants at ease with regard to the observation encounters.

There was no predesigned observation schedule (De Vos et al., 2011); since it was argued that the teaching and learning of patient-centredness is such a complex entity it would not be possible to be captured on a single schedule. Rather, everything that was thought relevant to the study was recorded in writing and within less than 12-24 hours after the observation encounter it was refined into more detailed field notes (Babbie & Mouton, 2001).

The details of the observation settings are described in Chapter 6 with the clinician teachers' interview data. Individual interview procedures with the clinician teachers, which took place after the respective observations, are described next.

4.7.4   Individual interviews with clinician teachers

Face-to-face semi-structured individual interviews (Creswell, 2009) were conducted with the clinician teachers in order to determine how they created or planned to create learning opportunities to enhance the development of patient-centredness in undergraduate medical

students. (See Addendum 3 for the interview schedule.) This type of data collection had the possibility of giving a detailed picture of the teachers' beliefs about the teaching of patient-centredness (De Vos et al., 2011). Semi-structured individual interviews were chosen since the clinician teachers were all extremely occupied with clinical responsibilities and it was not possible to get them all together for a focus group interview. Furthermore, they were all from different disciplines and levels of seniority, which could perhaps inhibit some of the participants in giving their personal opinions. The individual interviews were arranged with the respective clinician teachers after their teaching session in the clinical area was observed. These individuals all felt positive about being part of the study and both the clinical observation and interview was fairly easy to arrange with each individual. The interviews were held after the observation encounters in order to enable the participants to reflect on their teaching session, with the goal of clarifying any actions or incidents that were unclear to the researcher.

4.8   DATA ANALYSIS

Qualitative analysis converts raw data into findings and there are no clear rules on how this should be done, only guidance. Patton (2007) suggests that the final destination for each researcher is unique and will only be known when one arrives at it. Miles and Huberman (1994) see the analysis of data as three concurrent streams of activities, namely data reduction, data display and conclusion drawing. The three-levelled analysis process as suggested by these authors was chosen since this study had various data sets, bringing with it the risk of losing important aspects in the data. Another analysis approach that was considered for this study was an integrative approach as suggested by Creswell (2009). However, when considering the complexity of integrating the various data sets, the structured analysis process suggested by Miles and Huberman was regarded as simpler and more appropriate.

An overview of the analysis process in this study is provided in the next section, and data reporting follows in Chapters 5 and 6, with a discussion of the findings in Chapter 7. Below is a diagrammatic representation (Diagram 4.4) of how the analytic process of Miles and Huberman (1994) was adapted for this study.
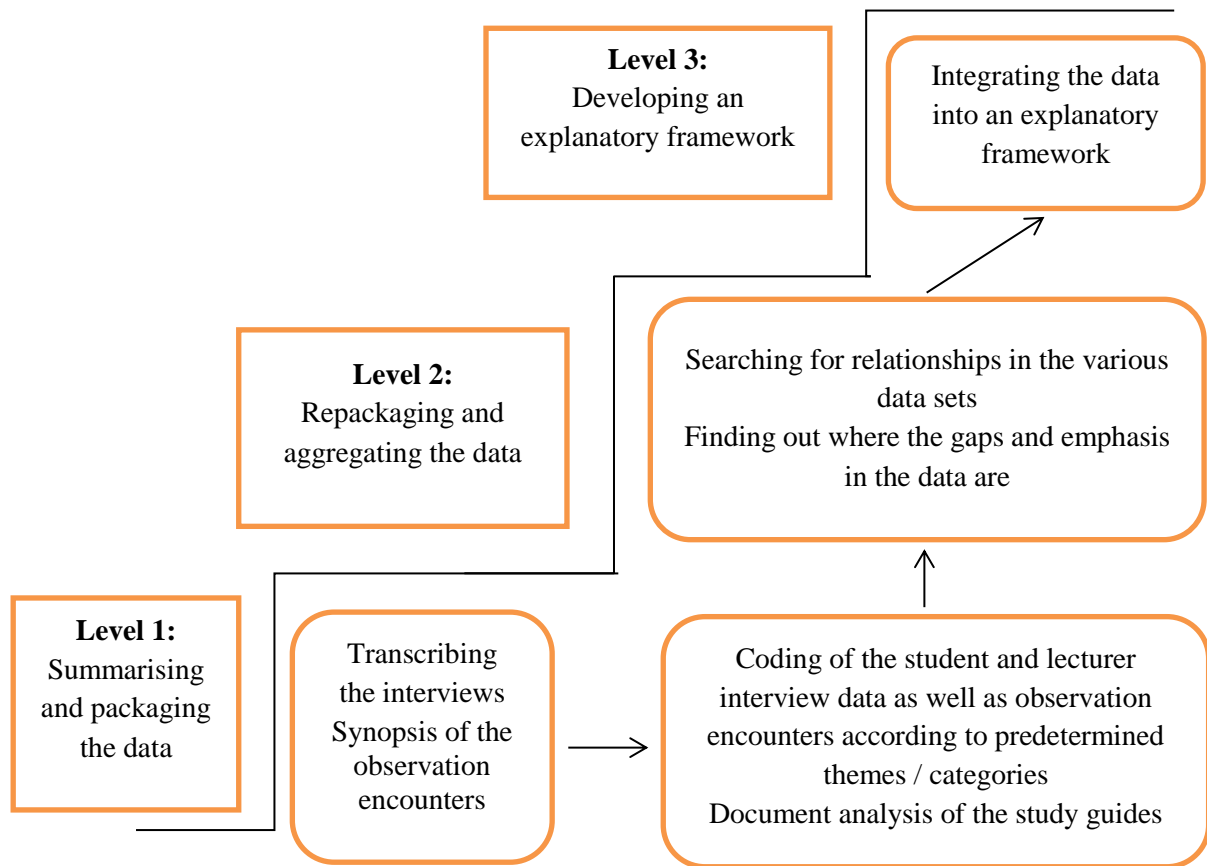
Diagram 4.4:   The ladder of analytical abstraction (adapted from Miles & Huberman, 1994)

4.8.1   Level one: Summarising and packaging the data

The first level of analysis included two steps: firstly the transcribing of the interviews and secondly the coding of these transcribed documents. The data sets that had to be analysed as part of this level were focus groups from the students, individual interviews and observations from the clinician teachers, and study guides (documents). It is important to mention that since the interviews were conducted by the researcher herself, there was a good sense of the data even before the coding process started. The processes that were followed in analysing these data sets were all different and therefore they are discussed separately.

4.8.1.1   Analysis of study guides

There were no issues with regard to legislation on the confidentiality of the information, so once ethical clearance was obtained, the electronic formats of the study guides were available for analysis. Content analysis was done with the written documents, transforming them from a qualitative into a quantitative format (De Vos et al., 2011). With the first search attempt that

was done the results for the words 'patient-centredness' and 'patient-centred' were very low, so phrases that could have a similar meanings such as holistic, biopsychosocial, empathy, caring or shared decision-making were also used. The outcome of this analysis was summarised in tables (see 3.7.2).

4.8.1.2   Analysis of the student focus group interviews

The focus group discussions were digitally recorded, transcribed and *ATLAS.ti* software was then used to enhance the data analysis. An analytical framework approach with sensitising concepts was followed to organise and later report the qualitative data. Before the coding was done, the transcripts were read several times in order to get a sense of the whole. A deductive analysis was then performed by making use of overarching sensitising concepts (themes) (Patton, 2002) as taken from the IM. A constant comparing process that was iterative took place between the themes of the IM, and the data and additional aspects that were evident in the data but not present in the themes of the IM were identified as new themes. A second step was then followed to sub-code the data (Saldaña, 2012) as each of the larger themes was broken down into the smaller categories for each theme. This was done according to how the categories emerged inductively from the data within each theme. The details of these results are discussed in Chapter 5.

4.8.1.3   Analysis of the individual interviews of the clinician teachers

After the student interview data were analysed, the individual interviews of the clinician teachers were coded by making use of an analytical framework approach. The themes and categories as found in the student interview data were used as the analytical framework. Although this was a deductive process, there was an iterative comparative process between the themes and categories found in the student interview data and the clinician teachers' interview data. This was done in order not to miss any important findings during the analysis process.

4.8.1.4   Analysis of the observation encounters of clinician teachers

During this part of the analysis process each of the observation encounters was rewritten as a synopsis. The observation encounters that were done were random and few, therefore it was acknowledged that no conclusions could be made from it as a whole; they were rather utilised to provide context and boundaries to the study (Yin, 2014). These observation encounters were

particularly useful in understanding the clinical teaching and learning environments from both the students' and the clinician teachers' perspectives.

4.8.2   Level two: Repackaging and aggregating the data

During level two analysis all the datasets were reconsidered and the themes and categories were re-checked in case any changes had to be made to the classifications. The findings of the student interviews and the clinician teachers were combined in order to determine which themes and categories overlapped and whether there were any obvious qualitative relationships between the two data sets.

Data from the observation encounters were then matched against that same clinician teacher's interview data. A diagram matching the specific data was compiled for each of the clinician teachers observed and interviewed (see 6.3.1).

4.8.3   Level three: Integrating the data into an explanatory framework

During this last phase of data analysis, the themes, as identified from the findings of the two main data sources (students and clinician teachers), were combined and discussed. The discussion and explanatory framework that emerged attempted to address the research questions and provided a final synthesis by integrating the findings.

4.9   ETHICAL CONSIDERATIONS

Approval to conduct the research was obtained from the Health Research Ethics Committee of SU (S13/09/167). Institutional permission was obtained as well as permission from the respective hospitals where data were generated. Participation was on a voluntary basis and informed consent was obtained from each participant. The anonymity of all participants was guaranteed and information was kept confidential at all times. In addition, no individual was identified in the recordings as only the date and rank of the clinician teacher was stated. All data collected were stored in a locked facility and on a password-protected computer.

Patients were not directly involved in the study as the study did not interfere with their clinical care.

4.10 CONCLUSION

In this chapter the rationale as well as the purpose and aims of the study were stated. Furthermore, the decision to make use of a case study research design was motivated and the details of the research process were outlined. The next two chapters present the findings that emerged from the data and their analysis.

Chapter 5

THE RECEIVED CURRICULUM: FINDINGS FROM THE STUDENT INTERVIEW DATA

5.1   INTRODUCTION

Following a theoretical perspective (Chapter 2) in exploring the key concepts of this study the empirical part of the study was conducted from two perspectives, namely the received and the taught curriculum. Since student perspectives have the possibility to provide a rich view of the received curriculum (Harden, 2001), focus group interviews with final-year medical students were conducted in an attempt to understand how the students perceive the curriculum as it is conveyed to them. These are the findings that are presented in this chapter. Student interviews were conducted with the aim of answering the secondary research question, namely what are the factors that enhance or inhibit the learning of patient-centredness for undergraduate medical students. The clinician teachers' perspectives of what is taught in the curriculum with regard to patient-centredness are presented in Chapter 6. According to Miles and Huberman's analytic ladder (see 4.4) this chapter deals with a level one process, since it is about the preparation of the data for analysis and then the presentation of the findings per themes and categories as they proved to fit the data.

5.2   LEVEL ONE OF DATA ANALYSIS: PREPARING THE TEXT AND FINDING CATEGORIES THAT FIT THE DATA

5.2.1   Preparing the text in order to perform the analysis

Student interview data were transcribed and then saved with a unique code for reference purposes. Despite the fact that the researcher conducted the interviews, the transcripts were read and re-read in order to be reminded of the details that were communicated in the interviews. An advantage of the researcher also being involved in the curriculum that was studied for this case study was that the data that were generated were familiar and it was relatively easy to label the units of meaning (Henning et al., 2004). *ATLAS.ti* computer software was used in the process of analysing the data.

5.2.2   Finding categories that fit the data

During the earlier phases of the study and in the process of exploring the literature about the teaching and learning patient-centredness, Fishbein's (2002) model was introduced. It was thus decided to use the various elements that form part of the IM in the data analysis process. By making use of content analysis (Patton, 2002), the components of the IM, namely background factors, attitudes, subjective norm, self-efficacy, skills and knowledge, and environment were utilised as 'sensitising concepts' or themes, in order to group together the rich data that were generated from the focus group interviews. Although inductive analysis is usually the preferred approach used in qualitative inquiry, data can also be analysed according to an existing model or framework, an approach referred to as analytic induction – as was done in this study (Patton, 2002). Deductive analysis was done by making use of an existing set of themes from the IM which were 'tested' against the data. It is important, however, to note that alongside this process there was a constant awareness of looking at the data afresh and inductively in order to detect any undiscovered patterns. It would thus be possible to return to the framework at the end and suggest possible alterations or newly emerging themes or elements (Patton, 2002).

As a level two activity, the findings of the student interviews were looked at again and repackaged (Chapter 6) and as a final analytic step (level three) such data were integrated with all the data sets (Chapter 7) in order to develop an explanatory framework in Chapter 8.

In the following section a brief explanation is given of the various factors acknowledged in the IM and then the findings of the student interviews as categorised are presented. The purpose of the data analysis component is to identify and understand the factors that enhance or inhibit the development of patient-centredness in undergraduate medical students.

5.3   THE INTEGRATIVE BEHAVIOUR MODEL (IM)

The Integrative Behaviour Model, a behavioural science theory, (Fishbein, 2000; 2008; Fishbein & Cappella, 2006) was identified as being suitable to serve as an analytic lens for student focus group data. Behavioural science theories are suitable for health profession education studies, since these theories are aimed at understanding how certain interventions cause certain outcomes when incorporated and therefore they include causal components that have the potential to inform the design of interventions (Cilliers et al., 2015). The model used

was described in Chapter 2 in some detail, but its key features will be highlighted before being applied to the analytic process.

Most relevant studies reported in the literature where behavioural theories were applied made use of quantitative datasets (Davis, Campbell, Hildon, Hobbs & Michie, 2014; Godin, Bélanger-Gravel, Eccles & Grimshaw, 2008). Some authors in HPE have, however, also successfully made use of the IM with qualitative data (Audétat, Dory, Nendaz, Vanpee, Pestiaux, Junod Perron & Charlin, 2012; Cleland, Knight, Rees, Tracey & Bond, 2008). The motivation for using the components of the IM model to assist with the analysis of the data in this study was an attempt to understand the students' experiences in a systematic way, starting with an existing model of how behaviour is explained. Once human behaviour related to a particular phenomenon is understood, one may consider how to plan interventions to influence and perhaps change that behaviour (Cilliers et al., 2015).

The IM (Fishbein, 2000) proposes that any behaviour is likely to take place if one has a strong *intention* to perform the behaviour, has the appropriate *skills and abilities* to perform the behaviour and if there are *no environmental or other constraints* preventing the performance. An intention again, is determined by three main factors, namely an *attitude* towards performing the given behaviour, the *perceived norms* concerning the performance, and *self-efficacy* with respect to performing that specific behaviour. Recognition is also given to *background factors* such as individual differences, personality, demographics, and culture. These factors might well have empirical associations with behaviour, but since context and cultures are so variant, the model allows for flexibility by proposing these as background variables (Yzer, 2012).

The structure for presenting the findings in this chapter is as follows: the factors as identified by the IM by introducing them as a theme (deductive analysis) are introduced first, followed by the evidence relating to that theme as it was found in the student data. The data per theme is very broad and therefore it was further organised into more specific categories (inductive analysis). Lastly the data that did not fit the themes as suggested by the IM are categorised and explained. The six themes as identified by Fishbein's model are outlined in Table 5.1.

Table 5.1:   Themes and categories of student focus group data

Theme 1: Attitudes	Category 1: The patient is seen as a whole person with their own needs
	Category 2: Personal satisfaction for doctors and patients
	Category 3: Involving the patient in the information and decision-making process
	Category 4: The role of the doctor in the doctor-patient relationship
Theme 2: Subjective norms	Category 1: Pressures related to patient-centredness
	Category 2: The influence of role models
Theme 3: Self-efficacy	Category 1: Past experiences with patient-centred behaviour
	Category 2: Perceived difficulty of being patient-centred
Theme 4: Background factors	Category 1: Demographic variables such as gender and age
	Category 2: Culture
	Category 3: Personality
	Category 4: Personal experiences
	Category 5: Exposure to media and social pressure
Theme 5: Skills and knowledge	Category 1: Theoretical knowledge
	Category 2: Relevant skills required
Theme 6: Environment	Category 1: Limited time and work stress
	Category 2: Context of clinical practice
	Category 3: Limited resources and system failures

The data that did not fit the categories indicated in Table 5.1 were aspects related to assessment and therefore a further theme that included these findings was added. This formed the seventh theme and it was termed 'Assessment'.

The rest of this chapter is a discussion of the findings as grouped per theme and then subdivided into categories. The following data codes apply to the various quotes from the interviews:

- Gr = Group
- F= Female
- M=Male
- For example, Gr7F1 would mean Group 7, Female participant 1.

5.3.1   Theme one: Attitudes

The IM describes *attitudes* as beliefs about the consequences of certain behaviour. It is therefore an individual's own judgment of how favourable or unfavourable the performance of the specific behaviour would be (Fishbein, 2000). In the context of this study, the theme *attitudes* relates to a student's belief that being patient-centred will lead to either unfavourable or favourable outcomes for the patient and the doctor. In order to allow the students to reflect on their own perceptions during the interviews the prompt that was given to discuss was whether they thought patient-centredness was a useful approach and why they thought so.

An aspect that became clear at an early stage of the data analysis was that students had different understandings of what patient-centredness means and this understanding then automatically influenced the way they valued behaviour. The various understandings of what patient-centredness meant to the students will not be described as part of this *attitudes* section, but later under *skills and knowledge* (section 5.3.5).

The theme *attitudes* was further divided into four categories that emerged inductively from the interview data, namely (1) the patient is seen as a whole person with their own needs, (2) personal satisfaction for doctors and patients, (3) involving the patient in the information and decision-making process, and (4) the role of the doctor in the doctor-patient relationship. Where applicable, data are reported in terms of both positive and negative illustrative comments from students.

5.3.1.1   Category 1: The patient is seen as a whole person with personal needs

Students displayed an overwhelmingly positive attitude towards a patient-centred approach with the acknowledgement that it is better for the patient when he or she is recognised and treated as a human being with his/her own expectations. The students admitted that although it is not what they would generally do or observe in practice, a systematic approach, where the patient is seen as an individual, would lead to positive outcomes for the patient. The following quotes serve to illustrate such views:

"You have to take his (the patient's) needs into consideration, and it definitely has a better outcome, because the outcomes for the patient differ from the outcomes of the doctor." (Gr1F2)

"I think we have to make that mind switch and realise that if you actually see a patient and you see them thoroughly and you treat them as a person, you will sort out a lot more issues and get to the real source of the problem much sooner than you would by just treating their symptoms." (Gr1F3)

"Well, treating the patient as a whole, not just the disease. So, knowing, the patient's ideas about the disease, and how it's affecting his life. So, you are trying to get the patient better, you're not just trying to remove their disease or kill the disease." (Gr6F1)

Acknowledging the patient as a whole person and as a unique human being with an own set of needs and expectations was a notion that was clearly important for the students. However, most of the students admitted that because they would generally see patients for only short and interrupted time periods in the clinical areas, they hardly ever get to know patients as 'persons'. The negative effect of this state of affairs was evident with students saying that they sometimes have to remind themselves consciously that the patient was still a person and not only an item or a disease. As illustration:

"I hardly ever saw patients more than once." (Gr7F1)

"You can easily get lost in all the complexities of medicine, and then start de-personifying the patient. So it can become an intellectual puzzle for us and we forget in the end what it is about. The main goal should be the patient." (Gr7M2)

"On ward rounds the doctors tend to glance over the patients and they just focus on the students and on the notes and on the disease. So often it happens that we walk out of a room and the patients call us students back and ask us, 'Doctor, like what is wrong with me?' They don't even know what their disease is, and that happens a lot, that's quite scary." (Gr1F3)

Some students indicated that the best they could do with regard to patient-centredness was to greet their patients and inform them of procedures that would be done on them:

"I will always greet my patient and introduce myself." (Gr4M2)

"Before you touch a patient and stick a needle in them you ask for their permission." (Gr1F3)

Conversely, the small group of students that did the longitudinal integrated module at the RCS were the only ones that spoke about experiences and benefits of getting to know the patients beyond their diseases:

"I think I always believed that it's about taking the patient as an individual person, and I think it starts with actually getting to know your patient, not just making sure you've ticked all the blocks on your history kind of thing, but actually getting to know the patient a little bit more than that, and then really making management decisions with them." (Gr6F1)

"I mean like we have spent a year now at Hermanus, so you live in the community and some of the patients come back three or four times, and you get to know them and you see the value of what you have done and what you have encouraged." (Gr6F2)

The evidence seems to indicate that the attitudes of students towards patients change once they have opportunities to know patients more intimately and a relationship can develop between them.

5.3.1.2   *Category 2: Personal satisfaction for doctors and patients*

What emerged from the previous section was that medical students realised the value patient-centredness had for patients. There were, however, some students who commented on the personal satisfaction from both the patient's and the doctor's perspective when patient-centredness was practised. These students valued the end effect of this approach and thought that one day it could help them enjoy their jobs:

"I don't know which it is, the chicken or the egg, about the patient centredness and the enjoyment they find in their jobs. I don't know if they enjoy their job, that's why they are patient-centred, or they are patient-centred and that's why they enjoy their job. I don't know, but I seem to notice that. I notice that, once those two are present, the doctors just seem to be happier and seem to enjoy it more, and even late, after call, there is always that energy that pulls them through." (Gr6F2)

"I don't know whether it's that, but patients seem so much happier and more content and less grumbly and grumpy. I don't know, but I think some of the most precious moments was to have seen a patient and addressed all their concerns, even if they weren't necessarily their primary medical concern, also looked at the other things, looked at a bit of preventative medicine, asked

about the family and where they come from and that, to then when the patients walk out they're like, 'Thank you doctor for your time.' Just that little thank you and you know you have sorted them out and they are going out, to take that patient-centredness and actually see that and the impact it can have was really incredible this year." (Gr6M1)

The comments on doctors' work satisfaction were all from the students in the LIC, while students that were placed in the other settings mainly commented on doctors who were generally stressed, get compassion fatigue and some who even suffer from burnout. It was interesting that the students mostly blamed difficult patients for the compassion fatigue of the doctors. One student said:

"The doctors get compassion fatigue and burnout if they get so many difficult patients to handle." (Gr1F3)

Students also said that understaffing led to neglect or disregard of doctors and that they were becoming tired and emotionally blunt. The example below illustrates an experience one student had:

"Then of course I also do believe that doctors aren't really managed well. A lot of the doctors are so burnt out that they have little compassion left for anything, and that no matter how much they want to show empathy, or how much they want to have a patient-centred approach, if they are that tired and that beat down, I mean some doctors said to me that after COMSERVE, they don't want to work. They don't want to work for a year. In fact they just don't want to work ever in the government again. I don't want to be like that. But I think being burnt out and not managed well, is a barrier to patient-centred care. If you don't manage your doctors well how are you going to retain them?" (Gr4F1)

(COMSERVE refers to the community service that the students have to do after graduation.)

Many of the participant students were exposed to doctors in the clinical areas who were described as being burnt out or cynical. Doctors that were rushed and not focused on the patients are aspects that were also evident in categories such as role modelling (see 5.3.2.2) and too little time (see 5.3.6.1). These categories are discussed later in this chapter.

5.3.1.3 *Category 3: Involving the patient in the information and decision-making processes*

The focus in this category was the value students placed on the importance of patients understanding their disease and their involvement in the decision-making processes. The students generally indicated that when a patient-centred approach was followed, patients are empowered and in the end they could suffer from less disease-related complications. By way of illustration:

"There is a distinct benefit in patient-centred care in the sense that patients take responsibility for their illness. So complications can be picked up earlier, or can be prevented. If you keep that benefit in mind, then you (as the doctor) will be more likely to do that." (Gr2M1)

"It's definitely better for the patient, because it empowers the patient to be part of the decision-making, and also the patient will be more compliant with whatever plan there is." (Gr5F1)

What was highlighted in all of the interviews was that giving information to patients was a major component of patient-centredness. Most of the students said that they make use of an approach where they would explain to patients what is going to happen to them or what is wrong with them. For instance, one student said:

"Sharing is very important, yes, providing the patient with information about the particular condition." (Gr5F2)

What became evident during the interviews, however, was that there were some students that had experienced the 'sharing' component of patient-centredness as a one-dimensional conversation with patients, often not checking for understanding from the patients' side. For example:

"I think just basically telling them what the plan is for the day. That is what we normally see." (Gr 8F2)

"Sometimes I just feel the doctors … even if it's just ten minutes, have to explain to them (the patients) what they have …" (Gr8F2)

However, other students indicated that explanations to patients should be followed by checking for understanding, thus being aware of a bi-dimensional action that should exist between the patient and the doctor. At least three participants indicated this awareness:

"I think that it is good to spend time with the patient, to explain, and make sure that they understand why they must be compliant." (Gr5F3)

"Also finding out what is the level of understanding of their condition and then work up from there ..." (Gr5F2)

"So you actually have the opportunity to talk to the patient, to tell them about the procedures they're going to have, and make sure that they want it." (Gr4M1)

A problem students highlighted was that they often saw a patient only once. Then they would tell the patient everything there is to know during the consultation, while they actually knew the patient would not be able to understand or remember much of it. One participant commented as follows:

"With a lot of our patients, you may not see them ever again, so it's your one time to really make a difference and say everything you need to say." (Gr5M4)

Students were also of the opinion that the majority of their patients did not really want to take responsibility for their own health; they wanted the doctor to make decisions on their behalf. One student said:

"Some patients like it when the doctor just does. They say the doctor should know ..." (Gr8F2)

According to the students' experience the patients generally wanted to be able to shift the blame onto the doctor or the health system if anything went wrong with their health; therefore they did not want to take any responsibility. One of the student participants had the following to say:

"You do get patients that want the doctor to be paternalistic, they want the doctor to make the decision, they want no complications to happen, and if complications happen, they are allowed to blame the doctor, so that's an ideal situation. So they have this attitude of 'I don't understand anything anyway, so you (the doctor) make the decisions'" (Gr4F1)

There were also comments related to the fact that not all patients would necessarily prefer the patient-centred approach of communication and that doctors should have the discretion to approach each patient differently:

"I think to me it depends on the patient, because sometimes you get a patient that is well, knowledgeable and understanding enough to be able to share their management with them." (Gr2F2)

In addition, one factor that students thought had an influence on patients' needs for more or less information and involvement was socio-economic status. Students spoke about the fact that lower-income patients will often be less inclined to demand information. One participant said in this regard:

"It's a socio-economic thing. I think patients that are poor, they just feel like they are at the mercy of whoever is treating them, but people who do come to the same hospital with medical aid, like they just feel more entitled to knowledge, and will actually demand it, because [they feel] 'I'm paying for this.'" (Gr3M1)

There was at least one prominent example where a student shared an experience of witnessing patient-centredness with regard to decision-making. She described this as follows:

When we were on ophthalmology, there was a patient that was referred with cataracts, and when the doctor examined her, actually, she needed an operation, but after the consent and everything, the patient decided that she doesn't want it. The doctor said, 'No ma'am, it's fine, you are welcome to come back.' So actually it was medically indicated, but the patient didn't want it and the doctor said no, it's fine. That was also a nice example of patient-centredness, for me." (Gr3F3)

This example shows that there are incidents of patient-centredness to which some students are exposed to. However, not all students get such an opportunity and not all of them will necessary recognise this behaviour as patient-centredness if the doctor does not explain it to them as such. This student clearly understood the process as being patient-centred, since there were other students who had similar patient situations and they did not recognise the patient-centredness in that. One illustrative example:

"The patient was very intelligent, did her own research on Google, and could tell the doctor better, ended up making not a good decision and never followed up again. She was diagnosed

with cancer, went on the belief that radiotherapy and chemotherapy is not going to work, they will go the alternative, natural route, so I don't know where she is now …" (Gr5F2)

The above example seems to be an informed decision of a patient; however the students were not impressed by this scenario and were clearly irritated with the patient making his/her own decisions. Furthermore, from the interviews a few comments also emerged that care across as being arrogant, including students judging patients for not being able to understand their disease and/or treatment. Two illustrations:

"I think a lot of our patients are illiterate, the language barrier, sometimes they don't fully grasp. You just don't have the time to sit down and explain." (Gr2M2).

"I think most of the time medical professionals gets irritable that patients don't understand, and you try to explain to them in the simplest form, but still they lack that knowledge or understanding and the intelligence to understand basic things." (Gr1F5)

With regard to sharing information with patients and involving them in the management of their disease it was evident that students valued this as a very important aspect of patient-centredness. There were, however, some students who still held traditional or paternalistic views of the role of a doctor. The perceived passivity from the patient's side could have prompted them to take such paternalistic views. These findings are described in the next section as part of the doctor-patient relationship.

5.3.1.4   *Category 4: The role of the doctor in the doctor-patient relationship*

The role of the doctor in the doctor-patient relationship is a complex one and although there has been a shift in the balance of power between the doctor and the patient over the years, the solution may not be to give the patient complete autonomy. The relationship between the doctor and the patient needs to be a shared process to have optimal outcomes (Stewart, 1995). In the interviews none of the students expressed explicitly negative attitudes towards patient-centredness, but it was evident that certain attitudes existed that pointed to deeper, perhaps unconscious, negative feelings towards sharing information and giving responsibility to patients. While patient-centredness encourages the idea of an open or more democratic doctor-patient relationship, some comments from students pointed to aspects of the traditional and old-fashioned paternalistic relationship. Some of the students said that some patients were not intelligent enough to understand their disease and should therefore be told by the doctor what

to do. Students were judging the patients that they were seeing at the governmental institutions as not being able to manage their own diseases. By way of illustration:

"I think medical professionals get frustrated or irritable that patients don't understand, and you try to explain to them in the simplest form, but still they lack that knowledge or understanding and the intelligence to understand basic things." (Gr 5F4)

"You try to give them the responsibility, but the minute they don't bite, then it's easier and it's more efficient for you to take control of their health, because if you are going to negotiate, it's going to take up a lot more time, especially with the type of patients that we see here. They don't necessarily have the ability to take that responsibility for their conditions." (Gr1F3)

It was interesting to see that in some cases where patients were actually well informed and wanted to equip themselves with more knowledge it was perceived by students as inappropriate. The comment from one female student below illustrates a perception that some patients seemed to know too much and would then make wrong decisions regarding their own health:

"That comes down to the character of the patient, giving a patient that is very educated and intelligent too much information, and obviously patients go to Google or whatever; it can empower them a bit too much I think, and perhaps making wrong decisions for themselves." (Gr5F2)

The illustrative examples in this category indicate that students did not quite know how to handle situations where patients had knowledge of their disease and wanted to take part in the treatment decision-making process.

Overall, with regard to attitudes towards patient-centredness, students seemed to view patient-centredness as something good and the way medicine should be practised. However, contradictory to what they said they believe, various paternalistic and non-patient-centred attitudes also emerged from the data.

5.3.2   Theme two: Subjective norms

The theme *subjective or perceived norms* relates to a person's belief that specific individuals or groups will approve or disapprove of performing the behaviour, or that the social referents within the relevant context themselves engage in this behaviour (Fishbein, 2000). In this study, the context was the clinical environment where the students had contact with real patients and

pressure from the staff working there to behave in either a patient-centred way or not. While it is acknowledged that medical students have interaction with various health-care professionals such as nurses, physiotherapists, doctors and others in the clinical environment and all of them potentially have an influence on their professional development, it is the influence of the doctors that was the focus of this study. The students were thus specifically prompted in the interviews to comment on the doctors' approving or disapproving of their being patient-centred. Students' comments that referred to subjective norms were categorised into this theme and then, as a further step, it was deconstructed into two categories: firstly, whether there was pressure to be patient-centred or not and secondly, role modelling of the doctors in the clinical environment.

5.3.2.1   *Category 1: Pressures related to patient-centredness*

In terms of the context of the study it is important to point out that the students that formed part of the study had mainly been placed in a tertiary hospital for their clinical rotations, however for some of the rotations they were placed in smaller (secondary) hospitals, and during some of the Family Medicine rotations they were placed in district hospitals or out-of-hospital clinics. It was clear that the pressure put on them to be patient-centred or not was influenced by the environment in which they were working.

When prompted in the focus group interviews about situations that the students could recall where they were either encouraged or discouraged to be patient-centred, some of their responses were quite emotional. Students shared varied reactions from doctors when they attempted to practise patient-centredness in the clinical environments and these were overwhelmingly negative. One student participant shared such an experience:

"I remember an experience, an emotional experience, where I presented the patient in a holistic manner, and then immediately the doctor is like, 'That's such stupid information, I don't need that information. Just tell me what's relevant.' So, it's the way that doctors come across. The humiliation that goes with when you do try to have a patient-centred approach and the way that you are humiliated, because it's not what is practised and it's not the norm." (Gr7F1)

One major pressurising factor that students experienced was the biomedical focus in the clinical areas with the purpose of only understanding the disease and treatment. In these situations there was generally little or no encouragement to understand the patient in his or her wider context. One student had this to say:

"Often doctors will ask us, 'Okay, show me how you examined this or that on your patient,' or 'Show me how you elicited this from your patient,' but no one has ever asked me, 'Show me how you explain your management plan to your patient.'" (Gr2F3)

It seemed as if the manner in which the students should be engaging with patients varied in the departments where they were working. However, what made it stressful for the students was that these expectations were not clearly communicated to them, as such expectations often form part of the hidden curriculum and students had to discover this in sometimes unpleasant ways. One student said in this respect:

"I've been told on one of my rotations when I made time to sit down with a patient that was emotional, by the registrar that if I want to spend time on emotions, [to] go and do Family Medicine: 'We don't have time to do this. We have a lot of work to do.'" (Gr8F5)

Some students were of the opinion that patient-centred behaviour was less prominent in the surgical disciplines and that surgery was much more task-oriented. However, some students had different experiences:

"If you compare the medical side versus the surgical subjects or rotations, you can see there is a varied way of dealing with patients and conducting consultations. For example, in medical there is more patient-centredness, whereas in the surgical rotations, you just want to get the job done, it is very problem-orientated." (Gr5F1)

There were also other students that experienced the medical side (which would include Family Medicine) as equally challenging. The difference here was perhaps the fact that the Family Medicine department advocated for patient-centredness in the classroom setting, and hence setting expectations for the students, while the other departments never mentioned anything about patient-centredness in their teaching. One student verbalised this as follows:

"My problem with Family Medicine is they teach you patient-centredness in theory, but if you look in practice, very few of the doctors actually practise medicine in that way. So you will have the consultant that is teaching you, telling you that you should take time with every patient, but the rest of the doctors, they are also overloaded, just trying to get through the patients for the day." (Gr1F3)

The only two departments that were explicitly acknowledged for encouraging the students to treat the patient holistically were Family Medicine and Psychiatry. Family Medicine was further

commended for the amount of time dedicated to the teaching of patient-centredness. Ironically, an emphasis on patient-centredness seemed to create a problem of its own, namely expectations from the students' side. The students expected to observe and implement such practices during their clinical placements and if this did not happen, they were disillusioned, as illustrated by one female participant's comment:

"For me the biggest discrepancy in terms of realistic expectations and what is taught is what I have seen in Family Medicine. I really value the fact that they want us to see the patient as a whole ... I just think that the people that are teaching are not sitting on the frontline of this war that we are fighting ... We obviously can't get this [patient-centredness] right in a tertiary setting where all the doctors are overloaded, and what they are doing is high stress, high risk, and all of those things. But in primary care we've seen the same thing. You come to the clinic at eight, you know that these patients have been waiting since 05:30 or 06:00 in the morning; they are sitting all the way out on the pavement. You want to help them, so you want to know their social circumstances, but what are you going to do about it?" (Gr4F2)

Students indicated that patient-centredness, as they understood it, was not being practised by the doctors in the clinical areas and furthermore that what they had been taught did not help them to deal with the situations with which they were confronted. As an illustration:

"So you're going to spend all this time now to talk to them, and now you hear okay, the wife has been beaten by the husband, the husband is an alcoholic, the brother in law is a 'Tik' addict, the daughter has been raped at school, now you talk to this patient and you counsel her and you tell her you must get a social worker, and we're going to get you help. Are we going to get help for every person sitting there? I mean, look at the percentage of our patients that live in these horrific circumstances. So we spend all this and emotion, hearing all these horrific stories, telling these patients, 'It's good that you talk about it, we're going to help you', but how?" (Gr4F2)

The student faced with this clinical scenario was clearly distressed and lacked the ability to handle the situation. Some of the comments of the students revealed feelings of despondency with the type of patient problems they encountered and they clearly did not know how to respond appropriately. One could argue that the students should be equipped with more relevant skills such as the awareness of teamwork, to approach these situations in order to assist them in feeling less overwhelmed, and furthermore to ensure that they understand what the role of a

doctor is, as well as how the team they work in can be optimised for optimal patient-centred care.

Furthermore, student participants indicated much pressure in the clinical areas to focus on biomedicine and academic aspects, because during ward rounds doctors paid little attention to the patients, the emphasis being mainly on academic knowledge as well as the disease and treatment. Two students commented as follows:

"Another one of the problems I think is the academic drive and more specifically to Stellenbosch is the hierarchy; where you get this consultant who is on top and he gets to ask the questions. It's not a discussion anymore, it's whether you know it or not. If you don't know it, you are doing badly; I'm not going to ask you again. That kind of thing, that academic pressure also leads you to disregard the patient, because I rather need to know what is wrong and everything about what is wrong instead of you and your context." (Gr7M3)

"I have heard some people say they think academics are more important. They will rather rush through as many patients as they can and be good academic doctors who know a lot, than to be patient-centred doctors." (Gr8F2)

Students tend to adapt to what the hidden curriculum signals to be the most important issues and in this case it was the disease and management of the patients. Generally, the impression the students gave in the interviews was that there was little pressure on the students to be patient-centred. It was only the Psychiatry and Family Medicine departments that encouraged students to behave as such. Despite this pressure students indicated that they found it challenging to apply what they had learned about patient-centredness in the clinical areas and that there was little role modelling that they could observe to assist them in learning this. The powerful impact of role modelling in the process of learning patient-centredness has to be acknowledged, and it is highlighted as an important finding from the data.

5.3.2.2   *Category 2: The influence of role models*

Role modelling is often accepted as potentially having the greatest influence on students' development of professional behaviour, and the saying that behaviour is better *caught* than *taught* seems to be true (Van Mook, Van Luijk, De Grave, O'Sullivan, Wass, Schuwirth & Van der Vleuten, 2009). The following quotes illustrate the value students assigned to the role modelling of doctors in the various clinical departments.

"You have role models in the hospital, you see those people and you want to be like them, so you just pick up on their demeanour and their bedside manner." (Gr3M1)

"Even if you are not actively being aware of what you are exposed to, you are taking it in somehow, and that becomes ingrained in you. You get used to the doctor that is doing it, so I'm going to do that." (Gr2F1)

The students shared various experiences to illustrate both good and bad role modelling situations and they agreed that both positive and negative examples are needed in the learning process. However, they also indicated that they had to decide for themselves which role models they would aspire to and they were aware that there was no specific guidance in the curriculum as to the qualities of a good role model. Three comments serve as illustration:

"It is very personality dependent on who you're going to choose as your role model; someone else might think those characteristics are totally weak or lame." (Gr3F2)

"You see people that you realise this is what I don't want to do, and you see people who you know you want to imitate and you want to sort of channel that kind of positive energy." (Gr1M1)

"I think you must know how you must be; you must see how to do it and how not to do it. So it is important to have bad role models to see how you mustn't do it." (Gr5M2)

One's own understanding of what a 'good doctor' is will obviously influence one's perception of who a good role model is and from the interviews it became clear that such an understanding differed among the participant students. Some of the comments from the students signalled the perception that a doctor that is patient-centred and has good communication skills is usually not so good with their clinical work. At least two respondents referred to this issue:

The doctor is extremely, extremely good, but not necessarily with patients. Good research and all the rest of it." (Gr5M1)

"I think one might think a good doctor is someone who knows all the lists and the other one might think the good doctor is someone who can see 90 patients in one day and another guy might think a good doctor is someone who sits with the old auntie and comforts her." (Gr3F2)

For other students the role of a doctor in society was not clear, as illustrated by the following quote:

I feel like you come here to be a doctor and then you've got to be someone's lawyer, you've got to be their this, their that, fix things at home, think about everything that's going on in their lives, and then you kind of feel like, 'It's so out of my hands.' Like, 'How much can I actually do as one person?' And that's put me off a lot." (Gr2F2)

These responses emphasise that there should be a common understanding of what a good doctor is according to the institution and the medical curriculum and also that this should be communicated to students right from the application and orientation processes.

The examples of both good and bad role modelling (summarised in Table 5.2) as students experienced them in the clinical areas provided authentic real-life scenarios they encountered when working with doctors in the hospitals and clinics.

Table 5.2: **Scenarios of doctors displaying patient-centredness as well as non-patient-centredness**

Positive role modelling examples
"When we were on ophthalmology, there was a patient that was referred with cataracts, and when the doctor examined her, actually, she needed an operation, but after the consent and everything, the patient decided that she doesn't want it. The doctor said, 'No ma'am, it's fine; you are welcome to come back.' So actually it was medically indicated, but the patient didn't want it and the doctor said no, it's fine." (Gr5F2) *"She is a senior registrar surgeon, so I mean they are all busy, and for every patient, she sat on their bed and she greeted them by name, even if she looked in the file beforehand, but she greeted them by name, and she said do you understand what's happening, do you have any questions, this is the plan. It took just a minute, but she did it for every patient." (Gr8F1)* *"I had a doctor once, I remember they would be there with their food and normally the response is to ask the nurse to feed the patient, but she literally fed the patient while she was giving us the lecture. I mean for me that just spoke volumes. She asked us to move the patient and to roll the patient around. So that for me modelled that whole patient-centredness". (Gr7F1)*
Negative role modelling examples
"He just picked up the paper and then threw it down in front of the patient and said, 'You have cancer.'" (G5F3) *"I saw a doctor telling a woman that she has a bilateral breast cancer one day in clinic, by the by. Like, 'Listen ma'am, so your mastectomy dates are this and this,' and then the patient asked him, 'What do you mean mastectomy?' So he told her that her breasts are going to be cut off before he told her that she has breast cancer." (Gr4F2)* *"I think we get taught in our curriculum that you have to have empathy, this is how you take a history, this is how you work with a patient, but then you get to ward rounds (and I understand time is an issue and there are a lot of patients), but then what we get from the doctors doing the ward rounds is like no, I don't want to hear anything about the family, just tell me what's wrong with the patient, and then we kind of copycat, take that on." (Gr4F3)*

It seems that role models need to be aware that they have to make the implicit explicit if they want students to observe the behaviour that they display. Otherwise it is possible that students do not see what the lecturer wants them to observe. In the following example the doctor displayed patient-centred behaviour by giving a well-informed patient the opportunity to make her own decisions, but since the doctor did not explain his or her behaviour to the student afterwards, the student interpreted it in a negative way and a valuable learning opportunity was missed with the student not recognising the patient-centredness displayed by the doctor.

Although this quote has been used previously to illustrate another point (see 5.3.1.3) it is an example of a missed opportunity for student learning and therefore it is used again here. The student articulated this as follows:

"The patient was very intelligent, did her own research on Google, and could tell the doctor better, ended up making not a good decision and never followed up again. She was diagnosed with cancer, went on the belief that radiotherapy and chemotherapy is not going to work, they will go the alternative, natural route, so I don't know where she is now ..." (Gr5F2)

A further perception from the students that was evident was that the doctor who was most powerful in each department was also the most influential role model. Two students verbalised this perception as follows:

"When you come in [your third year], you are going to follow the cool doctors or the more superior ones in the department." (Gr 3F1)

"Some of the departments make it very difficult in the sense that when the head of the department mirrors a negative attitude, and where they don't want to hear about the biopsychosocial aspects, then it makes it very difficult." (Gr2F3)

The students mentioned more examples of negative role models than positive ones during the interviews, and although they were saying that they would rather follow the positive examples, it is not clear whether they were just saying that because they thought that would be the right thing to say. The next factor that determines intention is self-efficacy and this factor is dealt with next.

5.3.3   Theme three: Self-efficacy

Self-efficacy is a key term in social cognitive theory and it is about an individual's belief that one has the capability to organise and perform the actions required to produce certain attainments (Zachariae et al., 2015). This perceived behavioural control refers to the belief that one has, or does not have, to perform certain behaviour and it may be based on past experience with the behaviour as well as other factors that increase or reduce the perceived difficulty of acting in a particular manner. All together this leads to the perception of having or not having the capacity to carry out the specific behaviour (Fishbein, 2000).

In the interviews the students were not very keen to talk about their own patient-centred practice. The examples they offered were more related to what they had observed others (the doctors) perform rather than what they (the students) did. The reason for this reticence could perhaps be that the students have much more of an observer role in the clinical areas and are not the main role players in the doctor-patient relationship. Students' comments that referred to self-efficacy were categorised into this theme and then as a further step this theme was divided into two categories: firstly, past experiences with patient-centred behaviour and secondly, the perceived difficulty of performing the behaviour. These two categories, supported by interview data, are presented next.

5.3.3.1   Category 1: Past experiences with patient-centred behaviour

The IM states that self-efficacy may be based on past experience with the behaviour, so having had opportunities to practise patient-centredness before will have an effect on a student's belief of his/her ability to perform this behaviour recurrently. The next comment from a female student illustrates this notion:

"One learns of it, but it's theoretical, and until you actually come to practise [it] over and over, it was not initially there … I think you are still warming up to it, but I found in my fifth and sixth year, I was more convinced of it. So, I got it through practice and experience." (Gr7F4)

Students also indicated that if they do not get sufficient opportunities and encouragement to practise the patient-centred approach in various settings, they would be reluctant to do so, partly because they have not seen the positive effects of such an approach. Two comments pertinently alluded to this:

"You've been taught it [patient-centredness], and you learn to appreciate the value of it, then you think it's something good to implement. But if you don't know or if you haven't experienced yourself how it can benefit someone, then you might be less inclined to do it." (Gr6F1)

"I always sort of knew that, and that was the definition we'd learnt from Family Medicine, etcetera, but actually seeing that in practice and doing that practically was such an incredible experience. I find myself, if I interviewed a patient, we are taking the history, I find myself asking, 'Okay, but tell me where do you live and who stays with you.' Not because you have to tick the box for Family Medicine or ICF, but because it's actually like influencing my management." (Gr6F2)

However, one male student from the LIC illustrated his confidence in the patient-centred approach after he had the opportunity to practise it. He commented as follows:

"I'm so glad I learnt it so that even if I go back into a setting like Tygerberg, I can still use it there, or it should still at least be my approach to still be patient-centred and not just focus on biological functioning." (Gr6M1)

Another (female) student made a comment that indicated her commitment to patient-centredness despite the circumstances. Such a strong belief and confidence that she could be patient-centred in any given setting shows high self-efficacy:

"I cannot be <u>not</u> patient-centred anymore. It was very hard for me in surgery because everyone is so focused on doing the surgery and getting the work done, they totally completely forget about the patient. That's the first time it touched me, and I'm like okay, but patient centredness is actually important." (Gr6F3)

It is important to note that most of these comments displaying self-efficacy were made by students who were part of the LIC.

5.3.3.2   *Category 2: Perceived difficulty of being patient-centred*

Students indicated in general that it was difficult for them to practise patient-centredness in the settings in which they were trained in, but they felt that once they graduate and become doctors they will attempt to be patient-centred. The main factor that influenced their perceived difficulty of being patient-centred was sufficient time to implement the approach they had been taught in medical school when they were working in the clinical areas. It almost seemed as if once the students started to observe how busy the doctors in the clinical areas were and how they were practising medicine, they felt that the taught approach was too time-consuming and thus too difficult to perform. One male student verbalised this as follows:

"It is definitely important to be caring, but in the same way, you cannot as a human being treat the disease and try and sort the socio-economic circumstances and take care of the patient's psychological health, and ... Due to time we have to prioritise, and it's not a good thing that we prioritise disease above psychological health at all. It's not good, but it's just realistic." (Gr4M2)

In terms of future behaviour it is unlikely that students will attempt a patient-centred approach while perceiving it as difficult or even unrealistic. Examples of students' views with regard to the perceived usability of the approach are provided below:

"What is getting taught to us is not being portrayed or practised out there [in the clinical areas] ... all the doctors are overloaded ...." (Gr2M2)

"It is nice to have this approach, but on ground level it does not work." (Gr4F1)

"If you want to see the patient holistically you slow the system down and the other patients wait even longer." (Gr4F3)

The complexity of the practice of patient-centredness was highlighted by the fact that the students from the LIC who generally verbalised positive experiences and self-efficacy showed they were confused about what patient-centredness actually is in practice and how it should be applied to various scenarios. One female student responded as follows:

"I think it isn't always possible. I mean, sometimes in casualty the lady with a pneumonia, you're like, 'Okay, coughing, chest, yes, pills, go home,' and obviously in emergency situations where it's not necessarily practical, or indicated." (Gr6F2)

This quote is another example indicating that students have difficulty in applying the comprehensive patient-centred approach they get taught in theory to everyday scenarios when just some aspects of patient-centredness might be relevant. It would seem as if students tend to not recognise the doctors' behaviour as being patient-centred when they apply patient-centredness in specific scenarios.

There seem to be a few factors that increase or reduce the difficulty of practising patient-centredness. Too little time available and a complex clinical learning environment were highlighted as two major hindering factors. Some examples of the environmental issues are discussed in the section on the teaching and learning environment (see 5.3.6), but in order to understand the students' experiences and factors influencing patient-centredness, a discussion of the background factors that can influence their intention, and ultimately their behaviour, are explained next.

5.3.4   Theme four: Background factors

It is important to acknowledge that there are *background factors or external factors* such as demographic variables, culture, personality, other individual differences and exposure to media and others that can have an indirect effect on the three determinants of intention that were discussed in the previous section (Fishbein &Yzer, 2003). In order to make sense of the students' comments in this regard, the findings were grouped together in five categories.

5.3.4.1   Category 1: Demographic variables such as gender and age

Gender and age as factors that could possibly influence patient-centredness were aspects that were discussed in the groups, but students did not seem to have particularly strong opinions about them. The extracts below are examples of a conversation during one of the focus group interviews on whether female or male doctors are seen as being more patient-centred:

M1: "Females are more patient-centred, more caring. Not exclusively, but they are just nicer people."

M3: "That's not my experience." (Gr2)

With regard to the question whether junior doctors (most often these were registrars) or senior doctors (which were usually the consultants) were inclined to be more patient-centred, students had mixed experiences that they could share. The majority of students indicated that the senior consultants were more patient-centred and that this was due to the consultants' more extended life experience. They also had less academic pressures and patient responsibilities than the registrars. At least three comments highlighted this observation:

"The consultant has achieved all of that, has all the credentials, and is actually more down to earth, choosing to be alongside the patient, asking, holding their hand." (Gr5M5)

"Our consultants are actually better than the registrars. The registrars are the ones that are academic driven. They are under stress, the patient load lies on them." (Gr7F6)

"I have noticed that the younger generation doctors will rather take the time to sit and explain to the patient." (Gr2F2)

Another factor the students discussed was that some international medical programmes required students to have a first degree before they could study medicine. They were of the opinion that

being more mature would be a great advantage for students and that it would help them to have a passion for medicine and thus develop patient-centredness fairly easily. Two illustrative comments:

"I still feel the age at which we start medicine is way too early. The kind of work that you have to do require a certain amount of maturity that an 18 or 19 year old does not have and it overwhelms you at that stage. It can put you off completely." (Gr4M2)

"It is so much to expect from a person at the age of 18 to know what he wants to do for the rest of his life." (Gr5M3)

In the interviews there were some students who also had to complete a degree (e.g. BSc) before they were admitted to the medical programme. They felt quite strongly that at the age of 18 students do not really know what they want and what they want to study.

5.3.4.2   *Category 2: Culture*

The students did not contribute much in terms of culture being a factor in patient-centredness. However, there were a few comments about upbringing, as illustrated by the following quotes:

"Not everybody comes out of the same context. We are not brought up in the same way with maybe good communications skills that you learn at home, and how to approach people." (Gr8F3)

"We come from different backgrounds and just because I got a straight A, you do not know where I come from and what my parents taught me." (Gr4F1)

Students were only referring to the culture of the doctor and not of the patient, while the cultural background of the patient is an important factor to be taken into consideration (see 2A.5) since this has been proved to have an influence on the doctor-patient relationship.

5.3.4.3   *Category 3: Personality*

In most of the focus group interviews students were of the opinion that personality plays a major role in the way doctors approach patients. The quotes below indicate the impact students think personality may have on behaviour:

"It is definitely a personality thing." (Gr4M3)

"I think the people who have poor relationships with the patients and who don't show empathy and sympathy are the same people who have problems with their own personalities." (Gr2F4)

'I think it is a matter of personality. Some people don't have the personality to ask someone how they are today ... whereas other people are more social and are more open to ask patients." (Gr7F4)

"It really depends on the student or the doctor's personality, or whether they believe in it, whether they are going to do that for the rest of their life." (Gr3F2)

It seemed as if the students were under the impression that for those with people-friendly personalities interaction was probably going to be patient-centred, and the rest were almost being excused for not applying that approach with patients. None of the students mentioned explicitly that patient-centred communication skills can be learned by all students. To illustrate:

I think the real barrier is the doctor themselves. I think it has a lot to do with their personality and what they are willing to do for their patient." (Gr6M2)

"For me, it comes naturally. For some of my colleagues, no matter how many times you preach on it, they don't get the ICF, they don't like the patient-centred approach, and they're never going to do it. So, it depends very much on the person practising, on their beliefs, whether they are going to do it." (Gr6F1)

From the interviews it was also evident that the students thought about the possibility of including personality as a part of entrance criteria in medical school. Some students were of the opinion that aptitude and psychometric tests should thus be part of the entrance testing:

"You will under-catch this problem with psychometric testing. That is the only place. You cannot teach somebody to be something that he is not. You can't teach somebody an aptitude that they don't have. For example you cannot take somebody from the street and make them a 100 m Olympic athlete." (Gr4M1)

However, other students were of the opinion that there is no suitable test one could administer, since medicine is such a diverse field with space for a variety of personalities:

"In terms of having a batch of applicants for medical school, obviously everybody is going to have a different personality; obviously we have medical students who have the basis of wanting

to care for people, or most of us having the basis of wanting to care for people and that's why we go into the profession, but I don't think there is a specific criteria or personality trait that you can look out for to determine whether the person already has the sharing and caring, or has the potential to become sharing and caring. I think if you had to do that, you would inevitably lose out on a certain portion of people that could be brilliant doctors and be better patient-centred. So I don't know if there is a specific criteria that you can apply to medical school applicants." (Gr2M2)

While the IM classifies personality as a background factor that only has an indirect effect on behaviour, it also recognises the possibility of empirical associations between some variables and behaviour. According to the findings presented above, personality seems to have a more direct influence on patient-centred behaviour, and therefore an aspect that perhaps needs to be considered more seriously in student selection.

5.3.4.4   *Category 4: Personal experiences*

It would seem as if previous experiences with regard to personal or family incidents or diseases are an aspect that students recognised as a factor that could potentially influence how doctors behave towards patients. By way of illustration:

"He said he explains everything to the patients because of previous experiences, and when he saw colleagues being prosecuted for not telling a patient what they are going to do." (Gr1F2)

"Usually they have a life story, 'Oh, but my mother this or my father this,' then they implement their own experience in the clinical setting." (Gr8F6)

The fact that this issue did not emerge as a strong theme could be because students were quite cautious to share their personal feelings and experiences in the focus groups. This could be because it is generally believed that doctors have to be able to cope with everything and that they should not to let their personal experiences influence their work.

5.3.4.5   *Category 5: Exposure to media and social pressure*

Another discussion point in the groups were the expectations students had when they started as first-year medical students versus what they knew by their sixth year of studies. To quote two such views:

"I think everyone has a very naïve view of what medicine is going to be, the 'Grey's Anatomy' kind of thing …" (Gr1M1)

"And I think general society gives us this view. I think … doctors does still have quite a bit of status in life and people tend to put them on a pedestal." (Gr1M2)

Some students blamed some of their idealistic views on the media while others saw the general public as the culprit in wrongly viewing the medical profession.

The fact that the IM recognises that background factors are important and that there may be indirect or even direct links between these factors and the behaviour of individuals illustrates the flexibility and adaptability of the model to various cultures and contexts.

What further distinguishes the IM from some of the other behavioural models such as the widely used TPB (Ajzen, 1985) is that the IM recognises that people will only be able to act on their intentions when they have the required knowledge and skills and when the environmental factors do not hinder behavioural performance (Yzer, 2012). So, even if students have the intention to be patient-centred, they need the appropriate skills and knowledge together with an environment that is conducive to patient-centred behaviour. In the next section the aspects skills and knowledge, and environment are discussed.

5.3.5   Theme 5: Skills and knowledge

Since patient-centredness is such a vague concept that is difficult to define (see Chapter 2, section 2A), it makes it challenging to determine what the underlying knowledge, skills and even attitudes for such a competence could be. While knowledge and skills are closely related, one has to acknowledge that knowing about something does not imply that one can actually do that thing. It is therefore important that one separates these two aspects. From the students' comments it would seem as if the students had some theoretical knowledge about patient-centredness and that they value it, but they found it difficult to identify the underlying skills or activities required and they felt that the teaching of patient-centredness was mainly theoretical. Two categories were identified here, namely theoretical knowledge and relevant skills required.

5.3.5.1   Category 1: Theoretical knowledge

Most of the students seemed to have good theoretical knowledge of what patient-centredness entails, so it would seem as if they have been taught that in the curriculum. Next are some

examples of quotes demonstrating their theoretical understanding. The students managed to verbalise the most important components of patient-centredness highlighting both the 'caring' and 'sharing' constructs as described in Chapter 2.

"It's having a holistic approach to a patient and not just focusing on what their problem is, but looking at everything that encompasses what they are and who they are as well." (Gr5M2)

"Patients must know that you have heard where they are coming from, not just telling them everything you know, so that they feel like you actually care about what is wrong with them." (Gr5F2)

"It's a way of involving the patient in the disease as well, including them in management, and them taking responsibility for the management of their illness." (Gr7F2)

There were also students who clearly misunderstood the concept, thinking that being exposed to patients at an early phase in the curriculum and performing procedures on real patients meant that they were patient-centred. As an illustration:

"We have seen a lot of patients and done a lot of procedures, so patient-centred being we are used to patients." (Gr5F1)

When students were prompted about patient-centredness being taught in the curriculum, they recalled that they had been taught certain approaches during their Family Medicine rotation, but they were not quite sure what the relevant approach was called. Some said it was the biopsychosocial method while others were referring to the International Classification of Functioning, Disability and Health (ICF) method. Some students indicated that the biopsychosocial method, as they understood it, could be applicable to all departments, while the ICF was very comprehensive and that a doctor would need the help of other role players such as the occupational therapist or physiotherapist in order to do it correctly. One of the students mentioned the three-stage assessment as an approach, but was not able to distinguish it from the other two approaches that were mentioned. Below are examples of such comments:

"The only thing that I can think for myself that I can use in other departments, is really the biopsychosocial. So I think biologically how am I going to treat that, psychologically what do I need to look at, and then socially what do I need to look at too. That's all, I think. The ICF and all that, is just too much." (Gr3F5)

"The ICF is really a good tool, honestly, and it really helps with a lot of information, but I think in the clinical setting, it's not practical."(Gr1M1)

It would seem as if the misunderstandings students had about what patient-centredness really is, and how it should be applied in various scenarios, caused them to develop unrealistic expectations for themselves as well as for the doctors that they observed in the clinical areas. One example serves as illustration:

"Now I go out and I want to practise being a good doctor and being patient-centred, and if I can't do that, I feel kind of like I'm a failure and then I let the patients down." (Gr8F6)

It appeared as if students were trying to be patient-centred according to a textbook definition and if they could not do that 100% accurately, they felt guilty.

It is evident from the comments above that the students were taught about patient-centredness in theory and that they generally understood and believed in the benefit of such an approach, but the skills required to practise the approach in clinical practice seemed to be problematic. This matter is further explained in the next section.

5.3.5.2   *Category 2: Relevant skills required*

From the evidence it seems as if students could not recall when and where they were taught specific skills related to patient-centredness during their training; they felt that they were more or less left to learn these skills in an opportunistic manner and at their own discretion. This is a potentially problematic situation, since it would mean that not all students would have been exposed to the same learning opportunities. To illustrate:

"Patient-centredness is a skill that you learn, and it wasn't a class that taught us that. It's the past, since third year being in hospital. You kind of orientate yourself to the patient." (Gr8M1)

"I never actually heard a doctor say to a student, 'Do you think that you interacted appropriately with that patient?' I have in fact never heard any comment given on the way a student interacted with a patient." (Gr4F1)

"We learn it from personal consultations with patients and seeing what they appreciate more and what they don't appreciate that much." (Gr1F5)

"We are left on our own to learn the whole patient-centred approach, because there is so much academic things to push into a very limited amount of time." (Gr1M1)

The participating students identified various skills that they experienced to be lacking in order to be able to practise patient-centredness, for example the handling of people from various backgrounds, certain communication skills such as the ability to explain concepts to patients in understandable terms, and applying their theoretical knowledge to individual patients. Some students commented as follows:

"It's for you to tolerate people of different backgrounds, and people don't know how to do that." (Gr5M3)

"Helping us to lay concepts down in understandable terms for the majority of people, if they can teach us skills like that." (Gr5F1)

"I think the challenge is not necessarily to teach students these things theoretically, because in Family Medicine we do things like breaking of bad news. They teach us you are supposed to put the patient in an environment where they feel safe where they can react to the news. But to actually internalise that and to gain the insight as to which patients actually need that extra, I think that's where the challenge lies." (GrF1)

"We need communication skills." (Gr7F2)

Another aspect that further complicates communicating with patients in multilingual contexts is the fact that in some cases neither the doctors nor the students are able to speak the language of the patients. Not all patients are proficient in English and there are groups of patients that speak only Afrikaans or only Xhosa, which makes communication problematic. Students highlighted that they would have wanted to be able to speak to patients in their mother tongue, since involving interpreters presented certain challenges. To illustrate:

"Language is a big thing, because a lot of people don't understand Afrikaans or English, and then you have to get a nursing sister involved, and she doesn't necessarily know how to convey the message to you correctly." (Gr1M2)

"I find it hard because I don't even know if they understand what I am trying to say. So, if we knew more languages, it would have been a good thing." (Gr7F6)

It was interesting that one of the students commented that it is the responsibility of the doctors to learn the language of the people they will be treating most often in future:

"I think it's an onus on the doctor to some extent to educate yourself, learn the language that you know most of your patients are going to be speaking." (Gr6F3)

There are initiatives in the curriculum to help the students to learn more languages, but the curriculum is already so full that there is not enough time to assist them properly in mastering an additional language.

5.3.6   Theme 6: Environment

According to the IM it is possible that someone can intend to behave in a patient-centred manner, and perhaps even have the necessary knowledge and skills to do so, but if the working environment is constraining, they might not display patient-centred behaviour. In this section the constraints identified by the students to behave in a patient-centred manner are discussed. Factors related to the environment that the students mentioned centred on topics such as limited time and work stress, context of clinical practice, limited resources, and system failures.

5.3.6.1   Category 1: Limited time and work stress

Limited time to behave in a patient-centred manner was highlighted in the interviews as being a major constraint. The following quotes illustrate the students' experiences of both the doctors and themselves having to do much more than they had time for:

"Doctors are always in a rush and we are tired and overworked." (Gr1M1)

"I say most barriers are usually personal, like the personality of the person, but also time constraints. I mean, if the single doctor needs to see 60 patients in eight hours, I mean you only have 10 minutes for a patient. So I think that is really a barrier to patient-centred, is understaffing and time constraints, and you really can't do it." (Gr6M1)

Ward rounds tend to be goal-oriented with procedural task (ward work) that gets priority and then the patient discussions are more about the patient than with the patient. The narrative below is a classic example of a student verbalising how he/she has lost the caring part due to time pressures.

"Workload is just too much. You won't get through your day, and then other patients will suffer because you don't get to them. You have to treat the disease first." (Gr2M3)

"You are post call, you are very tired, then people become less sensitive, less patient-centred. So it's definitely one of the things that makes a big difference, is how tired you are and overworked." (Gr4F4)

It would seem as if one of the consequences of time constraints is that the students are mostly expected to do procedures (ward work) when they are working. However, students need the exposure and practice opportunities of these practical skills; this should not be the only focus when they work in the clinical areas. It seems clear that they should also be allowed the time to develop their clinical reasoning and communication skills with the patients, as illustrated by the following quotes:

"We have to do all the ward work and then you have to go and study in the evenings." (Gr1F2)

"We were so busy in my previous block, we did not even have ward rounds, we only did ward work, like took bloods." (Gr8F5)

Some students had the notion that being patient-centred would take up much of the doctor's time, however when discussing time as a factor in the interviews and how that may influence a doctor to be patient-centred or not, the students from the LIC were the only ones who mentioned that they had observed experienced doctors who worked in this way:

"I used to think time, but then I saw Dr X work; he is incredibly quick with patients, but he covers all of them and he does a patient-centred approach with every patient in the 15 minutes that it takes everybody else to see ... So, I think it's actually just about the mind-set. I think if you realise the importance of being patient-centred and what it means to the patients and what it means to the doctor-patient relationship that forms between you. So I think it's just your mind approach, that if you value it, you will find a way to make the time for it." (Gr6F2)

Students also pointed out that having a relationship and follow-up consultations with a patient could be a time-saving factor in the long run. One participant put it this way:

"Well, I think time is a bit of a barrier initially, especially if you don't know the patient yet. If you don't have a lot of time, or if you have got a long list to see, then you might be less inclined to ask questions other than purely what is wrong, how can I fix it." (Gr3F3)

Students also verbalised that when they were pressed for time, stressed and tired, they tended to become self-centred. As indicated by one student:

"When we're so bogged up and stressed, we're not going to care how your (the patient's) day was. I am then more worried about my own problems." (Gr5M1)

All students seemed to have experienced stress caused by having too little time. They felt that not having adequate time was a major barrier to being patient-centred.

5.3.6.2   *Category 2: Context of clinical practice*

Participant students were of the opinion that some of the clinical areas where they were working made it easier to practise patient-centredness than others. Students experienced the primary care setting as being more enabling compared to the hospital setting:

"Well, you see, I do believe that in a primary care setting, that just the setting itself is also so very different and enables one to be more aware of it. Again for example the tertiary institution, where people are, the rarest or the end of the line diseases are from all over the Western Cape being referred there. So, a patient comes in with a diagnosis that's interesting and the people jump onto that, but you see the patient only in that setting. You don't see where they are coming from; you don't know where they live." (Gr6M1)

"So I think just the setting itself enables a patient-centred approach, in the primary care setting it is medicine practitioner orientated. I have been to Hawston; I know what that looks like. I've been there with the riots. We saw the shootings and everything. I drive through Zwelihle every single day, we worked at the school. I know where the patients come from because I've seen it. That in itself enables me, like if I get a patient and they're like, 'Oh, I'm from Zwelihle,' I already have a picture in my mind, even though there are better and worse parts of Zwelihle, I have a picture in my mind of where the patient is coming from. So, I think the setting itself, where you work, makes a big difference." (Gr6F3)

"You live in the community and some of the patients come back three or four times, and you get to know them and you see the value of what you have done and what you have encouraged." (Gr6F2)

Students that were part of the LIC placements and who had personal relationships with their patients valued these relationships and felt they were very satisfactory. They mentioned,

however, that the down-side of a relationship with patients is getting involved and emotionally exposed. One student put it this way:

"I think the other barrier that I found was, that you become so much more involved in your patients, and that's not always easy to deal with. Like if something goes wrong, I had a lot of my Family Medicine patients die this year, I mean really just like random kind of thing. But it was more difficult having sort of John who I knew very well and knew about his family die versus John who has a liver disease." (Gr6F2)

In contrast to these roles and responsibilities, the same student indicated that there was comfort in the other rotations with the focus on the biomedical aspects:

"In a way I just want to get back to the surgery rotation and not get into the nitty-gritty of every patient." (Gr6F2)

The students seemed to be torn between two contrasting views: (1) a desire to care for patients in a holistic way, and (2) only being able to see the patient as 'a disease' and not getting involved in any way.

5.3.6.3   *Category 3: Limited resources and system failures*

It was evident from the data that the healthcare system with all its challenges had an impact on various levels. The students referred to examples where doctors and they themselves behaved in ways that are not patient-centred due to resource constraints. Two comments to illustrate:

"You want to go and sit for half an hour, but unfortunately you have a ward round. It's not our unwillingness to be patient-centred, but it's the system and the resources we have. If there are 60 patients waiting outside, you cannot sit and listen to the patient." (Gr8M1)

"I am so frustrated with the system. I am looking for urine dipsticks, and I can't even find it and I'm so frustrated. I think that also, because then I'm irritated, and now I need to work with a patient." (Gr3F2)

The categories that were discussed under the theme *environment* made it clear that these factors are very important and could potentially be the final indicators of whether students display patient-centredness or not. As indicated by one participant:

"I think often the doctors can't really help for not being patient-centred. Sometimes it's just the system that lets them down as well. For instance, when we were on obstetrics and gynaecology, the one evening they had to start doing caesarean sections for patients who are likely going to need it in a few hours just to get the labour ward like empty, or to empty it up, and that is not necessarily the best, or like a patient-centred thing, but they didn't really have a choice." (Gr4M3)

The IM provided a structure that assisted the researcher in analysing the results of the student interviews. It was clear from the analysis at this point that many factors are involved in the teaching and learning of patient-centredness. While all of these factors potentially play a role, it does not seem as if they have to take place in a certain order. It also seems as if the same factor may be an enabler or constrainer, depending on the nature of each teaching-learning situation.

5.4   LIMITATIONS OF THE INTEGRATIVE MODEL (IM) WITH REGARD TO THE FINDINGS

It was possible to organise most of the data from the student interview data according to the elements from the IM; however, one aspect that the IM did not account for was the students' comments about the assessment of patient-centredness in the MB,ChB programme. Data to support the motivation why this factor needs to be added are explained in the next section.

5.4.1   Theme 7: Assessment

From the data it emerged clearly that, when the students were with patients in the clinical areas, they focused on what they knew they were going to be assessed on during their practical examinations, which, in most cases, was biomedicine. The students indicated that they experienced most of the discrepancies with regard to how they were supposed to approach patients during their 'case presentations'. Case presentations during clinical rotations are typically when the student presents a specific case or a patient to the doctor. Sometimes these case presentations are done formatively (not for a mark), but most of the time the assessment is summative at the end of the clinical rotation and the doctor (the examiner) will allocate a mark. The student would normally get time to examine and interview the patient (unobserved) prior to the presentation and then have about 20 minutes to perform the case presentation with the doctor listening. The expectations of the doctors from various disciplines regarding which

information is important and relevant for the case presentation vary and this clearly confuses the students. Two students commented on this aspect as follows:

"They (the doctors) will never evaluate us on patient-centredness. Only in Family Medicine, and maybe Psychiatry they give you a mark for that, but never ever the other doctors, they don't want to know who they (the patients) are, what work they do, where they're from or how many children they have." (Gr8F1)

"I think another thing is that for example, if I'm on surgery, I find myself under so much pressure to be on academic level on ward rounds that my focus is not on the patient's socio-economic status. I want to know what your problem is, is it ulcerative colitis, good, and then I am so focused. Examine, ten minutes, do bloods, if the consultant comes I can give him all the facts, I have enough time to sleep and study about ulcerative colitis, and I can tell him everything about ulcerative colitis. I don't care about the patient, I've got no time, but that's the reality. Because I hate embarrassment. I hate feeling stupid." (Gr5F4)

Assessment is not explicitly mentioned as a factor in the IM, but it was clear that for the students it was a driving force. The students wanted to know what they would be assessed on at the end of their rotation so that they could focus their preparations and presentations on those aspects. In the interviews students suggested that assessment of patient-centredness during their case presentations would help them to not forget such practice. One student said, for example:

"I think you can't make someone to be a people's person, but I think you can enforce the whole patient-centredness as a skill. So for instance, make it in all your evaluations, no matter what block, by your psychosocial as part of the assessment. If you do not have this aspect, they must mark you down. Then it will force people to start thinking about it and it will become second nature for everybody later on." (Gr3F2)

It thus seems that whether students behave in a patient-centred manner or not may also be strongly influenced by reigning assessment practices.

5.5   SYNTHESIS

It appears as if the IM can be effectively used in seeking to understand the complexity of students behaving in a patient-centred manner. The IM assisted the researcher in categorising

the data into meaningful parts so that it was possible to proceed to a more nuanced understanding of the teaching and learning of patient-centredness.

It would seem as if the students had fairly good intentions to be patient-centred, yet the exposure they experienced in the clinical settings over several years of training allowed them to form ideas which may now contradict many of their initial beliefs. It was evident, however, that the students who were placed in the LIC had stronger and more positive attitudes towards patient-centredness than the other students.

The students in the Stellenbosch MB,ChB context have the opportunity for much patient contact, but it is in these same clinical learning environments that the students were experiencing little pressure and had limited opportunities to learn patient-centredness. Their perception was that factors such as poor role modelling, no feedback on their interaction with patients and no opportunities to reflect on their behaviour contributed to a low sense of self-efficacy.

Two aspects were highlighted by the findings. Firstly, assessment, which does not appear as a factor in the IM, was an additional factor that influenced students' learning behaviour; secondly, personality (one of the background factors) was mentioned by the students as a stronger factor than suggested by the IM. Students indicated that personality was a very important factor in patient-centred behaviour, while the IM suggests it only has an indirect influence on the behaviour. This aspect is discussed in more detail in Chapter 7 (see 7.3.4).

In the next chapter the findings from the data rendered by the participating clinician teachers are presented, and finally, the relating themes between Chapter 5 (students) and Chapter 6 (clinician teachers) are discussed in Chapter 7.

Chapter 6

THE TAUGHT CURRICULUM:
FINDINGS FROM OBSERVATIONS OF AND
INTERVIEWS WITH CLINICIAN TEACHERS

6.1   INTRODUCTION

In an attempt to gain insight into the 'taught' curriculum (Kelly, 2009) of the MB,ChB programme it was important to obtain the views of some of the clinician teachers who were involved in the teaching of the selected group of MB,ChB students. There are multiple clinician teachers in various contexts who are involved in the teaching of the students, but since it is acknowledged that the learning of patient-centredness mainly happens in the clinical environment, it was decided to focus on the clinician teachers who are involved in clinical teaching. The data-gathering process as explained previously (see 4.6.1) was both an observation encounter and individual interview. The main purpose of the observation encounter was to understand the context in which the teaching and learning opportunities with regard to patient-centredness are created. Following the observation encounter, an interview with the clinician teachers involved was arranged in order to discuss the activities that were observed during the observation encounter and to explore the view they have about the teaching and learning of patient-centredness in the undergraduate medical curriculum (See Addendum 3 for the interview guide). It is important to note that the year the students were in were not important, the focus in this data gathering session was on the lecturers and not on the students being taught.

Table 6.1 below summarises the opportunities that were identified by the module chairs/departmental heads and which was subsequently utilised as part of the data-gathering.

Table 6.1:   Summary of teaching and learning encounters observed

	Department	**Teaching and learning opportunity that was identified**
Example 1	Surgery	Ward round in tertiary hospital with 3rd year students and one clinician teacher
Example 2	Internal Medicine	Ward round in tertiary hospital with 3rd year students and one clinician teacher
Example 3	Obstetrics and Gynaecology	Clinic at the tertiary hospital with 6th year students and one clinician teacher
Example 4	Family Medicine / Community Health and Rehabilitation	Student observations (5th and 6th years) in a district hospital with various clinician teachers
Example 5	Paediatrics	Student observation (3rd year) in a tertiary hospital as part of a self-learning assignment

As the observation opportunities were much varied, it was not possible to make any generalisations from their data as a whole. It was thus decided to use their information to firstly contextualise the various teaching and learning environments of the five chosen clinician teachers. Secondly, it was important to validate what was said in the respective individual clinician teachers' interviews. With regard to the use of terminology it is also important to point out that in the context of this study the terms 'clinician teacher', 'lecturer', 'doctor' and 'consultant' are used interchangeably. Furthermore, a registrar refers to a doctor who is in training in order to become a specialist and an intern to a newly qualified doctor. All of these doctors are part of the team that supervise the students when they work in the clinical areas.

The analysis of the clinician teachers' data was done on both level one and level two of the analytical ladder developed for this study (see Diagram 4.4). In the next section the findings of the data are discussed according to these levels.

6.2   LEVEL ONE OF DATA ANALYSIS: PREPARING THE TEXT AND FINDING CATEGORIES THAT FIT THE DATA

Level one of the analysis process comprised summarising and repackaging the data. Accordingly, the field notes of the observation encounters were rewritten and the interviews

from the clinician teachers had to be transcribed and coded. Following that, the transcripts of the individual clinician teachers' interviews were analysed deductively according to the set of themes and categories that were previously identified from the student data (see Chapter 5).

6.2.1   Data of the observation encounters

In order to make use of observations as a data-gathering technique, the researcher (I) had to be part of the teaching and learning opportunities identified for the study. In a qualitative study where observations are used as a data-gathering source it is important to mention what the background and lens of the researcher is.

Since patient-centredness is difficult to define and often differs from context to context, and from patient to patient, I decided not to make use of an observation schedule as I entered the clinical environment with vague guidelines of what I was looking for. My goal as researcher was to be a silent member of the teaching and learning sessions while I observed and made field notes. Directly afterwards I wrote detailed notes of what I observed and experienced with regard to the teaching and learning of patient-centredness (see 4.7.3). Hence I provide a short narrative of my reflections at the time that I entered the clinical environment.

I was feeling comfortable and strangely at home being back in the hospital. I had not worked in a ward like this for more than 20 years, yet the environment still felt very familiar. What was however very new and kind of strange to me was the new role I now had (Babbie & Mouton, 2001). Previously I used to be dressed in a nursing uniform and patients would call me if they needed any help, or clinician teachers would ask me to assist with tasks; but now I was only an observer and part of the medical team. So while I saw nursing things that needed attention and care I realised it was not my role to do something about it, for example the drip of one patient that was empty; the one patient was clearly thirsty but she could not reach the water which was standing on the trolley. Another example was a patient that clearly looked lost after the team of doctors walked away from her, with no-one talking to her.

It is relevant to mention that being a nurse and doing this study about the development of patient-centredness in medical students allowed me to look at this matter through a lens that was not influenced by any one of the medical specialities, but rather in terms of caring for patients in general. Although Babbie and Mouton (2001) suggest that a complete observer is less likely to develop a full appreciation of what is being studied, the opposite was true in my case. With my nursing background and being part of the students' clinical skills training it was

possible for me to blend into the environment and situate myself as a complete observer, while still getting the full appreciation of what was being observed. Therefore, ecological validity, as described by Plowright (2011), was high in this situation since the observation encounters represented everyday activities without the researcher intervening to create or construct the research context.

The data of the five observation encounters provided a rich data source. While the data were clearly not adequate to make any generalisations of the clinical teaching platform, they assisted in providing a better understanding of the context where students have opportunities to see and learn with patients. The field notes of the five observation encounters were rewritten and a summary of each is provided below.

6.2.1.1   *Clinician teacher 1: Summary of observation encounter as part of a ward round*

The ward round in the tertiary hospital was attended by me, the consultant, eight MB,ChB third-year students, an intern and a registrar. The ward round started at about 08:00 and the purpose was to re-evaluate some of the patients that had previously been admitted to the ward and to decide on a plan of action with them. After having seen three patients (about 45 minutes) the consultant had to go to theatre to operate for the day, so the 'teaching ward round' was stopped. However, the students went on to help the registrar with ward work.

During the observation the consultant displayed aspects of patient-centredness, but these aspects were not according to the exact textbook definition of what patient-centredness entails. From the consultant's perspective it was clear that she knew all the patients that were discussed and they knew her, so there was no need for time spent on getting to know each other and getting an initial history, thus those aspects of patient-centredness were not demonstrated. For the students, however, this was different, because they moved through the ward for only two weeks (that is how long the rotation is) and most of them had not seen the patients before. The students almost act as observers without real responsibilities with the result that they often only observe fragments of the patients' stay and treatment in the hospital. The consultant displayed the 'caring and sharing' components of patient-centredness in various ways, but since there was no discussion afterwards about patient-centred behaviour, one could not be sure what the students learned from this ward round and whether they realised that some of the behaviours that they had observed were actually context-specific applications of patient-centredness. If

patient-centredness is about the clinician teacher having the ability to see the patient behind the disease and not only the disease and the treatment, this clinician teacher displayed patient-centredness. However, to utilise this as a learning opportunity for the students the clinician teacher should have made her/his actions overt and allowed students to reflect on patient-centred behaviour in the specific context.

6.2.1.2   Clinician teacher 2: Summary of observation encounter as part of a ward round

This observation encounter took place in one of the busiest medical wards in a tertiary hospital on a morning from 07:00 to 08:00. The ward was crowded with staff and patients, and since there was not enough space in the rooms, the corridor had been adapted with drip stands where patient trolleys could also be placed. It was evident that these 'bed spaces' did not have oxygen and suction equipment available and there were no curtains for privacy, so the adaptation had actually created a potential safety hazard. The nursing personnel were very busy, it was the change-over of their shifts and they were sorting out what they had to do for the day. Doctors were standing in the corridors looking tired; they were all waiting for their respective ward rounds to start so that they could hand over and go home.

For our ward round it was the consultant, myself, the registrar, the intern and only four MB,ChB third-year students. There was some talk between the consultant and the students as to why they were so few, but nobody really answered. The registrar and intern who were part of the ward round looked irritated and tired as they had been working all night. During this ward round I did not observe any patient-centredness apart from an obvious attempt from the clinician teacher to make sure patients were addressed by their names and surnames. The ward round discussions were focused on biomedical content and there was some talking taking place around the patients, without involving them. Furthermore, the discussion took place at a level that patients could not understand. The consultant made very good use of aspects of the one-minute preceptor (a teaching technique to develop clinical reasoning skills) to encourage students to think about the patients' conditions and treatment, but there was no attempt to look beyond the disease and treatment in any of the patients that were seen.

6.2.1.3   Clinician teacher 3: Summary of observation encounter in an outpatient clinic

The students started to see patients since 08:00 that morning so that when the consultant arrived, they could present their patient to him. That day was regarded as a quiet morning in the clinic as it is the high-risk patient clinic and there were only 16 patients booked for the morning. On other days an average of 120 patients come to the clinic. The clinic has six consultation rooms so that doctors can see patients simultaneously. I was sitting on the examination couch in the corner of the room and they soon appeared to forget about me. The four students that were there were senior medical students and they seemed confident in what they were doing. They saw each patient completely unsupervised for about 30 minutes and then they presented the patient to the consultant. The consultant entered the room and introduced himself very politely to the patient followed by a few minutes of talking to find out where the patient is from. In all the cases the patient was sitting in a chair with the consultant and the medical student both standing in front of her. The students had to do a presentation based on the main complaint, the relevant findings of the physical examination and the plan of action for treatment that the student would suggest. In between, the consultant stopped the student to ask questions and then lectured on certain aspects. It was a conversation happening between the two of them, but at times they would look at the patient and on the odd occasion perhaps ask the patient something. Otherwise, the patient was not involved in the discussion at all. In general, the patients sat quietly with no facial expression and in many cases it was not clear what they understood of the whole conversation. At the end of the discussion the consultant and/or the medical student would explain briefly to the patient what would happen next.

Overall there were aspects of patient-centredness seen in the consultations such as greeting the patient and explaining what would happen next. At the end, however, all the discussions were focused on biomedicine and patients were not actively involved in the conversations. All the interaction that happened between the students and the patients were unsupervised and students were only given feedback about their knowledge of the field; nothing was ever mentioned about patient-centredness. It is important to mention that the context of this specialist clinic was somewhat challenging, since it is a reference clinic with little or no longitudinal follow-up of patients. Also, patients generally have high-risk conditions and many of them do not understand the language of the clinician teacher.

6.2.1.4   Clinician teacher 4: Summary of an observation encounter of student observations in a district hospital

This observation encounter was quite different from the others in the sense that the clinician teacher who was in charge of the students informed me that there was not any specific teaching and learning incident that he wanted to single out for me to attend. He wanted me to observe the students and what they were doing throughout the hospital for half a day and after that I could have an interview with him.

I started to observe the students that were working in the outpatient clinic. Students were seeing their own patients and after they had done the history-taking and physical examination of each patient, the doctor on duty arrived to see the patients with the students. The students would then present the patients to the doctor and give their diagnosis and treatment plan which the doctor would then discuss with them. This was all focused on the problem with which the patients presented. It was a good learning opportunity for the students to develop their clinical reasoning skills and in some cases even do some procedures under the supervision of the doctor. However, the history-taking and communication between the students and the patients mainly happened unsupervised. It was apparent that some students had an inclination to be more patient-centred than others, but there was clearly no incentive or recognition from the supervising doctor for students who were displaying patient-centred behaviour. There were aspects in the environment that were patient-centred, especially in the way the students and the doctor approached the patients; the environment was friendly and both students and patients were handled with respect. However, it was only the patients' biomedical aspects that were discussed as part of the teaching sessions.

My next observation point was the theatre where two students were placed with a clinician teacher administering anaesthetics. Here the patient was already sedated and the operation was in progress so I observed the clinician teacher sitting at the head of the patient discussing the patient with the students. This context and timing of my observation did not provide much by way of teaching and learning opportunities for patient-centredness, but I took note that the patient's privacy was being respected, and the procedures being done and the environment in general were both patient- and student-friendly. Furthermore, all the people working around the theatre bed were treated respectfully.

After this observation I took some time to visit each ward in the hospital and observed that the students in the wards were extremely busy; they seemed to be part of the staff and not merely observing. The hospital was not so busy and smaller than others where the students normally work and the students attempted to treat students, patients and fellow staff members with respect. The students were working with and learning from the interns, registrars and sisters. Although I did not observe a specific teaching or learning incident focussed on patient-centredness during this observation, it was clear that the students were getting plenty of opportunities to learn about biomedicine.

6.2.1.5   *Clinician teacher 5: Summary of an observation encounter with student observations in a tertiary hospital as part of a self-learning assignment*

In this rotation I was advised to observe a project that the students had to do as self-study. It is called 'the patient experience' and students are expected to find a patient that will be willing to allow the student to accompany them on a day when they come to the hospital for a clinic visit. The student has to experience all the patient's 'stops', namely the doctor's appointment, the pharmacy and all relevant investigations that are done. Afterwards the student has to write a reflective summary of the patient experience within the hospital as well as their own experience. They have to interview the patient and/or his/her parent or guardian in order to get a glimpse of the patient's views and experiences.

The student that volunteered to be shadowed had to go to the paediatric renal clinic and after he found a patient that was willing to be part of the project, I also asked for permission to observe their experiences. My role was simply to watch what the student did, since the patient experience is a curriculum activity that the students have to do on their own. My interest was in what students did and how they experienced it. The patient that was chosen was extremely knowledgeable about her child's disease since he had this disease since the age of 18 months. The mother and her child usually come to the clinic once a month and she makes sure that they come early so that they can be helped first. For the purpose of this observation I was not really interested in the patient's content knowledge but more in observing the student and seeing what he would learn from the experience. The student was very kind to the patient and his mother; he treated them with respect from start to finish and he never attempted to know better than the mother. First they had to see the consultant, then they had to go to the pharmacy and lastly to

the dentist. The patient was assertive and very well informed about the hospital, the system and her child's diseases.

This seemed to be an excellent exercise and the student said that he enjoyed getting to know the patient personally and experiencing the hospital 'through the patient's eyes'. He also commented that he was very fortunate to have met the patient, because now he had learnt that one's attitude changes once you experience circumstances from a patient's perspective. Although the mother in this case had feared for her child's life at times and had had bad experiences in hospital when nurses did not want to listen to her about how and when to give her child's medication, she remained positive towards the hospital and was extremely grateful for the progress in his condition. The student was of the opinion that in general medical personal does not use the knowledge of patients to their advantage. When patients take ownership of their disease and are informed, they may decrease the work load of the hospital staff. He concluded to say that he had learnt that patients have their own stories and that he should not look at all patients in the same way as not all patients are uninformed and unwilling to change their lives and take ownership of their conditions.

6.2.1.6   *Analysis and summary of the findings from the observation encounters*

The sections above provided a summary of the five observation encounters and although some of them were very different with regard to their context, discipline and teaching outcomes, some aspects were present in all five of these teaching and learning opportunities. It was clear from the start that five observation encounters in a complex and a multifaceted programme such as this one would not provide sufficient data to draw any firm conclusions. The observation data were therefore analysed and utilised in the following ways:

Firstly, the summary of each observation encounter was extremely useful in providing a context for the study and further assisting with the understanding of the complexities found within the clinical learning environment. Secondly, each observation encounter was matched against what was found in the interview data by making use of the identified themes and categories (see Chapter 5) as a guide. At the same time, there was a constant awareness that data that did not fit these themes and categories should not be ignored.

Themes that were strongly presented in the observation encounters and that need to be highlighted are the following:

- The continued focus on biomedicine in the clinician areas was prominent and little evidence emerged of the teaching of patient-centredness.

- There seems to be a lack of understanding among clinician teachers as to what patient-centredness really means; some clinician teachers consider good manners (e.g. greeting a patient by their name) as sufficient.

- Paternalism was observed in several instances and still seems to be ingrained in the way many doctors treat patients.

- When students interact with patients, they are often not observed by the clinician teachers and therefore they do not get feedback on their communication and interaction skills.

- Since the practice of patient-centredness is not the same for each medical speciality, context or patient, it needs to be made overt. It seems as if role modelling alone may not be sufficient.

- The pressures of too little time and many sick patients in the clinical areas were evident in most of the observation encounters.

These general findings from the observation encounters are further explored in Chapter 7 when combined with the findings of the students and the lecturers.

6.2.2   The results of interviews with clinician teachers

Another data source that was analysed at level one of the analytical ladder (see 4.4) were the individual interviews that were conducted with each of the selected clinician teachers after their respective observation sessions.

6.2.2.1   Analysis of the clinician teachers' interview data

After the interviews with clinician teachers were transcribed, each interview was coded deductively by relating it to the themes and categories that emerged from the student data. A deductive analytical strategy was used because the data of the clinician teacher and student interviews indicated many similarities and it thus made sense to use the same themes and codes

as a starting point. It was, however, critical that throughout the analysis process there was a constant sensitivity to recognise findings in the clinician teachers' data that did not fit the themes and categories as identified by the students.

6.2.2.2 *Findings of the clinician teachers' interview data*

Although the data from the clinician teachers' individual interviews largely corresponded to the same themes as those that emerged from the student interviews, it seemed as if the students were more aware of patient-centredness within the curriculum than the clinician teachers. What was most appealing was the opportunity to gain some insight into the understanding of patient-centredness by the various clinician teachers from the various disciplines. Table 6.2 represents the data of the clinician teachers' interviews as analysed against the themes and categories of the student interview findings.

Table 6.2:   Interview findings of clinician teachers

The data are grouped according to the identified themes and categories of the student interview findings (see Chapter 5).

The quotes of clinician teachers 1, 3, 4 and 5 were translated verbatim from Afrikaans to English. Patient-centredness =PC

<table>
<tr><td colspan="5" align="center">6.2.1 THEME 1: ATTITUDES</td></tr>
<tr><td colspan="5" align="center"><i>6.2.1.1 Category 1: The patient is seen as a whole person with their own needs</i></td></tr>
<tr>
<td><i>Interview findings: Clinician teacher 1</i></td>
<td><i>Interview findings: Clinician teacher 2</i></td>
<td><i>Interview findings: Clinician teacher 3</i></td>
<td><i>Interview findings: Clinician teacher 4</i></td>
<td><i>Interview findings: Clinician teacher 5</i></td>
</tr>
<tr>
<td>While PC was something the doctors don't actually have time for, patients would prefer that.

<i>"Whether this happens is probably not the case, but it (PC) should definitely have an effect on the patient. If my idea is to do a certain type of treatment but the patient's idea is just to be at home, then it is a huge difference and this will influence the treatment."</i></td>
<td>The doctor had a clear understanding of what the biopsychosocial model entails, but at the same time said that there was no time for it. All he thought one could accomplish was to greet the patient by the name.

<i>"I always call the patient by his or her name. Don't make the patient feel like a number, they're a person, an individual."</i></td>
<td>There was a feeling that PC was about greeting the patient and taking a good history to understand what the problem is, however nothing was mentioned about the patient's individual needs or circumstances.

<i>"It is important to greet the patients so that they know who you are and what you do. Maybe it is also good to know where the patient comes from."</i></td>
<td>PC was seen as much wider than only the disease.

<i>"It is recognising that it is about a human being. Because even if I only have two minutes for the consultation it can have a huge impact if the patient realises he/she is not only a number or just another problem."</i></td>
<td>The doctor viewed PC as part of clinical practice and having to consider what was better for the patient not the doctor.

<i>"How is it going to influence your patient, how is his quality of life going to change?"</i></td>
</tr>
<tr><td colspan="5" align="center"><i>6.2.1.2 Category 2: Personal satisfaction for the clinician teachers and the patients</i></td></tr>
<tr>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
</tr>
<tr><td colspan="5" align="center"><i>6.2.1.3 Category 3: Involving the patient in the information and decision-making process</i></td></tr>
<tr>
<td>The doctor said that whether patients wanted to be part of their management plan will depend on the diagnosis.</td>
<td>The doctor said that he sometimes tries to be PC and then involve the patient, but this was not the norm.</td>
<td>The doctor felt that in his speciality patients were often involved in the decision-making process.</td>
<td>The teacher role of the doctor was highlighted as being very important.</td>
<td>Working with children, the challenges of involving the parents (family-centredness)</td>
</tr>
</table>

155

"Some patients with severe cancers would rather not take ownership of their disease. They feel comfortable for me to make the decisions and they say it is all too much for them. They prefer it that way."	*"I try to become PC. The other day there was a patient with lung cancer. I saw the registrars just go through the protocol. So I said, 'No, no, no, this is not how you manage this patient. You have to give the patient some options.'"*	*"To me as a clinician it means that the patient must always be involved in the decision-making."*	*"When you see a patient it is your duty to teach. One should never think the patient is isolated, because your impact is wider, it includes his family and his community."*	in the decision-making process was highlighted. *"When it comes to decision-making clinician teachers mostly do what they think is good for them ... but with time we learn that what is good for me and good for the patient are two different things."*

6.2.1.4 Category 4: The role of the clinician teacher in the doctor-patient relationship

The doctor indicated that according to the circumstances the doctor's role will change; e.g. in an acute scenario it might be more paternalistic than in others. The informed consent conversation was seen as an ideal opportunity to involve the patient. *"With our informed consent I will talk about the operation. I will complete my story and then allow them to ask questions."*	There was some awareness that patients should be informed of what is happening, but this was seen as a very unilateral process without any deliberate intentions to involve the patients. *"Usually what I do is once we are done with our medical discussion ... I will just stay behind to tell the patient quickly: Looks as if you've got cancer, it looks like lung cancer."*	It seemed as if in many cases patients still want the doctor to make decisions on their behalf. *"We still get the situation where the patients will say, 'What would doctor do?' Every now and then I have to say to a patient what I think the right thing to do is; another option would be stupid."*	The role of the doctor and PC was highlighted as mainly a team effort. *"PC is when care, training, understanding, well-being, all of it come together. It is the synergism of all the members that are dealing with the problem."*	It was highlighted by the doctor that the doctor-patient relationship is complex with parents also forming part of the scenario. *"It becomes a bit difficult to do. Who do we really treat, the parents or the child? They often have different needs."*

6.2.2 THEME 2: SUBJECTIVE NORMS

6.2.2.1 Category 1: Pressures related to patient-centredness

It was felt that there was no pressure in the government sector to behave in a PC manner, while in the private sector there are more incentives. *"The pressure to be PC is less in the State sector because there are loads of patients and our salaries are not dependent on it."*	The doctors expect biomedicine from the students. *"I expect the students to have done that (the biopsychosocial) when they have taken the history and examined the patient. Unfortunately in our ward where the patient numbers are so many, we can't spend a lot of time on each of the components of the biopsychosocial."*	Some of the doctors in the department are so focused on the way they do things, and they do not regard PC as a value. One of them actually said: *"Do you want to see a healthy patient walking out of here or someone that was sweet-talked but collapsed dead?"*	PC and related feedback was identified as a critical component in the process of students learning about PC. *"I call students in and have a conversation with them. I said to the one, so this is just another case, but what if it was your daughter. How would you have felt?"*	An assignment was added to the students in the 3rd year in order to help them to understand the patients' point of view better and improve the students' communication with patients. *"They (the students) did not want to speak to the patients or touch them. They were afraid. This assignment helps them."*

6.2.2.2 Category 2: The influence of role models

The doctor recalled that she learned PC mainly through role modelling. It was now a teaching strategy that she often used, however actions are never explained afterwards. *"I do not think it (role modelling) is ever expressed overtly and it was never explained to me either."*	Nothing	Role modelling was regarded as a powerful teaching strategy, but since it is not planned it can have its own problems. *"Students evaluate a role model by how much they learn from them and not how they interact with patients."* *"The problem is that we do not know what the norm of a role model is."*	A point that was made by the doctor was that PC and student-centredness were very closely related and that supervisors should be role models of both. *"Whether it is your patients, your students or your colleagues; when you look at them you should see their expectations, hopes fears, their insecurities ..."*	A doctors valued role modelling as a way she had learnt PC. *"Nobody taught it to me; it was the example that I got."*

6.2.3 THEME 3: SELF-EFFICACY

6.2.3.1 Category 1: Past experiences with patient-centred behaviour

This doctor felt that her context provided opportunities for a PC approach. *"We as surgeons have the informed consent conversation that has to take place."*	In the context in which this doctor was working at the time, he felt it was not possible to practise PC. *"We tend to concentrate on the acute medicine rather than on the other aspects."*	This doctor felt his practice often included patients in the decision-making process. *"In my field there are often decisions about the baby and I will involve the mother."*	The doctor felt that PC was not about a long list of things to do. *"It is about caring and a connection, not about a wonderful diagnosis that has been made."*	The doctor was quite confident that she liked people and therefore behaved in a PC manner. *"I would sit on the bed step at the mother's feet when I speak to her."*

6.2.3.2 Category 2: Perceived difficulty of being patient-centred

The doctor made practising PC sound fairly easy for her. *"When I have a patient with cancer and we decide to go palliative, I stop and say OK; social worker, disability grant, speak to family, etc."*	The doctor gave an example of how he attempted to be PC, but did not get to it. *"I have personal experience with that PC thing at the bedside, and it just doesn't click."*	This doctor felt that he tries to be PC, but the context makes it difficult. *"The expectation from the subspecialist is that he must sort out the problem."*	The feeling was that PC does not need to be difficult or take a lot of time. *"Look the patient in the eyes and make him/her feel comfortable."*	The doctor felt that respect towards the patient was not difficult to learn. *"They learn respect, and that builds a special relationship between you and the patient."*

6.2.4 THEME 4: BACKGROUND FACTORS

6.2.4.1 Category 1: Demographic variables such as gender and age

Nothing	Age and gender were mentioned as possible factors that could influence PC. *"One would think that females would maybe be a bit more ..."* *"The more mature you are and the more experience you have, the more you tend to treat patients with dignity."*	Experience that comes with age was mentioned as a factor that can increase PC. *"I think it is something that had become easier over the years."*	Nothing	The feeling was that to be able to stay in Paediatrics one needs to be able to work with people, and that one can learn it as one gets older. *"Some people will later learn to be able to speak to patients. They change with time."*

6.2.4.2 Category 2: Culture				
Nothing	Nothing	Nothing	Nothing	Nothing
6.2.4.3 Category 3: Personality				
The clinician teacher felt personality is a huge factor. *"Personality of the doctor is important, for some people it does not come easily and naturally and they will do it (PC) less."*	The doctor said personality was a strong determinant. *"I think it's a personality thing, it's an individual thing. It comes from within the person. Some people are just not talkers."*	What kind of person one is was again mentioned as a determinant of PC. *"You are either going to be like that (PC) or not."*	Nothing	Personality was mentioned as a key factor. *"Personalities are important. Some students will not be able to do that, some will never be warm."*
6.2.4.4 Category 4: Personal experiences				
Nothing	The doctor said that life experiences can have an influence on PC. "*I remember I went with my grandfather to a clinic … I was a medical student at the time… the doctor spent time to talk to me and showed me the ECG … I actually appreciated that back then, and I'm still following it through now. "*	It was recognised that when you have had the same experience as a patient it was easier to speak to them. "I*t is easier for someone who has children to speak to someone else about what might happen to a child.*"	Nothing	Nothing
6.2.4.5 Category 5: Exposure to media and social pressure				
Nothing	Nothing	Nothing	Nothing	Nothing

6.2.5 THEME 5: SKILLS AND KNOWLEDGE

6.2.5.1 Category 1: Theoretical knowledge

The doctor was of the opinion that one can teach the theory of PC to students in a classroom setting. *"Surely in a lecture and explaining it in words to the students. I am not sure however how they are going to practise it; maybe in simulation."*	The fact that PC is more easily taught in theory than in practice was highlighted. *"PC is easy to write on a piece of paper, but it's really taught at the bedside. You can read it and understand it, but if you can't apply it at the bedside, it means nothing. So, I think there is this dissociation between what we are teaching students at the bedside and what they are reading."*	Nothing	Nothing	Nothing

6.2.5.1 Category 2: Relevant skills required

The fact that she could not speak Xhosa was not seen as a huge barrier to a certain doctor. The doctor felt that there were at least staff members that could act as interpreters. *"One of the staff members can interpret the conversation. However, then the conversation is different because then I do not talk directly to the patient."*	The doctor recognised that to be able to adapt PC according to various scenarios was a vital skill that students should have. *"It has to be patient specific. It depends on the condition and what the main problem is."* However, it was also evident that PC was misunderstood as something that could not be applied to all patients.	Nothing	Mindfulness training was mentioned as a strategy to teach skills that are required in PC.	It was acknowledged that doctors who want to work with children need specific skills. *"If you do not like to work with people you are going to struggle a lot."*

160

	"So it depends on the situation and the patient him- or herself. You can't do it to every single patient."			

6.2.6 THEME 6: ENVIRONMENT

6.2.6.1 Category 1: Limited time and work stress

The doctor felt that students' learning is influenced by the busy environment in the sense that they mainly have to help with the ward work. *"We rely on it that they learn when they work with us. It is a random thing and it gets harder the bigger the groups get."*	Doctors would refer patients as soon as they need any help beyond their disease. *"What I do when I see a stroke patient, I will refer to the social worker and ask them to deal with that component because I just don't have time myself to deal with that aspect."*	Time was mentioned as a factor that influences PC. *"I think time is a huge factor, because the more patients we have the less time we have per patient."*	The doctors felt the reason why there was not enough time to supervise students was that supervision is not understood correctly. *"The problem is that supervision or training has been separated from patient care. Doctors should work with the students and not make it an academic activity."*	Too little time from the doctors' side and the big groups of students were mentioned as factors that impede the teaching of PC. These factors were the reasons why this rotation initiated the mentioned assignment (6.2.1.5) for the students.

6.2.6.2 Category 2: Context of clinical practice

The comments that were made with regard to the context were related to the large numbers of students and the fast pace in the department. Furthermore, in their setting the registrars were acknowledged as key role players in the teaching of students, yet they were under massive stress.	It was clear that context can have a huge influence on PC practices. *"In nephrology we tend to concentrate on psychological components. The reason for this is, we have a very small number of patients, and we see them all the time. It's unlike other disciplines, where you see the patient,*	The feeling was that students who work in a tertiary hospital mainly see the very sick patients. This is a difficult context. *"When you are on a sub-specialist level there is an expectation that you have to sort out the problem.* *So you kind of expect the other things have been sorted*	The importance of context was stressed a lot in this interview. *"PC is not a rigid list of guidelines. It is about the context, because the situation in which you work will determine in which way you can offer PC. It is also a team effort."*	The context of the tertiary hospital with its challenges for student education was highlighted. *"The babies in the wards are acutely sick or very small and some are immune suppressed. Students cannot work with them."*

"The registrar must do the ward round, he must see that the patients do not die, he must go to operate in theatre and he must finish the clinic. These are the things that will stop him from spending time with the students."	*you get them better and they go. We have a long-term relationship with the dialysis patients, so we know them very well. So, because of that relationship, we tend to start concentrating on other aspects of the patients."*	*out, you just focus on the problem."*		

6.2.6.3 Category 3: Limited resources and system failures

The doctors mentioned the logistics of wanting to be PC by giving patients the opportunity to go and think of their treatment options and come back at a later stage. *"It is a case of, now is the only time that I can operate on them, otherwise I might only get to them again in six months' time."*	Due to resource constraints patients do not stay in the ward long enough so that the students can really speak to them. *"There is so much pressure on us; we need beds and the ward is overflowing, that you have to discharge the patients quick. The students can't afford to spend time on the social aspects."*	The nursing personnel were mentioned as a resource that has to be considered since their availability influences the times the clinics can be open. *"And the pressure comes from the nursing staff as well. There is no way that you can continue after 16:00."*	The doctors shared an example of how busy the doctors are some days, but said that despite this challenge one needs to remain sensitive. *"The other day there was a child that was raped who had to wait for 8 hours before the doctors saw her. I asked the doctor afterwards how he would have felt if it was his child."*	Due to limited resources the assignment that the students compile as part of the rotation is marked by one person alone, so there is no time for personal/detailed feedback. If there were more time in the rotations the doctor could provide the students with more constructive feedback.

6.2.7 THEME 7: THE ASSESSMENT OF PATIENT-CENTREDNESS

Nothing	Nothing	Nothing	Nothing	Nothing

No findings that did not fit the chosen analytical framework (see findings in Chapter 5) emerged from the clinician teachers' interview data. However, there were four themes/categories in the framework that were not mentioned by the clinician teachers. These were Theme 1: Personal satisfaction for the clinician teachers and the patients; Theme 4: Culture; Theme 4: Exposure to media and social pressure; Theme 7: The assessment of patient-centredness. It was very clear from the interviews that the clinician teachers had varied interpretations of what patient-centredness means and that obviously influenced the way they responded to the prompts during the interviews. Furthermore, there was a sense that some of the clinician teachers had actually given up on attempting to practise patient-centredness and, furthermore, to teach this to the students. One of the reasons they gave was that the environment was acting as a barrier to patient-centredness. Moreover, they believed that the clinician teacher's personality was a key factor and that for some clinician teachers it will just not be easy to be patient-centred.

6.3   LEVEL TWO OF DATA ANALYSIS: REPACKAGING AND AGGREGATION OF THE DATA

Proceeding to level two of the analysis process (see Diagram 4.4) it was possible to determine the shared categories and themes between these two data sets.

As a further level two activity in the data analysis process, the findings from three data sets were reconsidered, repackaged and aggregated in order to look for explanations or qualitative relationships. Five individual cases representing the five clinician teachers' scenarios were constructed by comparing the clinician teachers' interview data and observation impressions with the students' interview findings. While I was expecting to find some similarities between the two datasets, it was also anticipated that there would be discrepancies since it was not possible to observe everything the clinician teachers were saying in their interviews in a single observation encounter.

It needs to be highlighted again that there not many observation encounters and they were relatively limited. They also took place in an ad hoc manner and the data generated from them (see 6.2) was inadequate to draw any general conclusions. However, the goal of utilising these scenarios was to see what (if at all) similarities existed among the data sets per lecturer, and in the end, among the five clinician teacher scenarios.

6.3.1 The diagrammatic representations of the combined interview and observation findings

The findings from the students' interviews (Chapter 5) were used as an analytical framework against which the findings from the observation encounter and interview for each clinician teacher was mapped. Diagrammatic representations for each clinician teacher were compiled by making use of arrows pointing towards the themes and codes of the findings from the student data as well as additional colour coding to highlight certain aspects. Below is an explanation of the way in which the colour coding was utilised.

Black represents aspects that were correctly understood by the clinician teachers (interview data) and then they were also observable during the observation encounter.

Green represents aspects that were correctly understood by the clinician teacher (interview data), but were not visible during the observation encounter.

Red represents aspects that were either misunderstood or not mentioned, and also not present in the observation encounter.

It is important at this stage to add as a disclaimer that in the case of some of the aspects not being evident in the observation encounters does not imply that these aspects will always be absent in the clinician teachers' teaching. One has to acknowledge that it was not possible to observe some of the aspects in the analytical framework in a single observation encounter. The aggregation of the data from the student interviews, observations of clinician encounters and interviews with clinician teachers for each clinician teacher is displayed in diagrams 6.1 to 6.5.

Clinician teacher one
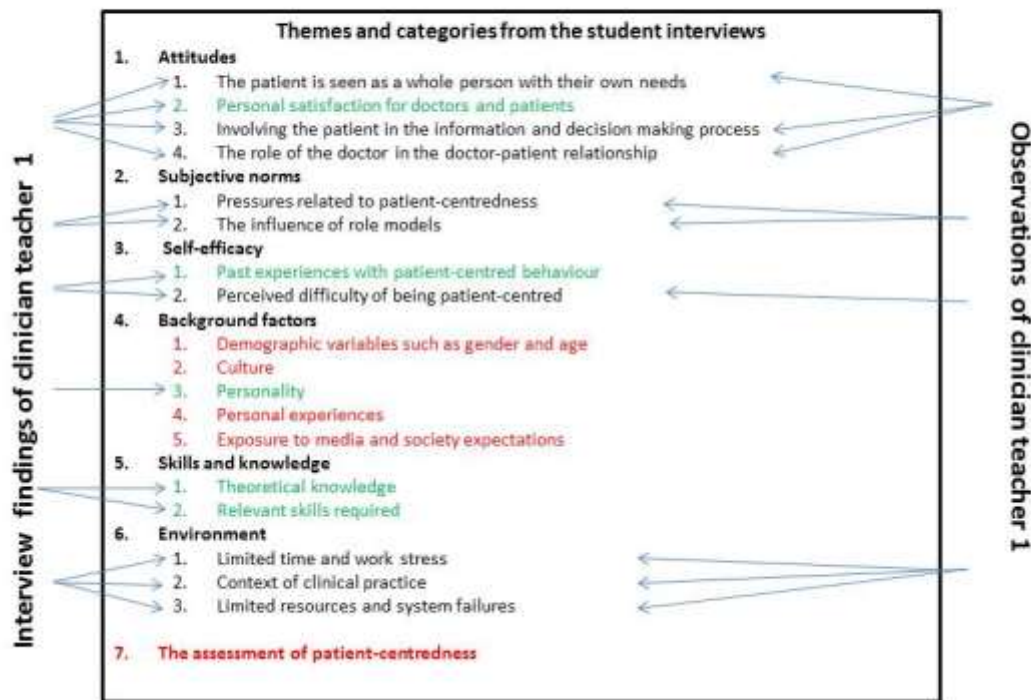
Diagram 6.1: Relationship between the observation encounter and interview: Clinician teacher 1

From the detail in Diagram 6.1 it is evident that 14 of the 21 themes and categories from the student interviews were present in the interview findings of this clinician teacher, while only nine were observable in the observation sessions. This example represents the most matches out of the five examples, but this could be due to a range of factors which makes drawing any firm conclusions problematic. What was prominent from this example, however, was the way in which the clinician teacher managed to contextualise the practice of patient-centredness despite a busy clinical environment in a tertiary hospital ward. Furthermore, the clinician teacher had a high sense of self-efficacy, which seemed to engender a positive attitude towards patient-centredness.

Clinician teacher two

Themes and categories from the student interviews

1. **Attitudes**
   1. The patient is seen as a whole person with their own needs
   2. Personal satisfaction for doctors and patients
   3. Involving the patient in the information and decision making process
   4. The role of the doctor in the doctor-patient relationship
2. **Subjective norms**
   1. Pressures related to patient-centredness
   2. The influence of role models
3. **Self-efficacy**
   1. Past experiences with patient-centred behaviour
   2. Perceived difficulty of being patient-centred
4. **Background factors**
   1. Demographic variables such as gender and age
   2. Culture
   3. Personality
   4. Personal experiences
   5. Exposure to media and society expectations
5. **Skills and knowledge**
   1. Theoretical knowledge
   2. Relevant skills required
6. **Environment**
   1. Limited time and work stress
   2. Context of clinical practice
   3. Limited resources and system failures
7. **The assessment of patient-centredness**

Interview findings of clinician teacher 2

Observations of clinician teacher 2

Diagram 6.2: Relationship between the observation encounter and interview: Clinician teacher 2

In this example only nine of the 25 themes and categories from the student interviews were present in the interview findings and just four were observable in the observation sessions. The findings in this example were focused on the environment (tertiary hospital ward setting) being a major barrier. In essence, this was considered a clear demonstration that patient-centredness may not be easily regarded as an option in such contexts. The focus here was clearly on biomedicine and students were motivated to understand that as best as possible in order to become good doctors.

Clinician teacher three
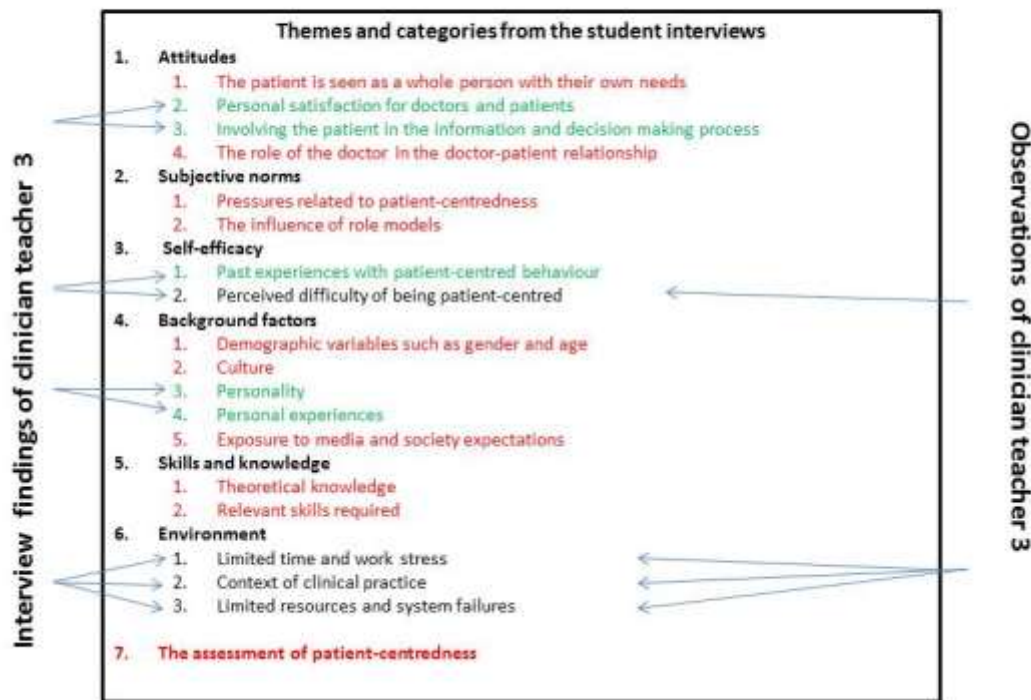
Diagram 6.3: *Relationship between the observation encounter and interview: Clinician teacher 3*

Of the 25 themes and categories from the student findings 9 were acknowledged by the clinician teacher in the interview in this case, but in the observation only four were present. With regard to the theme attitudes this clinician teacher indicated during the interview that certain patient-centred principles are valued and necessary, but when observed in real life, this was not evident. There could obviously be various reasons for this position; however, it may be suggested that 'doctor-centred' attitudes are so firmly rooted in the practice of medicine that some clinician teachers do not recognise it – despite their good intentions to acknowledge and involve patients more.

Clinician teacher four
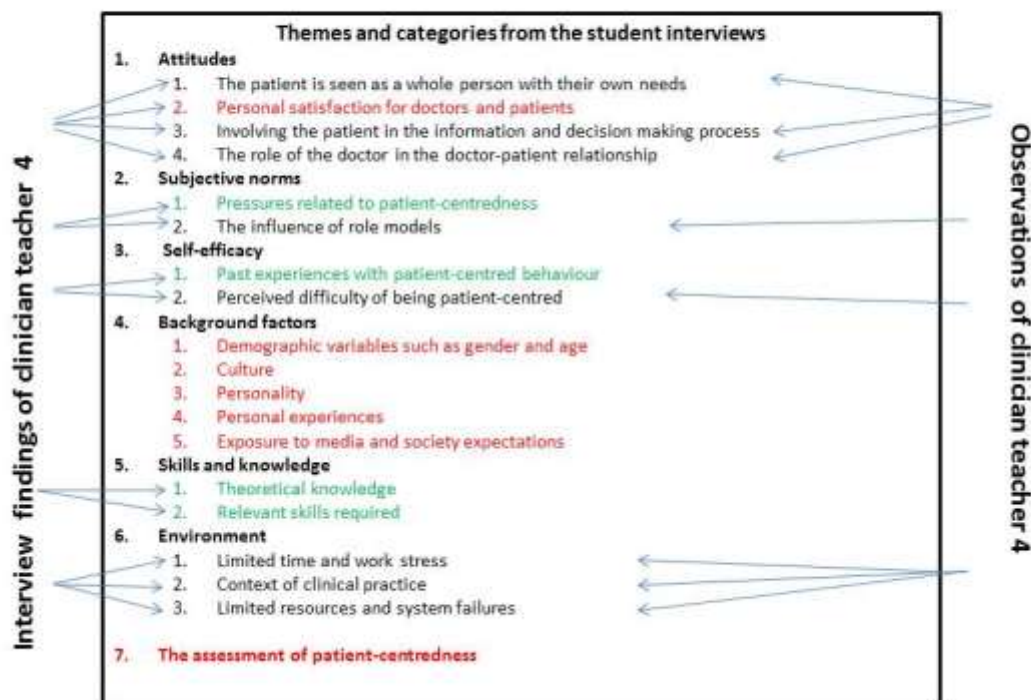
Diagrame 6.4: Relationship between the observation encounter and interview: Clinician teacher 4

The fourth example shows that reference was made to 13 of the 25 themes and categories from the student findings, while only eight were evident in the observation encounter. One of the possible reasons why this example had so few matches between the two datasets was that the clinician teacher with whom the interview was conducted was not the only doctor observed with the students. When I as researcher initially requested to observe the clinician teacher while teaching, he insisted that I rather observe the students by following them in the clinical areas in order to see what learning opportunities they are exposed to. This clinician teacher who was in charge of the students' teaching and learning at this particular site (secondary hospital) had an exceptionally good understanding of patient-centredness and the practice thereof and his view was that clinical supervision and learning should not happen as a single session, but rather be a spectrum of events facilitated by a team of personnel. Despite attempts to create a positive learning environment for the students, it was evident that the local health system was overloaded with too many patients and a focus on biomedicine.

Clinician teacher five
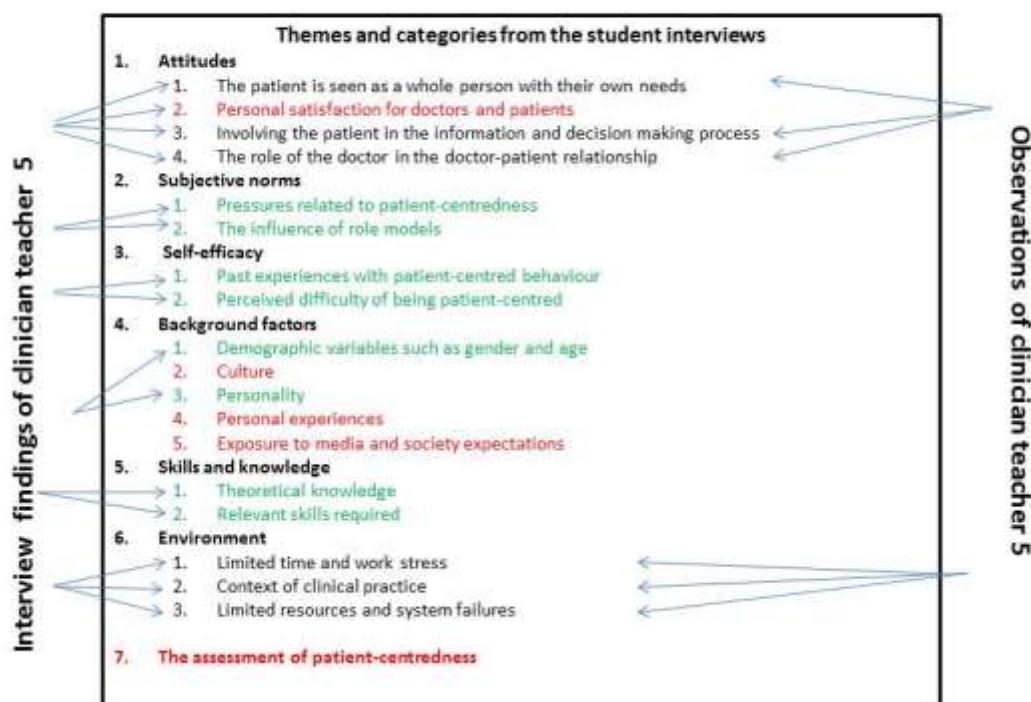
Diagram 6.5: *Relationship between the observation encounter and interview: Clinician teacher 5*

Fifteen of the 25 themes and categories from the student findings were mentioned by the clinician teacher in this example, however only four were visible during the observation. Again, as in the previous example, this can partly be explained by the fact that the clinician teacher that was interviewed was not the one teaching the students. This example was different from the rest in the sense that this teaching and learning opportunity was a self-study activity. As previously explained in the observation summary (see 6.5), students had to shadow a patient for their hospital visit and then write a reflection report about that activity, so they were not taught by someone directly, it is rather the reflection on an event that may allow the students to learn or not to learn. It was clear from the interview that while the clinician teacher's intentions with this self-study activity were to help students understand patients' experiences, this was a missed opportunity to learn about patient-centred principles. The observation encounter revealed that the tertiary hospital environment where the students were placed was facing financial constraints resulting in staff shortages, and that patients consequently had to wait very long before being attended to.

6.3.1.1   Conclusions from the diagrammatic representations

With regard to the five clinician teacher cases that were informed by three separate datasets, it was not possible to draw any firm conclusions. However, a theme that emerged prominently from all these cases was the importance of the environment in which the learning took place. This may confirm that patient-centredness is hugely dependent on environmental factors, which needs to be kept in mind when creating or developing teaching and learning opportunities for medical students.

6.4   SYNTHESIS

This chapter provided an overview of the analysis process as well as the findings that emerged from the data. Overall, the data from the clinician teachers confirmed that while the doctors in question noted that patient-centredness is an important component of a doctor's competences, the biomedical component of the patients' treatment dominated their practice. They admitted that having too many patients and too little available time to explore anything beyond the patient's disease and main complaint were mostly the factors that influence their behaviour. Furthermore, the interview data suggested that the personality of the doctor constitutes a major factor in determining any inclination towards being patient-centred or not.

These findings are explored in more detail in Chapter 7 where the third step of the analysis process, namely the interpretation and discussion of the findings, is dealt with.

Chapter 7

DISCUSSION AND SYNTHESIS OF THE FINDINGS

7.1   INTRODUCTION

This study identified several factors that may assist curriculum developers and clinician teachers in understanding the various factors involved in the teaching and learning of patient-centredness in an undergraduate medical curriculum. What emerged from the data was that some of these factors seem to be in conflict with others in the process of such teaching and learning.

Chapters 5 and 6 addressed the first and second level of analysis according to Miles and Huberman's ladder of analytical abstraction (Miles & Huberman, 1994), while in this chapter the findings of the study are discussed at the third level of synthesis. The discussion is offered according to the themes of the interview findings which revolve around the elements of Fishbein's Integrative Model of Behaviour (Fishbein, 2000). Following the discussion of the findings, conclusions are presented in Chapter 8 to build an explanatory framework that addresses the research questions of the study.

In order to understand the various findings and discussion, this chapter starts with a brief summary of the findings of the various data sets as presented in the previous chapters (theoretical perspectives in Chapter 2, and empirical data in Chapters 5 and 6), emphasising the links that exist between these chapters. Throughout the discussion theoretical perspectives (Chapter 2) are used to support or explain the findings.

7.2   SUMMARY OF FINDINGS OF THE VARIOUS DATA SETS

7.2.1   Findings from MB,ChB study guides

The study guides of the MB,ChB programme were scrutinised for words related to the term 'patient-centredness' in order to determine the number of times reference is made to this term in the outcomes, activities and assessment of the various modules. This exercise provided the 'intended' curriculum (Kelly, 2009) with regard to patient-centredness. The details of these

findings from the Word search were presented in Chapter 3 as contextual data, but a reminder of the essence of these findings is given below.

It was evident that the majority of the modules/domains in the MB,ChB programme did not include any outcomes focused on patient-centredness or related terms. The few study guides that did mention these terms did it only a few times and even out of context at times. The only theoretical module that had several outcomes related to patient-centredness was the Health and Disease in Communities module, while the clinical domain of Family Medicine, Community Health and Rehabilitation had plenty of references throughout the early, middle and late clinical rotations. With regard to assessment it was again only Family Medicine, Community Health and Rehabilitation and the study guides of the Rural Clinical School that clearly indicated how the assessment of learning should include components of patient-centredness.

7.2.2   Findings from student interview data

Focus group interviews with final-year medical students provided rich information of students' learning experiences throughout their training period. These students were in a position to reflect on how they learned (or failed to learn) about patient-centredness.

The six elements in the IM of Fishbein (2000) were utilised as an analytical framework to categorise the interview data of the students deductively into certain themes. Throughout the analysis process (see Figure 4.4) care was taken to record any data which did not fit these themes separately. In this way, a seventh theme, 'assessment', was added to the framework. Within each theme categories were then formed inductively. The framework that emerged from the student interview data (Chapter 5), which represents the so-called 'received curriculum' (Kelly, 2009), was then used deductively to analyse data from the clinician teachers' interviews (Chapter 6) representing the 'taught curriculum' (Kelly, 2009).

In the rest of the chapter the terms 'doctor', 'clinician teacher' and 'lecturer' are used interchangeably at times, since the doctor who works with the patients is often the same person that teaches the students.

7.2.3　Findings from observational data and data from interviews with clinician teachers

Observation of clinician teaching sessions was done in order to better understand the context of the clinical learning and at the same time get a clearer picture of the 'case' that was being studied. After these observation encounters individual interviews were conducted with the respective clinician teachers in order to clarify and understand the observed actions.

To put the findings from the observations of and interviews with the five clinician teachers who were part of the study into perspective, it needs to be pointed out that they represented five different specialities in medicine (see 4.6.1). Only one of these was a family physician whose comments about patient-centredness in the interview displayed an in-depth understanding of this term. This was hardly surprising, since Family Medicine is the discipline where patient-centredness originated (see 2A.2.1) and much emphasis is put on this aspect in the training of their specialists.

As part of the clinician teacher data set, there was only one observation encounter for each, so this component of the data was merely used to verify and enrich the interview data. Another advantage of the observation data was the insight it provided into the complex clinical environment where clinician teachers both teach and work, and where students are trained. The interview data of the clinician teachers were analysed deductively against the findings from the student interview data. Next the findings of both the students and clinician teachers' datasets are discussed, bearing in mind that the sequence in which it is done is not an indication of the importance of the various factors.

7.3　FINDINGS ON FACTORS INFLUENCING THE TEACHING AND LEARNING OF PATIENT-CENTREDNESS

7.3.1　Factor one: Attitudes (see 5.3.1 and Table 6.2.1)

The term 'attitude' in this study refers to the belief students or clinician teachers hold about the consequences of being patient-centred (see 2A.2.2). The data revealed four categories as part of this factor and the discussion will thus deal with these categories. Overall, the findings indicated positive attitudes from both students and clinician teachers towards patient-centredness, with both acknowledging the benefits this approach can have for patients.

7.3.1.1 *The patient is seen as a whole person (see 5.3.1.1 and Table 6.2.1.1)*

The study indicated that both the students and the clinician teachers agreed that patient-centredness can assist them in seeing the patient as a whole person and not merely as a disease that needs to be cured. The benefits of a patient-centred approach on the outcomes of patient care have been well documented in the literature (see 2A.2.2). A challenge the students referred to with regard to getting to know their patients holistically as 'persons', was that they often only saw them once. Furthermore, the high workload and focus on disease did not provide time for much more communication with patients than greetings and short explanations of what was going to happen next. A student from the LIC, which represents a different teaching-learning environment, indicated that it was rewarding to be able to get to know patients and build relationships with them over time.

The challenge of not getting to know their patients seemed to bother the students more than it bothered the clinician teachers, because none of the teachers made reference to this matter. This could be due to two reasons. One could be that the clinician teachers who have been working in the system for a long time have become used to not really knowing their patients and this did not bother them any longer. Studies have shown that doctors tend to become more cynical and even burnt-out when they work for too long in conditions where they are overworked and stressed (Burks & Kobus, 2012b; Chen et al., 2007). A second reason could be that the doctors have the opportunity to get to know their patients better than their students do. An example here is the situation with one of the clinician teachers in the study (the surgeon) who knew the patients better than the students because she saw the same patient in the clinic, then did the informed consent process before the operation, performed the operation and finally did follow-up management in the ward. The implementation of LICs has proved to increase medical students' attitudes towards patient-centredness since it can provide students with the opportunity to see patients for longer times, follow them up and get to know them better (see 2C.2.2).

7.3.1.2 *Personal satisfaction for doctors and patients (see 5.3.1.2 and Table 6.2.1.2)*

The benefits that a patient-centred approach can have for doctors are less well described in the literature than the benefits it can have for patients. Job satisfaction (Stewart, 2003) and fewer malpractice lawsuits are benefits that have been recorded (Hudon et al., 2011; Levinson et al.,

1997). The findings show that it was only one student who was placed in the LIC that commented about work satisfaction for doctors as follows:

"I don't know which it is, the chicken or the egg, about the patient centredness and the enjoyment they find in their jobs. I don't know if they enjoy their job, that's why they are patient-centred, or they are patient centred and that's why they enjoy their job." (Gr6F2)

The overarching impression expressed by the students was that the doctors get burnout because of difficult working conditions. This confirms the body of literature on the relationship between doctors that do not have empathy (which is a component of patient-centredness) and the incidence of burnout (Brazeau, Schroeder, Rovi & Boyd, 2010; Dunn, Iglewicz & Moutier, 2008). The fact that senior medical students develop negative attitudes towards patient-centredness could be ascribed to their exposure to these burnt-out 'role models' they work with in the clinical environment.

The student interview findings as well as the findings from the data generated from clinician teachers indicated that patients seem to be more satisfied when they receive patient-centred care. Due to variables such as culture, educational level and the severity of a disease (see 2A.5), all patients do not want a similar patient-centred approach. Doctors and students thus need to be aware that all patients cannot be approached in the same manner, an aspect which is discussed further in the sections below about information sharing and the doctor-patient relationship.

7.3.1.3 *Involving the patient in the information and decision-making process (see 5.3.1.3 and Table 6.2.1.3)*

It was evident from the study that both the students and the clinician teachers displayed positive attitudes towards sharing information with patients since they felt that patients who understood their disease and take responsibility for it will have better outcomes (2A.2.2). It appeared as if the issue of sharing of information with patients was considered as one of the most important components of patient-centredness by the students as well as the clinician teachers. However, in most of the examples it appeared as if information sharing took place as a one-dimensional act where patients did not participate or ask questions to confirm understanding, as one student clearly confirmed:

"Some patients like it when the doctor just does. They say the doctor should know …" (Gr8F2)

Clinician teachers that were interviewed did not seem to be concerned about the passivity of the patients, again something they may have become used to. This reluctance of patients to be part of the conversation, understand their condition and become involved in their treatment plan could be due to various factors. Simply giving the patient information is insufficient; from a patient-centred perspective there are factors that need to be considered such as whether the patient is ready to receive the information (De Haes, 2006) and afterwards whether he/she has understood the doctor, or has any questions. There are also some factors that inhibit patients to take part in the doctor-patient interaction and cause them to prefer a doctor-centred approach, such as patients that have less education, those that have a worse prognosis (De Haes, 2006) and those that are from lower socio-economic backgrounds (Willems, De Maesschalck, Deveugele, Derese & De Maeseneer, 2005). For instance, the surgeon confirmed that her very sick cancer patients often prefer her to make the decisions:

"Some patients with severe cancers would rather not take ownership of their disease. They feel comfortable for me to make the decisions and they say it is all too much for them. They prefer it that way."(Clinician)

Regardless of the reasons why patients are passive in the doctor-patient interaction, without good communication skills training (see 2C.2.1) a paternalistic approach, which is still prevalent in the clinical areas, can be reinforced (see 2A.4).

Interestingly, while students were frustrated with some patients who did not want to be involved in their treatment plan, they also did not know how to handle situations where patients were knowledgeable about their disease. One student commented as follows:

"The patient was very intelligent, did her own research on Google, and could tell the doctor better, ended up making not a good decision and never followed up again. She was diagnosed with cancer, went on the belief that radiotherapy and chemotherapy is not going to work, they will go the alternative, natural route, so, I don't know where she is now ..." (Gr5F2)

Patients often do not do things exactly as the doctor advises them to do, and in such cases the students may assume that the patient will take wrong decisions. Since patients differ, and do not have the same needs with regard to information and decision-making, one may conclude that student doctors should learn to listen to the agendas of patients in order to find the right balance in the decision-making process (Bensing, 2000).

7.3.1.4   The role of the doctor in the doctor-patient relationship (see 5.3.1.4 and Table 6.2.1.4)

Seeing the patient holistically is a very important component of the doctor-patient relationship, since it is within this relationship that crucial information is exchanged and treatment-related decisions have to be made (Mead & Bower, 2000b; Ong et al., 1995). It is also in this relationship that doctors can either utilise the opportunity to share power or, alternatively, choose to be paternalistic despite patients' preferences (see 2A.4). Recognising the fact that the doctor-patient relationship is not a one-size-fits-all concept (Lussier & Richard, 2008), students may well be taught the ability to adapt their approach to suit the patient's needs, the urgency of the problem and the context. From the data it became evident that paternalistic views were still present amongst both the students and the clinician teachers. To assist students in viewing the role of the doctor and the patient differently from the way they are used to, 'disorienting dilemmas' may be created for students and they could be used as discussion points to stimulate reflection and in adopting alternative perspectives (Cranton, 2006).

In summary: It is evident from the data that students generally value the concept of patient-centredness and believe that this is how medicine should be practised. Both students and clinician teachers agreed that a patient-centred approach is important since the needs of the patient and the needs of the doctor often differ. The students seemed to have good intentions to be patient-centred, yet the way in which they behaved when they were in the clinical area contradicted their expressed beliefs. With regard to the clinician teachers, they were less positive, but generally agreed that the principle of patient-centredness is good for patients. The realities of the work environment have also caused them to argue for various reasons why patient-centredness is difficult to implement. The discussion that follows aims to explain the reasons why teaching and learning behaviours are often negative despite fairly positive attitudes.

7.3.2   Factor two: Subjective norms

Subjective norms in the context of this study arise from those values and assumptions that underpin a student's belief that the clinician teachers would approve or disapprove when patient-centred behaviour is demonstrated. Such norms are also related to the values held in terms of whether those same doctors should be or are willing to engage in patient-centred behaviour. A factor that was prominent in this theme and which has been documented as being

critical in terms of clinical learning is the hidden curriculum (Hafferty, 1998; Hafferty & Franks, 1994; Lempp & Seale, 2004; Wachtler & Troein, 2003), which forms part of the so-called learned curriculum (Kelly, 2009). From the data two prominent categories emerged which are discussed next.

7.3.2.1 *Pressures related to patient-centredness (see 5.3.2.1 and Table 6.2.2.1)*

Students reported in interviews that they were confused by the expectations the various departments/rotations had of them. This was particularly true for occasions where they had to communicate with patients and present patients for their assessments during the rotation. Some examples of humiliation occurred during patient presentations with students not knowing exactly what to do and then they included information that was, according to the doctor, irrelevant. According to one student, for example, a doctor remarked:

"That is stupid information; just tell me what is relevant." (Gr7F1)

This example highlights the impact of the hidden curriculum in the learning of patient-centredness, namely what students learn as they experience the difference between what is said and what is actually done (Skiles, 2005). When there is an agreed framework for communicating with patients across the various disciplines, students apparently find it easier to learn and clinician teachers find it easier to teach and assess skills related to patient-centredness (Rider et al., 2006).

The Family Medicine department was mentioned by many students as the department that consistently taught them about patient-centredness, including communication skills and how to apply them. However, it seemed as if there was a vast gap between what they were taught in theory and what was actually happening in clinical practice. The complexity of some of the patients that they had to see in the clinical areas left the students in distress, not knowing how they should be handling the perceived complex social circumstances. A strong theme that emerged in the interviews was that there was insufficient time available to practise patient-centredness and that it was rarely being practised by the clinicians – even in the primary health settings. This could be due to two reasons: it is possible that patient-centred practice is absent in clinical areas due to too little time (as the students suggested), or that students were looking for textbook definitions of patient-centredness and therefore did not recognise the applied and

contextualised patient-centred practices that they were observing. The next section addresses the issue of observing what the doctors do in the clinical areas.

7.3.2.2   *The influence of role models (see 5.3.2.2 and Table 6.2.2.2)*

Much has been written about role modelling of doctors (Passi et al., 2013; Weissmann et al., 2006), and in this study much of the data support earlier research on role modelling. The doctors in the study could recall how they had learned through role modelling and they said that they were now aware that the students were watching what they were doing. However, the doctors also admitted that they do not usually demonstrate overt behaviour, with the result that it is not quite clear what exactly the students have learned. One doctor has put it this way:

"I do not think it (role modelling) is ever expressed overtly and it was never explained to me either."

From the findings it was evident that both doctors and students felt uncertain about what constitutes a good role model. They seemed to choose their role models on the basis of aspects such as personality matches, or the most influential doctor, or the one with the most knowledge. It would seem as if students tend to imitate role models without critical reflection of the doctors' behaviour towards patients. It has been suggested that students can often learn knowledge, skills and attitudes by observing others performing tasks, (Schunk, 1996), but the following quote from one student illustrates that students find modelling on doctors' behaviour quite challenging:

"It is very personality dependent on who you're going to choose as your role model; someone else might think those characteristics are totally weak or lame." (Gr3F2)

For role modelling to be a consistent and reliable component of teaching and learning in an undergraduate medical curriculum, it requires the demonstration of skills, provision of feedback to students and prompts for imitation of behaviours such as patient-centredness. However, if role modelling is merely encouraging students' unselective and uncritical imitation of doctors' behaviours, its benefits should be weighed up against its potential harms (Benbassat, 2014; Cruess et al., 2008). It appears that for the learning of patient-centredness more than role modelling is required as issues such as incentives (in this case assessment), perceived need and social pressures have to be considered. What also became obvious from the data was that role modelling in itself may not be sufficient to explain the teaching and learning of patient-

centredness (see 2B.4.4). For instance, social cognitive learning theory acknowledges that at least five processes are needed for effective learning, namely a clear objective, modelling (demonstration), task-relevant knowledge, guided practice with feedback and opportunities to reflect on learning (Kaufman & Mann, 2010). It was unclear whether the doctors who participated in the study realised the value of the use or integration of such processes.

Another finding from the data related to role modelling was the perceived relationship between student-centredness and patient-centredness. Several participants indicated that doctors who supervise students need to be both student- and patient-centred. A study by Bombeke et al. (2010) indicated, for instance, that in order to support students as they develop professionally, a relational position with their supervisors is preferred and that students want to be treated as persons. This finding mirrors the similarities between being student-centred and being patient-centred, and in the learning of patient-centredness it seems important to take note of these similarities.

7.3.3   Factor three: Self-efficacy

Self-efficacy is about the belief an individual has in his/her ability to achieve particular goals and objectives or to demonstrate desired behaviours (Bandura, 1996). In the context of this study it refers to the belief a student has about his/her ability to demonstrate patient-centred behaviour. Two categories emerged from the data as being related to self-efficacy and they are discussed next.

7.3.3.1   Past experiences with patient-centred behaviour (see 5.3.3.1 and Table 6.2.3.1)

Not much of the student data pointed to evidence of a high sense of self-efficacy. Much evidence rather suggested that the circumstances students work under in the clinical areas make it too difficult to be patient-centred (see 7.3.6). Students that were placed in the LIC provided most of the evidence of high self-efficacy, but taking into account the small sample from the LIC, firm findings did not emerge. It may still be useful to note that LIC students indicated that they felt sufficiently confident to behave in a patient-centred manner, regardless of where they would be placed next. To quote one example:

"I'm so glad I learnt it (patient-centredness) so that even if I go back into a setting like Tygerberg, I can still use it there, or it should still at least be my approach to still be patient-centred and not just focus on biological functioning." (Gr6M1)

Self-efficacy is achieved by enactive mastery experiences, vicarious experiences, verbal persuasion, physiological states and psychological states (Bandura, 1997). According to Young, Schumacher, Moreno, Brown, Sigrest, McIntosh, Schumacher, Kelly and Cox (2012), the following three practices will assist in building self-efficacy of patient-centredness: (1) observing role models performing the behaviour, (2) having opportunities to practise, and (3) receiving feedback on one's performance. Student interview data pointed to all three of these aspects during the interviews. Firstly, the students were strongly influenced by the doctors in the clinical areas:

"Even if you are not actively being aware of what you are exposed to, you are taking it in somehow, and that becomes ingrained in you. You get used to the doctor that is doing it, so I'm going to do that." (Gr2F1)

The strongest factor in building self-efficacy seems to be 'enactive mastery experiences'. Students should therefore be provided with opportunities to practise by applying their knowledge and skills within various demanding situations (Van Dinther et al., 2011). The literature suggests that individuals who have a high sense of self-efficacy are more likely to display the behaviour they intend to perform (Parle, Maguire & Heaven, 1997).

Secondly, the students felt it was important to be given opportunities to practise with patients so that they can gain confidence in patient-centredness:

"You've been taught it (patient-centredness), and you learn to appreciate the value of it, then you think it's something good to implement. But if you don't know or if you haven't experienced yourself how it can benefit someone, then you might be less inclined to do it." (Gr6F1)

However, it appeared as if the students hardly ever received feedback from the doctors regarding their interaction with patients:

"Often doctors will ask us, 'Okay, show me how you examined this or that on your patient,' or 'Show me how you elicited this from your patient,' but no one has ever asked me, 'Show me how you explain your management plan to your patient.'" (Gr2F3)

The data indicated that all three aspects seem to be problematic in the Stellenbosch MB,ChB setting where students are exposed to role models that focus on biomedicine and do not practise patient-centredness; do not get opportunities to practise patient-centredness, and do not receive constructive feedback on the interaction and communication they have with patients. Therefore, due to an absence of most of the aspects that are supposed to build students' self-efficacy, one may conclude that the students in the study did not believe that they could be patient-centred.

7.3.3.2 *Perceived difficulty of being patient-centred (see 5.3.3.2 and Table 6.2.3.2)*

Data from both students and lecturers suggested that the application of patient-centredness in busy clinical environments was a huge challenge. Overall, the students indicated that although they believed in a patient-centred approach as they were taught in class, they did not see doctors making use of it in these complex settings and therefore did not know how to apply it themselves. The reasons they gave were that there are simply too many patients, there is too little time, and patients have too many problems (both biomedical and social or socio-economic in nature) that need attention.

Self-efficacy has emerged as an important aspect of how students learn in higher education; it is also emphasised in the reviewed literature on the factors that influence the self-efficacy of students (see2B.4.4).

7.3.4   Factor four: Background factors

The Fishbein model suggests that background factors can have a significant influence on behaviour. In this section the findings related to patient-centredness are discussed. These findings are related to demographic variables such as gender and age, and other variables pertinent to culture, personality, personal experience and exposure to media and social pressure. The students and clinician teachers in the study had strong opinions with regard to some of the background factors and how these can influence students in being patient-centred or not.

The students and doctors regarded age as a factor that could have an influence on the inclination to be patient-centred. Students pointed out that medical students who were older when they started the course were more mature than the others who had just left school (see 5.3.4.1). Students were also of the opinion that senior doctors were more patient-centred than the younger ones, but acknowledged that it was possibly due to other factors such as more workload

and personal stress that the younger doctors had to cope with rather than the age factor (see 5.3.4.1). Some doctors suggested that the older doctors had learned to be more self-confident and more tolerant with patients, but these qualities may not necessarily make them patient-centred (see 6.2.4). In addition, some of the consulted literature indicates that communication skills deteriorate if no follow-up training is attended; therefore highlighting the point that older doctors might be less patient-centred (Levinson, 2011). It is also suggested that increased experience does not automatically improve communication skills (Rotthoff, Baehring, David, Bartnick, Linde, Willers, Schäfer & Scherbaum, 2011). Altogether, no clear findings with regard to age could be reported from the relevant datasets.

There was mixed evidence from participant doctors and students on whether gender makes a difference in being patient-centred. Quite a substantial amount of research, however, has been done in this respect (Roter & Hall, 2004; Verdonk, Harting & Lagro-Janssen, 2007); it shows that women are more empathetic than men (Quince et al., 2011) and that female doctors provide more psychosocial counselling and preventive services than male doctors. While the patients of female doctors are more satisfied, they make more medical visits and thus have higher total annual medical charges (Bertakis, 2009). In the end the interview data in this study did not indicate clearly that gender does indeed make a difference to being patient-centred, as all the participating students had experienced both good and bad practices from male and female role models and fellow students.

Culture was briefly mentioned by some student interviewees with some of them recognising that all individuals are from different backgrounds and upbringing and they would therefore not all behave in the same manner. The literature shows that culture and ethnicity can have an influence on doctors' patient-centredness, with doctors behaving less affectively when interacting with ethnic minority patients (Schouten & Meeuwesen, 2006). The fact that none of the students mentioned anything about ethnicity and prejudice against particular ethnic groups could be due to the sensitive nature of these types of conversations in the current South African political context. It is also possible that students and doctors had opinions about this issue but were too hesitant to voice them.

The variable that was mentioned by almost all individuals and groups was the personality of the doctor. The majority of the interviewees were of the opinion that some people cannot communicate well and that they will not change, while for others it is simply easier to talk to patients. To quote one example:

"I think the real barrier is the doctors themselves. I think it has a lot to do with their personality and what they are willing to do for their patients." (Gr6M2)

As far as I could determine, no studies have yet been conducted on the relationship between personality and patient-centredness, and Fishbein's model regards personality as only having a marginal and an indirect impact on behaviour. One of the reasons that personality emerged as such a strong factor in this study is probably because most of the doctors who work in the clinical areas did not have formal communication skills training as part of their studies. The same is also true for the undergraduate medical students who were part of the study since no communication skills training is included on a longitudinal basis in their curriculum. One implication of doctors and medical students lacking good communication skills training is that those individuals that have more 'sociable' personalities may stand out as being 'patient-centred', while patient-centred communication skills can actually be taught to any doctor (Gordon, 2003; Kurtz et al., 2005).

In terms of the role of personality one may also argue that student selection may enhance the learning of patient-centredness and that doctor-patient communication could consequently be easier. Some universities have already started to make use of personality testing as part of their selection criteria (Magalhães, Costa & Costa, 2012) and there are studies that suggest some correlations between empathy and personality (Costa, Alves, Neto, Marvao, Portela & Costa, 2014). The students in this study also suggested some form of psychometric testing for admission to medical school (see 5.3.4.3), while others felt that as the scope of medicine is so broad and the options for specialisation are so varied, it would not be fair to select only a certain type of personality for a medical programme (see 5.3.4.3). The personality type who chooses to go into a certain specialisation area is a field that has been researched quite extensively (Borges & Savickas, 2002; Ferguson, James & Madeley, 2002), but since the focus of this study is undergraduate medical education, such details related to student selection may not be relevant.

Personal experience with certain diseases and how that could influence one to be more patient-centred was only mentioned by a few of the students (see 5.3.4.4) and one of the doctors (see 6.2.4.4) as a possible factor. While it makes sense that students or doctors who have been exposed to disease and perhaps experienced loss on a personal level will be more sensitive to other people in need, not much evidence emerged on this topic. A study that was conducted with medical students about their attitudes towards mental disease showed that once they had

had personal experience with mental diseases they were more positive towards such patients (Roth, Antony, Kerr & Downie, 2000). The tendency of health professionals to empathise with others that have shared the same experience has been described as the 'wounded healer' effect (Zerubavel & Wright, 2012). Obviously, personal experiences as a requirement for entrance into a medical programme may not be viable, but some institutions have incorporated innovative personal experiences of students into their selection processes. Such an approach could include students describing and sharing their illness experiences (DasGupta & Charon, 2004), the hospitalisation of students and the shadowing of patients (Hojat, 2009).

The last variable that was mentioned was whether exposure to media and social pressure has an influence on patient-centredness. Students were of the opinion that such exposure and pressures do have an influence. They also believed that some of them (the students) had enrolled for medical studies without knowing what it was really about (see 5.3.4.5). Some students indicated that they were influenced by TV programmes such as 'Grey's Anatomy' which romanticises medicine, while for others the status and respect that society gives doctors was appealing (see 5.3.4.5). The literature mentions a few aspects that could be related to the reasons for students having certain perceptions of the medical profession, including prototypical characters in the media, stereotypes, and students' role models (Draper & Louw, 2007), thereby confirming the students' perspective.

In summary: It may be fair to agree with Prideaux and colleagues that selection criteria for entrance into a medical programme cannot satisfy all of the factors required for being or becoming patient-centred (Prideaux, Roberts, Eva, Centeno, Mccrorie, Mcmanus, Patterson, Powis, Tekian & Wilkinson, 2011). Only long-term studies in various contexts may be able to prove whether 'nature' or 'nurture' wins the debate, but in the meantime it seems important that humanistic qualities, together with patient-centred communication skills, need to be fostered among medical students (Gordon, 2003).

7.3.5   Factor five: Skills and knowledge

Barnett and Coate (2005) argue that in order to prepare graduates for future work, curricula need to be designed around the dimensions of knowing, acting and being. While knowledge is thus essential in medical curricula, it is of little help when it is not about 'knowing'. Skills, again, need to be informed by knowledge, with both of these factors being components of a competence (Frank et al., 2010); therefore these two factors will not be discussed.

7.3.5.1   Theoretical knowledge (5.3.5.1 and Table 6.2.5.1)

Participant students in this study had good knowledge of what the term *patient-centredness* means, but it became clear that they did not know how to apply it (see 5.3.5). Students were also able to articulate their understanding of patient-centredness better than the clinician teachers – probably because they had done their Family Medicine rotations more recently. In contrast, the participant clinician teachers (except for the Family Physician) were quite vague when it came to the discussion of what patient-centredness was and it seemed as if they have not thought about this issue for a long time (see 6.2.1). The following extract from a study guide confirms how the term *patient-centredness* is used without explanation – and probably misinterpreted:

 "Theoretical blocks are student-centred, practical blocks are patient-centred."

It also needs to be mentioned that nowhere else in this specific study guide were any further references to patient-centred teaching, learning or assessment.

One of the clinician teachers was convinced that patient-centredness can be taught in a classroom setting, while another one pointed out that after it was taught in the class the challenge of applying it at the bedside is a reality:

"Patient-centredness is easy to write on a piece of paper, but it's really taught at the bedside. You can read it and understand it, but if you can't apply it at the bedside, it means nothing. So, I think there is this dissociation between what we are teaching students at the bedside and what they are reading."

With regard to the theory the students have been exposed to in the curriculum, the students were confused with regard to the framework they had been taught in following a patient-centred approach (see 2A.2.3). Some referred to the three-stage assessment (Fehrsen & Henbest, 1993), some to the International Classification of Functioning, Disability and Health (WHO, 2016) and others to the biopsychosocial approach (Engel, 1989). It was clear from the data that the students and some of the doctors believed that to be patient-centred one needed to 'tick certain boxes' (see 5.3.2.1), and if all were not ticked, one would fail the 'test' of being patient-centred. The statement by one clinician teacher: "*You cannot do it on every patient*" confirms this notion that patient-centredness needs to entail a long list of actions (see 6.2.5.1). Taking into account that patient-centredness is a broad concept with comprehensive definitions and approaches, it

seems important to simplify it for the students. Some authors have managed to describe the essence of it as a focus on the whole patient with his/her feelings, as well as a shift away from the doctor controlling the doctor-patient relationship (Stewart, 2003). The data suggest that while students are to be made aware of patient-centredness, it may not be possible or appropriate to practise the 'textbook' version of patient-centredness all of the time.

7.3.5.2   *Relevant skills required (5.3.5.2 and Table 6.2.5.2)*

With regard to the skills component, the student data indicated that the students lacked certain communication skills such as the ability to explain difficult concepts to patients and how to handle patients from various backgrounds (see 5.3.5.2). They also suggested that they did not formally learn the skills of patient-centredness in the curriculum. To illustrate:

"Patient-centredness is a skill that you learn, and it wasn't a class that taught us that. It's the past, since third year being in hospital. You kind of orientate yourself to the patient." (Gr8M1)

The patients that the students were seeing in the clinical areas often represented complex cases who presented with many medical and social problems. The students seemed to be overwhelmed by the extent of these problems and had various ways of coping with them (see 5.3.3.2 and 5.3.5.2). It was evident, however, that they did not have the skills to apply clinical empathy (Hojat, Gonella, Nasca et al., 2002) or the ability to understand the patients' inner experiences and to communicate such an understanding (see 5.3.5.1). The literature clearly indicates that too high levels of empathy, feelings of being overwhelmed and not being able to assist patients can cause doctors to experience burnout (Burks & Kobus, 2012). However, while the effect of too high levels of empathy and burnout is not the focus of this study, it remains a prominent component of patient-centredness and is thus important to mention. Doctors and medical students that maintain proper self-care and are content in themselves can, apparently, deliver better patient-centred care (Burks & Kobus, 2012).

7.3.6   Factor six: Environment

The environment factor relates to issues such as health systems and human resources. While these are not issues that can be resolved easily, they are critical since medical training cannot be separated from its systemic issues (Frenk et al., 2010). In the short term however, systemic challenges are not going to disappear and it seems important that medical graduates learn to function in such circumstances and learn to be patient-centred despite unfavourable

environments. Three sets of findings emerged from the data, namely time and stress, the context of specialisation, and limited resources and system failures. These sets are discussed in the subsections that follow.

7.3.6.1 *Limited time and work stress (5.3.6.1 and Table 6.2.6.1)*

Several comments highlighted the realities of the clinical environment with regard to too little time, too few doctors and too many patients (section 5.3.6 and Table 6.2.6). One participant commented as follows:

"*I mean, if the single doctor needs to see 60 patients in eight hours, I mean you only have 10 minutes for a patient.*" (Gr6M1)

The effect of one doctor having to see many patients is twofold: firstly, there is not time for long consultations and secondly there is usually not time left for dedicated teaching of the medical students. The situation in the South African context is probably worse than in many places elsewhere in the world where most of the literature on the training of medical students is generated. Yet, even more well-resourced environments have identified too little time for the teaching of students (Burns, Beauchesne, Ryan-Krause & Sawin, 2006; Spencer, 2003).

The positive spin-off of having numerous patients in the clinical areas is, however, the multiple opportunities students have to practise and actually learn from and with patients. The fact that patient-centredness is often learned with little patient involvement in some countries has been criticised (Bleakley & Bligh, 2008), but at most South African medical training facilities adequate patient resources are available. Related to the issue of involving patients, a suggestion that came from one of the clinician teachers was that supervision and patient care should not be separated (see 6.2.6.1). By combining these activities one can actually save time and allow students to work with a clinician who provides them with feedback on how they interact with patients.

Bearing in mind that the 'too little time' issue may not easily be changed, one student pointed out that knowing the patient will actually save the doctor some time (see 5.3.1.1 and 5.3.6.1). When doctors or students do not know the patient they are more pressed for time and the inclination is to revert to a biomedical position. The literature supports this notion of time saving in the long run, by indicating that patient-centredness does not take more time of the doctor

(Epstein et al., 2010) but patients may return fewer times to the doctor if he/she can deal with their real problems during consultations.

7.3.6.2   Context of clinical practice (5.3.6.2 and Table 6.2.6.2)

With regard to the different specialities in medicine and the potential influence that each specific environment may have on being patient-centred, the students and clinician teachers were of the opinion that in some areas in medicine it is easier to be patient-centred than in others (see 5.3.6.2). Examples that were mentioned were the chronic renal ward in the tertiary setting that is an environment where patients are cared for in a more holistic manner and where the doctors generally get to know the patients (see 6.2.6.2). The primary healthcare setting was also identified as an area where doctors often get to know their patients and therefore they are more patient-centred (see 5.3.6.2). The commonality between these areas seems to be the fact that relationships are established between the doctors and the patients, highlighting the fact that longitudinal placements can be done successfully in both out-of-hospital and tertiary hospital settings (see 2C.2.2).

While getting to know patients seemed to be a positive experience for the students, they were also aware of and reluctant to experience the consequences when patients die (see 5.3.6.2). This finding highlights the need for students to engage with patients, but also to be prepared for the reality that such engagement may end at some stage.

7.3.6.3   Limited resources and system failures (5.3.6.3 and Table 6.2.6.3)

An issue which apparently causes much frustration is that the clinical areas often do not have sufficient equipment and disposables. The frustrations that students and clinician teachers experienced in this respect (see 5.3.6.3) often caused them to be impatient with patients. It is important to acknowledge, however, that the clinical environment, with all its shortcomings, will be the work environment that the students will be faced with, and the curriculum will have to equip them with a high sense of self-efficacy (see 7.3.3) in order to be patient-centred despite adverse conditions. For students to be able to learn in the clinical environments where they are placed the service pressure should not be too high and both students and clinician teachers should be provided with a clear and realistic understanding of the outcomes that the students are expected to achieve (Gordon, Hazlett, Ten Cate, Mann, Kilminster, Prince, O'Driscoll, Snell & Newble, 2000).

7.3.7   Factor seven: Assessment

The role of assessment was not included in the IM developed by Fishbein, but students referred to this as a factor that has a distinct influence on how seriously they would regard patient-centredness as part of the curriculum (see 5.4.1). Students indicated that there is a clear message in the hidden curriculum for patient-centredness to be unimportant in the clinical areas. One element of proof for this is that almost no assessments for patient-centredness exist. The fact that patient-centredness is only assessed in two disciplines (Family Medicine and Psychiatry) the students only pay attention to this topic when they work in those rotations (see 5.3.3.1 and 5.4.1). They suggested that assessment of patient-centredness be added to all rotations, no matter what the specialisation is (see 5.4.1).

The way in which patient-centredness was assessed by some departments resulted caused the students to believe that it was probably not going to mean much to them in the long run. One student verbalised it in this manner:

"They should ask us how we could incorporate patient-centredness rather than telling us to regurgitate, whatever you think we should do, and maybe we would sustain it better." (Gr32)

From the student data and this statement in particular it would seem as if the students were not offered opportunities to incorporate their theoretical knowledge into their practices and that the assessments are thus without any application (see 5.3.5.2). This refers to the notion of knowledge versus knowing and that students are not able to use their knowledge in a meaningful or applicable manner (Barnett, 2009).

The impact of assessment on student learning is powerful and in some circles assessment is considered as the fastest way to change and enhance student learning (Cilliers et al., 2010; Norcini & Burch, 2007). With regard to the assessment of a competence such as patient-centredness, the observation of students (to see their performed or demonstrated behaviour), in conjunction with interviews (to understand why they have performed a certain action in a certain manner) seems to be effective (Rees & Knight, 2007). However, in order for assessment to have an impact on student learning, consequences may be needed – either in terms of their marks or how others view them as being competent or not. As the degree of impact strongly correlates with the severity of the consequences, adding only 5% (the ward mark) for patient-centredness has a weak impact (Cilliers et al., 2010; Cilliers et al., 2012). How to use assessment

in the best possible way to enhance patient-centred teaching and learning thus did not emerge from the data.

7.4   CONCLUSION

This chapter dealt with level three of the analytical ladder (Diagram 4.4) as it was set out for this study. Overall, the findings from the different sets of data suggest that students do not appear to learn effectively about patient-centredness in a structured manner in the current MB,ChB curriculum at Stellenbosch University. There are many possible reasons for this position, but the most prominent barriers seem to include the following: a strong current focus on biomedicine and doctor-centred attitudes that are carried over from one generation of doctors to the next; the powerful impact of the hidden curriculum (that is vastly different among the various departments); students' lack of self-efficacy, which may be the result of too few opportunities to see patient-centredness in action; and lastly, a lack of opportunities to practise patient-centredness with feedback and spaces in the curriculum for reflection. Non-assessment of patient-centredness also seems to be a major factor, since it sends the message that students do not have to pay serious attention to this component of medicine.

The final chapter of this dissertation provides an explanatory framework (level three of the analytic ladder) that brings together the findings of the study. The conclusions are drawn and the implications of the study are dealt with.

Chapter 8

CONCLUSIONS AND IMPLICATIONS

8.1   INTRODUCTION

In this final chapter of the dissertation a number of conclusions, based on the findings of the study, are drawn. As a reminder to the reader, the problem statement and research questions that guided the study are restated and the methodology used to address these questions is briefly explained. Next, a number of factual and conceptual conclusions are presented (Trafford & Leshem, 2012), followed by an adapted conceptual framework. The final part of the chapter discusses the implications and limitations of the study. Lastly, the potential contribution of the study to the field of medical education inquiry is highlighted.

8.2   SUMMARY OF THE STUDY PURPOSE, RESEARCH PROBLEM AND RESEARCH QUESTIONS

While medical schools and medical curriculum developers would probably agree that it would be ideal to deliver patient-centred medical graduates, it has been acknowledged that students are often less patient-centred when they graduate if compared to when they started their medical training (Bombeke et al., 2010; Tsimtsiou et al., 2007; Woloschuk et al., 2004). Reasons for the perceived decline in patient-centred attitudes and practices have been attributed to factors such as limited time, loss of idealism and the powerful impact of the hidden curriculum. However, little research on this issue has been conducted in South African medical schools. This study, which took the form of a programmatic case study within the undergraduate medical (MB,ChB) programme at Stellenbosch University (SU), and which followed after a pilot study on patient-centred attitudes (Archer et al., 2014), sought to answer the question whether, if at all, medical students at SU were learning patient-centredness. In order to answer this question, three subsidiary research questions were posed:

- What constitutes 'patient-centredness' in an undergraduate medical curriculum?

- What factors enhance or inhibit the learning of patient-centredness by undergraduate medical students?

- What learning opportunities for patient-centredness are created, or have failed to be created, by the clinician teachers involved in the teaching of undergraduate medical students?

8.3   METHODOLOGY

An explorative programmatic case study design, rooted in an interpretive knowledge paradigm, was considered most appropriate for addressing the research questions, as an in-depth understanding of the teaching and learning of patient-centredness within a specific programme context was sought (Yin, 2013). Within the boundaries of the chosen case, the use of qualitative data was deemed appropriate (De Vos et al., 2011) as final-year medical students and five of their lecturers participated in the study. Final-year students were considered information-rich participants since by the time of the interviews these students had almost completed their training and could take a post hoc perspective on their training and provide perspectives on how they experienced the learning of patient-centredness in the MB,ChB programme. The boundaries of the case are outlined in Chapter 3 of this dissertation.

A case study design calls for triangulation and thus the student participants attested to the *received curriculum* during interviews. The interviews by the student participants were followed by interviews with a purposively selected group of five clinician teachers based on the researcher's observations of five clinical teaching-learning incidences and which provided data on the *taught curriculum*. A document analysis of relevant study guides provided data on and affirmed the *intended curriculum*. The rationale for and selection of the sample groups for the data generation have been explained in detail in section 4.6.

With regard to the analysis of the data, the analytic ladder of Miles and Huberman (1994) was adapted for this study (see Diagram 4.1) which assisted with providing a more structured approach to the management of the various sources of data. When dealing with qualitative interview data, it can potentially become overwhelming; therefore, to assist with structure in the analysis process, the Integrative Behaviour Model (IM) (Fishbein, 2000) was used as an analytical framework. Although the factors included in the IM were found to be appropriate in categorising most of the findings, one factor was subsequently added, namely the role of learning assessment. It was important to arrive at an understanding of how students learn (or fail to learn) patient-centredness in the context of the SU medical curriculum, therefore the factors identified by Fishbein (with the addition of assessment) were taken into account.

However, the relationships among the various factors were found to be different from those provided in the original Fishbein model. This aspect is explained later in this chapter.

Based on the theoretical and empirical findings of the study, a number of factual and conceptual conclusions could be drawn, as discussed below.

8.4 FACTUAL CONCLUSIONS

In research, factual conclusions are based on evidence that emerged from the data; in this study a number of factors relevant to patient-centred teaching and learning were clearly confirmed. The conclusions are accounted for in terms of the IM framework that was used to interpret the data deductively.

8.4.1 Attitudes towards patient-centredness

The essence of patient-centredness is often interpreted as (1) a perspective change from a disease focus to a focus on the whole patient's feelings and experience, and (2) a shift from the doctor controlling the relationship, to communication and decision-making that involves patients (see 2A.2.3.3). From the findings of the study (see Chapter 7), it could be concluded that the participant students, towards the end of their medical education, held strong, positive attitudes towards a holistic view of patients, but less so in terms of the sharing of power in the doctor-patient relationship. Sharing information with patients and involving them in decision-making as part of the doctor-patient relationship seems a highly complex issue, since there are several factors from both the doctor's and the patient's perspective that influence student learning of patient-centredness (see 2A.4, 2A.5, 2A.6, 7.3.1.3, 7.3.1.4). The exposure of students to negative role models, doctors who are overworked and sometimes cynical (see 7.3.1.2), as well as the fact that students see some patients only once because of their practical placements (see 3.6.3), seem to hinder students in developing positive attitudes towards patient-centredness (see 2C.2.2, 2C.2.4).

The study also provided evidence suggesting that students, except for those placed in the longitudinal integrated clerkship (LIC), lack sufficient opportunities to get to know their patients and build relationships with them (see 7.3.1). The result is that students do not get enough time to communicate with the patients and thus tend to see them merely as a disease that they need to treat. It can therefore be concluded that if students were given the opportunity to build relationships with patients, they would be able to develop positive attitudes towards

their patients, their supervisors and ultimately themselves as doctors. Although the LIC was originally developed as a rural training concept, it became clear in this study that this model may be applied equally well in tertiary settings (see 2C.2.2).

In terms of students' and doctors' attitudes, findings from the study also indicated that the doctor-patient relationship is not a 'one-size-fits-all' concept (see 2A.4, 2A.5) and students need to be better assisted in developing flexibility and a repertoire of doctor-patient communication styles applicable to various situations. It can therefore be concluded that students can largely be assisted in interacting optimally with their patients if they are equipped with the skills to better judge the patients' circumstances and contexts, and if they are supported in acquiring the relevant communication skills.

8.4.2   Subjective norms (the hidden curriculum)

Subjective norms (the hidden curriculum) have proved to be important in how medical students learn patient-centredness (see 2C.2.1, 2C.2.3). It is no surprise that students reported that they found it to be confusing and stressful not to know how to interact with and approach patients in the various rotations (see 7.3.2). The empirical findings confirmed that biomedicine was still the focus of the teaching and learning programme and that was why the doctors sometimes frowned upon references to the biopsychosocial aspects of the patients (see 7.3.2). It can be concluded that an agreed upon framework, which includes communication skills training across all disciplines in the curriculum as well as modules from subjects in humanities, may offer better options for the improved teaching and learning of patient-centredness.

This study also confirmed that the structure and culture of the current clinical placements largely rely on ad hoc and opportunistic learning opportunities (see 7.3.2). Within this sphere, the powerful potential impact of role modelling has been highlighted. For role modelling to be useful, however, it has to be viewed as a sophisticated teaching tool and not simply the uncritical imitation of doctors' behaviours (see 2C.2.4). A logical conclusion, based on the doctors' roles as patient-centred practitioners, may be that doctors increasingly need to make their teaching actions and activities overt, and that they subsequently create opportunities for students to reflect critically on their role models as part of clinical learning.

Creating an environment that is both patient and student-centred is highly advisable since these two philosophies or approaches have various aspects in common. Students that are part of a student-centred learning environment are evidently more inclined to understand and practise

patient-centredness (see 7.3.2.2, 2C.2.5). One may thus conclude that creating caring relationships, and seeing both students and patients as real persons, are important elements of teaching and learning patient-centredness.

8.4.3   Self-efficacy

This study confirmed the importance of self-efficacy as part of medical students' competencies (see 2B.4.4). At the same time, however, there was also sufficient evidence from the empirical data to deduce that the students did not perceive themselves as capable of being patient-centred in the complex and time-pressured clinical environments where they were learning and working (see 7.3.3). If the enhancement of self-efficacy includes clear learning objectives, positive role modelling, provision of task-relevant knowledge and guided practice with feedback opportunities to reflect on learning (see 2B.4.4), it can be concluded that the training of SU medical students lack several of these components. They may thus have difficulty in building a sense of self-efficacy.

The empirical findings also suggested that students did not observe proper role-modelling of patient-centredness and neither did they receive feedback of their patient encounters with opportunities to reflect on their learning (see 7.3.2.2, 7.3.3). Keeping in mind that the most important component of building self-efficacy is to provide students with sufficient practical experience (see 2B.4.4), it would be fair to conclude that in order to promote patient-centredness, students should be exposed to sufficient patient-contact and practical experience thereof. The current problem seems that students often work unsupervised with no feedback and a clear focus on biomedicine (see 7.3.2, 7.3.3).

Some findings from the data however also indicated that where students were placed at the LIC, they experienced being more patient-centred, regardless of where they ended up working (see 7.3.3). This confirms the potential value of longitudinal placements for the development of self-efficacy (see 2C.2.2). Finally, it may be concluded that when proper role modelling and feedback on learning are combined with ample opportunities for practical experiences, students may be assisted in developing their sense of self-efficacy and thus patient-centred behaviour.

8.4.4   Background factors/characteristics

In this study it was found that several background characteristics have the potential to influence students and doctors to be patient-centred or not. These characteristics include gender (see 2A.6,

2C.3.1, 7.3.4), age and culture (see 2A.6, 2C.3.2, 7.3.4), personal experiences with diseases (see 2A.6, 7.3.4), and the influence of the media and social pressures (see 2A.6, 7.3.4). None of these characteristics represented very strong themes. While the findings highlighted the personality of an individual as a strong issue (see 2C.2.1, 7.3.4), there was sufficient evidence to conclude that a patient-centred approach can be learned by anyone, despite the influence of background characteristics. Therefore, background characteristics do not seem to play a determining role in a student's ability to develop as a patient-centred doctor or not.

8.4.5   Skills and knowledge

The empirical findings confirmed that the students had a fairly good knowledge of what patient-centredness means, but they did not know how to apply this 'textbook' knowledge in the clinical areas where they were working (see 5.3.5.1, 7.3.5). The findings further suggested that the students lacked some of the vital skills which will enable them to practise patient-centredness in the complex clinical environments where they work (see 5.3.5.2, 7.3.5). It can thus be concluded that in order for students to be able to practise patient-centredness in challenging clinical work environments, they need skills related to clinical empathy as well as a range of applied patient-centred communication skills (see 2A.2.3.2, 2C.2.2, 2C.3.3).

8.4.6   Environment

The environment where the students mainly learn about clinical medicine and where they will end up working one day has a very strong impact on learning and practising patient-centredness (see 2A.6, 5.3.6). From the findings it became evident that students were challenged by several factors that were hindering them to be patient-centred; however, some clinical environments were acknowledged to be more conducive to learning about patient-centredness than others (see 7.3.6.1, 7.3.6.2). The findings showed that more time is generally available to get to know patients and build relationships with them in clinical environments such as chronic care facilities, primary health care or longitudinal placements (see 7.3.6.2). Since getting to know patients and having time for relationship-building are considered key elements in learning to be patient-centred (see 5.3.6.2, 7.3.1.1), one may conclude that placements in specific clinical environments can assist students in developing their patient-centredness (see 2C.2.2). Finally, it can be concluded that the clinical environment with its challenges needs to be acknowledged as a fact and that students need to be equipped to practise patient-centredness despite the constraints that are experienced there (see 2C.2.1, 7.3.6).

8.4.7   Assessment

The empirical findings suggested that patient-centredness was only assessed in two of the disciplines as part of the students' practical rotations. When it was assessed, it was often only for a small portion of the marks and not applicable to real patient situations (see 7.3.7). The findings further confirmed that students do indeed value assessment as they will pay more attention to being patient-centred if there are marks at stake (see 7.3.7). It can thus be concluded that in order for the assessment of patient-centredness to be more meaningful and effective, it could be better integrated into the complete curriculum and not only focus on, for instance, communication skills and student behaviour (see 2B.4.5). Assessment of patient-centredness across the curriculum can thus potentially be utilised as a driving element to develop patient-centredness within medical students.

8.5   CONCEPTUAL CONCLUSIONS

Conceptual conclusions relate to a better understanding of the phenomenon as studied and interpreted by the researcher. Overall, this study has significantly broadened the researcher's insights into how patient-centredness is being taught and learnt within the context of the MB,ChB programme at SU. With such a new understanding, adaptations to the initial conceptual framework (see 2C.4.2) may be useful in the forms of broad conceptual conclusions and an adapted conceptual framework.

8.5.1 Firstly, and based on the major findings of this study, it seems that reducing patient-centredness to only a behaviour component may not do justice to the concept or its use (also see 2B.4.3). Rather, the outcome of patient-centred learning could be seen as graduates who are patient-centred, who can demonstrate patient-centred competence and who can integrate their tacit knowledge, applicable skills and supportive attitudes according to the requirements of the contexts in which their patients are treated.

8.5.2 The findings also suggested that the unique background characteristics of each student need to be viewed as something that may potentially influence his/her propensity to become patient-centred (see 7.3.4). However the learning opportunities created by the MB,ChB programme should be sufficiently adequate to enable all students to develop this competence.

8.5.3 The environmental constraints currently related to the teaching and learning of patient-centredness in the MB,ChB programme are real and will probably continue to remain as

constraints for the foreseeable future. Although the findings from the study did not provide strong indications of students' self-efficacy (see 7.3.3), it can be concluded that promoting student self-efficacy in the programme remains an important underpinning need in the teaching and learning of patient-centredness. This may contribute in overcoming at least some of the perceived and real learning barriers situated in the clinical teaching environment.

8.5.4 As the study has indicated, limited opportunities for students to promote their self-efficacy (see 2C.2.6, 7.3.3), one may conclude that more and repeated chances to practise, with feedback on interactions with patients, followed by opportunities to reflect on their learning, may afford better chances for students to develop a sense of self-efficacy.

8.5.5 Based on the fact that positive role-modelling was not clearly observed in the study, but reportedly plays an important role in clinical learning (see 7.3.2), it may be concluded that the potential of this element in the teaching and learning of patient-centredness is currently under-developed and under-utilised as a teaching and learning tool.

8.5.6 It became evident from the findings that the norms and values of the various clinical learning environments may have a strong influence on the learning of patient-centredness (see 7.3.2, 7.3.5, 7.3.6). It may thus be concluded that, in order for students to learn a patient-centred approach applicable to all disciplines of medicine, an agreed upon communication framework, underpinned by appropriate norms and values, may be needed in all clinical teaching and learning environments.

8.5.7 Evidence from the study suggests that some clinical environments are more conducive to the learning of patient-centredness than others (see 2C.3.3). Another finding was that when students have opportunities to develop relationships with patients they have more positive attitudes towards patient-centredness (see 7.3.1, 7.3.2, 7.3.6). Longitudinal placements in environments where students can build relationships with patients thus seem to have the potential to assist students in developing patient-centredness.

8.5.8 Assessment needs to be taken into account as an important factor that drives student learning (see 7.3.7) and it may thus be concluded that holistic and integrated assessment of patient-centredness as part of an integrated behaviour framework may contribute towards enabling student learning of the competence.

The conclusions from the study led to a number of adaptations to the original understanding of the teaching and learning of patient-centredness, especially within the context of the MB,ChB curriculum at SU. These adaptations are shown and explained in the following section.

8.6   ADAPTED CONCEPTUAL FRAMEWORK

The adaptations to the original understanding of the teaching and learning of patient-centredness are presented and explained in Diagram 8.1.

Programmatic and institutional context

Attitudes towards PC

Seeing the person behind the disease

Sharing power in the doctor-patient relationship

Assessment

Integrated and holistic

Knowledge and skills of PC

Communication skills

Applied theoretical knowledge

Self-efficacy

Students need to see positive role modelling, practice repeatedly with feedback and must be encouraged to reflect on themselves as well as on the role models

Intention

Student (with background characteristics) who is patient-centred

Knowledge,

skills

and attitudes

Environmental constraints

Subjective norms

Placement in environments with role models that is suitable for development of PC such as longitudinal clerkships

Diagram 8.1:   Adapted conceptual framework to explain the teaching and learning of patient-centredness (PC)

8.6.1   Explanation of the adapted conceptual framework

Since research has shown that the attitudes of medical students towards patient-centredness decline during their training at medical school (see 1.1), it is important to understand the factors that influence the teaching and learning of this competence (see 2C.3 and Chapter 7).

The use of Fishbein's IM as the analytical framework for this study was very useful since all its elements were found to be backed by the empirical data. However, since the IM explains a single behaviour rather than multiple behaviours influenced by different factors (Fishbein, 2000), it is less surprising that a multifaceted construct such as patient-centredness may emerge with different relationships among its various elements. Furthermore, as some components of patient-centredness are considered to be learnable (see 2A.2.3.3, 2C.2.1) it was deemed necessary to move the knowledge and skills components from where it originally were in the framework, acknowledging that these components are integral to a competence (see 2B.4.3, 7.3.5). Furthermore 'assessment' was added as a factor (explained in section 8.5) that could not be ignored within the context of teaching and learning in a university programme. A brief explanation of the adapted model, mainly based on the conceptual conclusions reflected in section 8.5, follows below.

It is important to mention that the conceptual framework as it is viewed for the teaching and learning of patient-centredness is displayed within a block that attempts to illustrate the programmatic and institutional context and boundaries of this study. Another aspect to note is that the proposed framework is not a process model as there is no specific order in which teaching and learning of patient-centredness could or should happen. The loose-standing elements in the framework rather suggest the complexity of learning patient-centredness within the confines of a large, complex curriculum such as in the MB,ChB programme.

Bearing in mind that the desired outcome of the teaching and learning is competence in patient-centredness (the final block in the framework), it is necessary for a student (despite his/her background characteristics) to be able to integrate knowledge, skills and attitudes within a certain context (also see 2A.7, 2B.4.2).

Since patient-centredness is viewed as a competence, the framework starts by placing attitudes as well as skills and knowledge at the beginning of the framework, indicating that these are the essential building blocks for students to achieve the competence. The attitudes, skills and

knowledge can be taught in various settings by making use of a variety of teaching methods (also see 2C.2).

The importance of self-efficacy as a factor in the teaching and learning of patient-centredness (also see 2C.2.1, 2B.4.4) is portrayed by allocating a bigger block to this component in the framework. In the process of developing self-efficacy, students need to experience positive role models, being afforded opportunities to practise in an environment that is conducive to the learning of patient-centredness, and be given feedback with opportunities to reflect on their actions as an important element towards re-enforcing learning It is also in this reflection process that students can explore new meanings and actions (also see 2C.2.6).

The reason why the block 'subjective norms' was put at the bottom of the framework was to indicate that this aspect is vital to the effective learning of patient-centredness in the curriculum (also see 2C.2.1, 2C.3.3). Opportunities to develop self-efficacy can be created in simulation or in real practice; however, this development process mainly takes place in the clinical learning environments where the hidden curriculum and the effect of role models are very pertinent (also see 2C.2.4, 2C.2.6, 7.3.2).

Assessment is added as a factor that has an important influence on student learning (see 7.3.7) and on patient-centredness in particular. For assessment to be effective, however, it needs to be holistic and integrated throughout the entire programme (also see 2B.4.5).

The final block in the framework indicating 'competence' is suggested to result once students with a high sense of self-efficacy develop a strong intention and can practise patient-centredness despite the environmental constraints to which they are exposed (also see 2C.2.1, 2C.2.6, 7.3.3).

Finally, the framework suggests that students may have an improved chance of cultivating an intention to be patient-centred once they have been exposed to a planned configuration of five key curriculum elements related to the teaching and learning of patient-centredness. These elements are attitudes, skills and knowledge, assessment, self-efficacy, and subjective norms.

8.7   IMPLICATIONS OF THE STUDY

The conclusions drawn on the basis of this research provide for a number of implications for various role players. The implications of the findings of this study for medical curriculum theorists, for medical curriculum developers and for future researchers are addressed next.

Owing to the nature of the study, there is no attempt to generalise, but possible implications for other classes of case studies (Yin, 2013) within similar contexts are pointed out.

8.7.1   Implications for theory

The literature that was explored for this study did not provide a framework that could be used to best understand the factors involved in the learning of a complex phenomenon such as patient-centredness in an undergraduate medical curriculum. Fishbein's IM, however, provided a framework that could be used to analyse the data in a meaningful way.

After the analysis and interpretation of the findings in this study, adjustments to the original conceptual framework (Figure 2.1) were suggested in order to highlight the complexity of the teaching and learning of patient-centredness (see 8.6). The complexities underlying such teaching and learning and how assessment has a distinct influence on students' learning has been a revealing factor in the study. It was also enlightening to discover that the teaching and learning of patient-centredness cannot be mapped out as a clear-cut process. In dealing with the phenomenon of patient-centredness it is important to consider different curriculum elements that need to be integrated across a programmatic pathway and thus be taught and learnt over a period time.

In terms of understanding the teaching and learning of patient-centredness in undergraduate medical students it is also important to acknowledge that such learning is about more than positive attitudes of students and providing them with patient-centred communication skills training: a critical aspect that has to be considered is the clinical learning environment in which the students are working. This learning environment needs role models that support the development of patient-centredness, thus cultivating a positive hidden curriculum for medical students.

The study also revealed that medical students' background characteristics (such as personality) do not have to determine their ability to be patient-centred. This finding was central to a better understanding of students' learning of this competence.

Optimal learning of the competence of patient-centredness was also linked to an understanding of the planning of a medical curriculum in ways that provide students with appropriate learning opportunities to do so. This includes the learning of related attitudes, skills and knowledge, followed by the appropriate assessment thereof. Students' self-efficacy can be strengthened if

they are provided with multiple opportunities to practise, with feedback and reflection, within environments where the explicated norms and behaviours support the practice of patient-centredness.

At meta-level, educational institutions that aim to produce medical graduates who are patient-centred need to be explicit about patient-centredness as a value and a core competence. In doing so the focus should be on students learning patient-centredness as a clinical practice that caters for a variety of needs within a diverse range of patients and settings.

In terms of re-conceptualising the patient-centred curriculum, the study has the clear implication of a jointly planned and well-coordinated approach in the formal, informal and hidden curriculum spaces with sufficient and well-trained faculty members/clinician trainers who understand the importance of the phenomenon in modern medical health practice.

Lastly, it is suggested that social cognitive learning, which is a main learning theory informing the teaching and learning of patient-centredness, be supplemented with aspects of transformative learning theory. Both role models and students may benefit from being reflective and willing to change their ways of thinking by engaging in conversations – all of these in order to consider alternative perspectives and determine the validity of their own views.

8.7.2   Implications for curriculum practice

One major conclusion from the findings of the study was that the current teaching and learning of patient-centredness in the MB,ChB programme at SU is inadequate. The following strategies and initiatives could be considered as possible ways of enhancing curriculum practice:

- Firstly, it is suggested that an agreed upon interpretation of patient-centredness needs to be accepted across the programme. A more uniform interpretation of what patient-centredness entails may assist both students and clinician teachers in learning and teaching this competence.

- While self-efficacy seems to be a key determinant in whether students will be able to practise patient-centredness, the students should be allowed to develop high levels thereof by firstly providing them with proper role modelling of patient-centredness and then giving them multiple patients with whom to interact. A clinician teacher should provide feedback and reflection opportunities afterwards.

- Since the study identified communication skills as a key enabler of learning patient-centredness, a uniform agreed upon framework needs to be determined in the programme and then needs to be implemented across all departments. Students should get opportunities to practise their patient-centred communication skills and get feedback on these skills. This should take place in all departments where they work and not only in Family Medicine and Psychiatry.

- The study findings have indicated that students need to be placed in environments that are conducive to relationship building. This includes LICs, in both rural and urban settings.

- The study showed that in order to enhance constructive alignment of the knowledge, skills and attitudes related to patient-centredness in the programme, the assessment should be holistic and integrated. This implies that assessment should ideally be workplace-based, and it should focus on the integration of knowledge, skills and attitudes. Furthermore, it should be included in the assessment criteria of all the disciplines where the students are assessed.

- The study has also pointed out that in order to utilise role modelling as an effective teaching strategy it is vital that all clinician trainers be encouraged to take part in faculty development initiatives that can provide them with the relevant skills required to promote patient-centredness.

- The study indicated that students should be provided with opportunities where they can critically reflect on the behaviour of their role models instead of simply imitating what they see the doctors in the clinical areas do.

8.7.3   Implications for future research

The need for ongoing research related to the teaching and learning of patient-centredness in undergraduate medical students remains critical for medical programmes and curriculum developers since medical graduates with this competence are required for the 21st century.

In an earlier section (see 7.3.4) reference was made to the debate around whether background characteristics (non-cognitive attributes) should be included as part of the selection criteria of medical schools. Such research is recommended in our context.

Another opportunity for research might arise from the suggestion that medical students need to be assisted in building their self-efficacy in order to overcome some of the barriers of the clinical learning environment. Linked to this aspect could be an inquiry in order to explore how medical students can be assisted in being reflective, firstly about the choice of their role models and secondly as part of building their self-efficacy when they reflect on the feedback that they receive.

Lastly, a call for improved ways of measuring and assessing patient-centredness is needed. Current instruments could be combined to provide a 360 degrees view of a student's patient-centredness, but an appropriate battery of tools could include instruments to measure students' communication and empathy skills, attitudes towards patient-centredness, self-efficacy towards aspects related to the hidden curriculum and their ability to reflect critically on themselves and their role models.

8.8   LIMITATIONS

Since a case study approach was used for this study, its findings and implications are context-bound, therefore if the study is to be repeated elsewhere or if the proposed framework for student learning of patient-centredness is applied elsewhere, the results might perhaps be different. However, a high level of trustworthiness and ecological validity was ensured in the study by making use of original and programme-related data sets. One may thus expect to find similar results in contexts that are similar to the MB,ChB programme of SU.

A limitation was the small sample group of clinician trainers that was involved in the study; however, the complexity and extent of the MB,ChB programme curriculum (as explained in Chapter 3) complicated the sampling. Due to the feasibility of the study it was not possible to sample all clinician trainers from all sites and all departments involved in the programme, therefore the five main departments were selected and sampled as the most information-rich participants.

The use of focus group interviews to gather data from the students was potentially limiting in the sense that some students could have felt inhibited and therefore did not share their true experiences. Focus group interviews however were held due to the big population group and with this method more students were selected to take part in the study.

By making use of the Integrative Model (IM) of Fishbein as both a conceptual framework and an analytical framework could have restricted the view of the researcher and thus be a limitation in the study. On the contrary however, I believe that given the complexity of the topic 'patient-centredness', the use of the IM framework assisted the researcher to stay focussed on the research question and within the boundaries of the set study.

Finally, one could see not including patients as part of the study as a limitation, however the study was primarily focussed on the teaching and learning of patient-centredness and in order to include patient-experiences could potentially have skewed the focus of the study.

8.9   CONCLUDING REMARKS

Finally, it is possible to conclude that this study managed to answer the stated research questions and in this process also made a contribution to the existing research. The main research question of this study inquired as to how (if at all) students in an undergraduate medical curriculum learn to be patient-centred. Based on the findings and conclusions from the study it is fair to claim that the factors influencing how students learn, or in many cases fail to learn, this competence is now better understood. By providing a better understanding of the phenomenon of patient-centredness, this study addressed the knowledge gap identified in Chapter 1, namely that the factors influencing the teaching and learning of patient-centredness in undergraduate medical curricula are not understood adequately.

The results of this study has major implications for the teaching and learning of communication skills as well as for faculty development; specifically related to clinical supervision and feedback. Furthermore, the study calls for the consideration of complex adaptive systems to be applied to the teaching and learning of patient-centredness in addition to a more linear behavioural model such as the IM.

Lastly it is hoped that as a knowledge contribution, this study can assist in making future clinician teachers and MB,ChB students more aware of the importance of the role of patient-centredness in modern medical curricula – thereby also rendering a better service not only to the patients of such doctors but also to their students.

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Addendum 1

Profile of the Stellenbosch doctor

PROFIEL VAN DIE STELLENBOSCH DOKTOR
PROFILE OF THE STELLENBOSCH DOCTOR

Die pas-afgestudeerde Stellenbosch-dokter moet oor die nodige kennis, vaardighede en gesindhede beskik om gedurende die internskap die beskikbare geleenthede optimaal te benut om na afloop daarvan daartoe in staat te wees om selfstandig in die primêre gesondheidsektor te funksioneer, en moet ook toegerus wees met die nodige vermoë en insig om persoonlik en professioneel verder te ontwikkel.

The recently graduated Stellenbosch doctor must possess the necessary knowledge, skills and attitudes to optimally utilise the opportunities available during the intershipso as to be able to function autonomously in the primary health care sector thereafter, and must also be equipped with the necessary ability and insight to develop further personally and professionally.

Addendum 2

Interview schedule students

DISCUSSION PROMPTS for Focus group interviews with students August '14

Personal reminder about the objectives:

To explore possible factors that enhances or inhibits the development of patient-centeredness from year 1 to year 6, as experienced by final year medical students.

To determine how lecturers/clinical teachers create learning opportunities to promote patient-centeredness in undergraduate medical students.

Today we are going to talk about patient-centeredness. The aim of the interview is to understand how you as final year medical students, experience the teaching and learning of patient-centeredness in the MBCHB curriculum.

First Part:

What is meant by patient-centeredness? How do you understand this term?

  Allow the students to discuss this for about 5 minutes.

In order to make sure that everybody in the group is clear on the definition of patient-centeredness I will supply them with the hardcopies of the following definition that is used in this study:

Patient-centeredness generally refers to two aspects; namely sharing and caring (Krupat et al 2000).

Sharing: Refers to where power is shared between the doctor and the patient and there is a good flow of information and involvement of the patient regarding decision making.

Caring: Refers to the degree to which doctors try to understand the problem by adopting the perspective of the patient by exploring the feelings and expectations of the patient.

This will then be our understanding of what patient-centeredness mean for the rest of the interview. This will take another 5 minutes

First theme to explore: student's personal experiences with patient-centeredness in the clinical area

<mark>Second question to ask:</mark>

Firstly we would like to talk about your personal experiences. Think back to a consultation between a doctor and patient that you observed in the clinical area, either in a good or a bad way.

Tell us how did the consultation go?

What were good and what not so good?

Tell us about patient-centeredness in this situation. Allow the students to discuss this for about 15 minutes.

Second theme: students' attitudes towards patient-centeredness

<mark>Third question to ask:</mark>

What, in your opinion, are the advantages and disadvantages of patient-centeredness?

What are obstacles to patient-centeredness?

And what could stimulate students to be more patient-centered? Allow the students to discuss this for about 10 minutes.

Third theme: development of patient-centeredness

<mark>Fourth question to ask:</mark>

Think back to when you first started to see patients during your training here at medical school.

What has changed in the way you interact with patients?

Why do you think that is the case?

What incidents, in your opinion, did influence your views and practices regarding patient-centeredness?

Can you think of specific learning opportunities or moments of learning that enhanced/ hindered your approach to patients regarding patient-centeredness? Allow the students to discuss this for about 15 minutes.

Closure allow 5 minutes for any other comments

Addendum 3

Interview schedule clinician teachers (lecturers)

The aim of the interview is to understand how the term patient-centeredness is understood and interpreted in your discipline and in the clinical areas; as well as how it is taught to undergraduate medical students.

Introductory question (ice-breaker)

What was your motivation for choosing medical school? How has this evolved over the years?

What is meant by patient-centered care? How to you understand this term?

How do you apply/interpret it in your daily clinical practice?

Is there a commitment to promote patient-centered care in your department?

What are the barriers and enablers to provide patient-centered care?

How is patient-centeredness taught in the clinical areas?

Any suggestions of how it can be taught differently?

What teaching strategies might be usefully employed?

Who do you think should teach patient-centeredness?

Would it be helpful to have guidelines on what should be taught?

What specific training programmes to teach patient-centeredness are you aware of?

In your view does the teaching of patient-centeredness have an impact on clinical practice? If no can you think of reasons why this is the case? If yes, can you think of how it impacts on practice?

Should students be assessed about patient-centeredness?

How might they be assessed?

The individual will then be asked for permission whether a teaching session with students in the clinical area can be observed by the researcher in order to see how the teaching of patient-centeredness is applied.

Addendum 4
Student informed consent form

INFORMED CONSENT FORM FOR <u>MEDICAL STUDENT</u> PARTICIPATION IN A RESEARCH STUDY: FOCUS GROUPS

TITLE OF THE RESEARCH PROJECT:

Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University: A case study of the final year.

REFERENCE NUMBER:

Principal Investigator: Elize Archer

Address: Centre for Health Professions Education, Stellenbosch University, Box 19063, Tygerberg, 7505

Contact Number: 021 9389647 (w); 0828562315 (mobile)

You are being invited to take part in a research project. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to accepted and applicable National and International ethical guidelines and principals, including those of the International Declaration of Helsinki October 2008.

What is this research study all about?

- *The purpose of this research is to explore what factors enables or inhibits student learning of patient -centeredness in an undergraduate medical curriculum. The interviews will be taking place at the Faculty of Medicine and Health Sciences or in the hospitals where you work during your 6th year (whatever is more convenient for you) .*

Why have you been invited to participate?

- *You have been invited to participate because you are a 6th year medical student during 2014 or 2015. We believe that you are in the position to tell us about the factors that could potentially enhance or inhibit patient-centeredness in the undergraduate medical curriculum.*

What will your responsibilities be?

- *If you agree to take part in the project, you will be asked to attend a focus group interview with other 6th year medical students.*

- *The interview will be send to you after it has been transcribed in order for you to verify that the information is correct.*

- *Your name will not appear on the transcription of the interview. You will only be identified by means of a randomly allocated number.*

Will you benefit from taking part in this research?

The information that is obtained in this study may be useful scientifically and possibly helpful to others. While there may be no direct benefits to you for participating in this study, we hope that we may find out more about the factors that enhance or inhibit patient-centeredness in undergraduate medical students. This in turn may improve the quality of care that the patients are receiving and will most likely improve teaching of medical students, but this is not guaranteed.

If you do not agree to take part, what alternatives do you have?

Your decision not to take part in this study will be accepted and understood and will by no means affect the quality of your relationship with the faculty.

Who will have access to the records?

- *The audio record of the interview will be held in a password protected computer. The transcript of the record will be numbered only with a random number allocated to your focus group and also stored on a password protected computer. If any aspects such as power abuse or personality disorders are identified during the research it will be reported and handled appropriately. Confidentiality in these cases will therefore not be guaranteed. Counsellors will be involved if needed.*

- *Any dilemma that causes discomfort will be dealt with by the researcher and feedback about the situation will be given to the patient, doctor and students involved in the teaching sessions. Appropriate feedback will be given to the MBChB program committee.*

  Sponsors of the study, study monitors or auditors or Research Ethics Committee members may only inspect the anonymised research records.

  The recordings and transcripts will be destroyed after the research has been completed.

If you do not agree to take part, what alternatives do you have?

You do not have to agree to be interviewed and can withdraw your consent at any time.

Will you be paid to take part in this study and are there any costs involved?

There is no financial incentive for this study; however there are no costs involved for you either.

Is there anything else that you should know or do?

- *You can contact Sr E Archer elizea@sun.ac.za if you have any concerns or complaints that have not been adequately addressed. .*

- *You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researchers.*

- *Permission to conduct the study has been obtained from the Institutional Research and Planning Division of Stellenbosch University.*

- *You will receive a copy of this information and consent form for your own records.*

DECLARATION BY PARTICIPANT

By signing below, I …………………………………..…………. agree to take part in a generic research study entitled Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University: A case study of the final year.

I declare that:

- *I have read this information and consent form and it is written in a language with which I am fluent and comfortable.*

- *I have had a chance to ask questions and all my questions have been adequately answered.*

- *I understand that taking part in this study is* **voluntary** *and I have not been pressurized to take part.*

- *I may choose to leave the study at any time and will not be penalized or prejudiced in any way.*

- *I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.*

Signed at (*place*)   .... on (*date*)   ....2014.

....

Name of participant   Signature of participant

STATEMENT BY THE INVESTIGATOR

I .... ,   declare that I have explained the information given in this document to

....

She/he was encouraged and given ample time to ask me questions. Conversation was conducted in English and Afrikaans and no translator was used.

Signed at ……………………………………………………… on ……………………………..

                                    (Place)   (Date)

....

Signature of Researcher   Witness

Addendum 5

Clinician teachers (lecturers) informed consent form

INFORMED CONSENT FORM FOR CLINICAL TEACHER /LECTURER PARTICIPATION IN A RESEARCH STUDY

TITLE OF THE RESEARCH PROJECT:

Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University: A case study of the final year.

REFERENCE NUMBER:

Principal Investigator: Elize Archer

Address: Centre for Health Professions Education, Stellenbosch University, Box 19063, Tygerberg, 7505

Contact Number: 021 9389647 (w); 0828562315 (mobile)

You are being invited to take part in a research project. It is very important that you are fully satisfied and that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to accepted and applicable National and International ethical guidelines and principals, including those of the International Declaration of Helsinki October 2008.

What is this research study all about?

- *The purpose of this research is to explore what factors enable or inhibit student learning of patient -centeredness in an undergraduate medical curriculum.*

Why have you been invited to participate?

- *You have been invited to participate because you are a doctor who is involved in the teaching of undergraduate medical students in either one of the following rotations: Surgery, internal medicine, obstetrics and gynaecology, paediatrics or Family*

medicine. Your name has been randomly selected in one of three categories: Senior consultant, junior consultant or registrar.

What will your responsibilities be?

- *This part of the data will be gathered at Tygerberg or at the Rural clinical school; wherever you do your teaching sessions.*

- *If you agree to take part in the project, an interview will be conducted with you as well as an observation encounter will be arranged while you teach undergraduate medical students.*

- *You will be informed which of your teaching sessions will be observed. During the observation encounter the researcher will be observing for teaching of patient-centeredness.*

- *Your name will not appear anywhere in any record or on the transcription of the interview or observation. The recordings and transcripts will be destroyed after the research has been completed.*

Will you benefit from taking part in this research?

The information that is obtained in this study may be useful scientifically and possibly helpful to others. While there may be no direct benefits to you for participating in this study, we hope that we may learn about methods to improve the teaching of patient-centeredness in undergraduate medical students. This in turn may improve the quality of care that the patients are receiving and will most likely improve the outcomes of medical students' patient-centeredness, but this cannot be guaranteed.

If you do not agree to take part, what alternatives do you have?

Your decision not to take part in this study will be accepted and understood and will by no means affect the quality of your relationship with your department and/or the faculty.

Who will have access to the records?

The record of the interview and observation encounter will be held in a password protected computer. All identifying information of all persons involved in the encounter will be anonymised in the process of transcription.

Sponsors of the study, study monitors or auditors or Research Ethics Committee members may only inspect the anonymised research records.

If you do not agree to take part, what alternatives do you have?

- *Your decision not to take part in this study will be accepted and understood and will by no means affect the quality of your relationship with your department and/or the faculty.*

Will you be paid to take part in this study and are there any costs involved?

You will not be paid and there are no costs are involved

Is there anything else that you should know or do?

- *You can contact Elize Archer elizea@sun.ac.za if you have any concerns or complaints that have not been adequately addressed by the researchers.*

- *You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researchers.*

- *Permission to conduct the study has been obtained from the Institutional Research and Planning Division of Stellenbosch University as well as the Department of Health (Tygerberg/Worcester).*

- *You will receive a copy of this information and consent form for your own records.*

DECLARATION BY PARTICIPANT

By signing below, I ………………………………..…………. agree to take part in a generic research study entitled **Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University: A case study of the final year.**

I declare that:

- *I have read this information and consent form and it is written in a language with which I am fluent and comfortable.*

- *I have had a chance to ask questions and all my questions have been adequately answered.*

- *I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.*

- *I may choose to leave the study at any time and will not be penalized or prejudiced in any way.*

- *I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.*

Signed at (*place*)   ....   on (*date*)   .... 2014.

....

Name of participant   Signature of participant

STATEMENT BY THE INVESTIGATOR

I .... ,   declare that I have explained the information given in this document to

....

She/he was encouraged and given ample time to ask me questions. Conversation was conducted in English and Afrikaans and no translator was used.

Signed at …………………………………………………… on ……………………………..

                    (Place)   (Date)

....

Signature of Researcher   Witness

Addendum 6

Approval letter: Tygerberg Hospital

Western Cape Government
Health

Tygerberg Hospital

REFERENCE: Research Projects
ENQUIRIES: Dr K Maart
TELEFONE: 021 938-4141

Date: 11 December 2013

ETHICS NO: S13/09/167

Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University: A case study of the final year.

Dear Mrs Archer

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at Tygerberg Hospital.

DR D ERASMUS
CHIEF DIRECTOR CO
Date: 18 December 2013

Western Cape Government

Health

Tygerberg Hospital

REFERENCE: Research Projects
ENQUIRIES: Dr K Maart
TELEFONE: 021 938-4141

Date: 11 December 2013

ETHICS NO: S13/09/167

Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University:
A case study of the final year.

Dear Mrs Archer

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at Tygerberg Hospital.

DR D ERASMUS
CHIEF DIRECTOR CO
Date: 18 December 2013

Administration Building, Francie van Zijl Avenue, Parow, 7500
tel: +27 21 938-5966   fax: +27 21 938-6698

Private Bag X3, Tygerberg, 7505
www.capegateway.go.v.za

Addendum 7

Institutional approval letter

11 December 2013

Ms Elize Archer
Centre for Health Professions Education
Stellenbosch University

Dear Ms Archer

Re: Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University: A case study of the final year

The researcher has institutional permission to proceed with this research project as stipulated in the research proposal.

This permission is granted on the following conditions:
- this study must be approved by the Health Research Ethics Committee at Stellenbosch University,
- this study must be approved by the Deputy Dean: Education, Prof Marietjie de Villiers,
- the researcher must obtain the participants' full informed consent for all aspects of their participation,
- participation is voluntary,
- participants may withdraw their participation at any time, and without consequence,
- data must be collected in a way that ensures the anonymity of all participants,
- individuals may not be identified in the results of the study,
- data that is collected may only be used for the purpose of this study,
- the privacy of individuals must be respected and protected.

Best wishes,

Jan Botha
Senior Director Institutional Research and Planning Division

Addendum 8

Progress report letter Ethics Committee

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY.
Jou kennisvennoot · your knowledge partner

Ethics Letter

25-Feb-2015

Ethics Reference #: S13/09/167
Title: Patient-centeredness in the undergraduate medical curriculum at Stellenbosch University: A case study of the final year.

Dear Mrs. Elize Archer,

At a review panel meeting of the Health Research Ethics Committee that was held on 16 February 2015 the progress report for the abovementioned project has been approved and the study has been granted an extension for a period of one year from this date.

Please remember to submit progress reports in good time for annual renewal in the standard HREC format.

Approval Date: 16 February 2015 Expiry Date: 16 February 2016

If you have any queries or need further help, please contact the REC Office 219389207.

Sincerely,

REC Coordinator
Mertrude Davids
Health Research Ethics Committee 2

Addendum 9

Transcribed interview example (student interview)

19 August (Part of a focus group interview)

Speaker Key

IV   Interviewer

MI   Male Interviewee

FI   Female Interviewee

IV   Good, thank you very much, it is Tuesday, and it is the discussion with the group from orthopaedics. Thank you very much to everybody for attending this. I'd like us to start just to explore the definition of patient centeredness. So you know, I see that you nod your heads. You know the concept. Just let's talk about it, things that come to your mind when you hear this word. What does it mean to you?

FI 1   What's important to the patient, apart from just what we want to help the patient with for whatever, but what they actually want out of the treatment as well.

IV   Okay, so what the patient wants out of the treatment.

MI 1   Recognising that we are treating an individual rather than a disease or a condition.

IV   Okay, so it's more than just the disease.

FI2   It's all about a collaborative goal to help the patient and what the patient wants, so everyone's perspectives need to be taken into consideration. It's sort of all the Allied Health practitioners working together towards a common goal. I think that's often overlooked because we each have the goal that we want to achieve, but it isn't always sort of in unison completely.

MI2   I also think that sometime you as a medical professional or whatever might have like a certain agenda. Like surgeons like to operate, and some people like to do research, and not to give a patient a certain treatment just because you want to do your research in that and you want to go to theatre or whatever, but because it's actually the best option for that particular patient.

IV   So not the doctor's own agenda, that's what you mean?

MI2   Yes, to act in the best interests.

IV   Okay, anything else you'd like to add?

FI3   That's also how I interpret it, that your focus, you should be careful because it's easy to get lost in all the complexities of medicine, and then almost de-personifying our patients. So it's such an intellectual puzzle for us that we forget in the end what it is. I mean the main goal of everything should be the patient.

IV   Okay, thanks for that. I think let's move on and pick up exactly on what you say, because I think that is where the challenge lies, is it's a complex world that you are in, and there is the risk of getting lost in all of that. Have you seen that happening?

FI3   Definitely.

MI2   Absolutely.

FI3   I have definitely seen that. I think a lot of these things are not something that you necessarily get taught in a classroom. Usually it's taught in a classroom, the idea of it, but I think it's more something that in the practical circumstance, you see the way that doctors interact with their patients, and by that you recognise where it's important for the doctor, not just if the patient's disease is healing, but whether the patient is doing better as well. So we see lots of examples of both sides of the coin. We see the doctors that every day they make eye contact, they talk to the patients, they know their surnames.

They ask them how it's going. They make sure that the patient is aware of where they are in the plan of treatment, and then you get the other doctors who literally walk past and say okay, so everything is good, next patient, okay, so everything is good, not even talking to the patient himself.

FI   I also feel that there are few sort of Departments in the hospital that have a ward round where all sort of teams, or professionals are together on the same ward round because you're treating the patient from your perspective, but maybe there is something that the OT or the physio has picked up along the way.

I mean, the patients speak to a lot of people, and they might say something to the physio or the OT or the doctor or the Sister working there, and that message doesn't always get conveyed. I think that is sort of like a missing link in the whole sort of patient centeredness. You know, we treat the patient individually and not as a team, although that's preached to us on numerous occasions sort of during our curriculum.

IV   Are there departments that manage to run such a ward round, or not really that you have been part of?

FI   Some.

FI2   There are some of the paediatric ward rounds that do the dietician and OTs.

FI3   And Brooklyn Chest as well, we've had meetings with everyone involved and everything is discussed.

MI   Often it's not necessarily a ward round where they go through everybody, but like where they will discuss a few patients who really will benefit from multidisciplinary.

FI   Psychiatry as well.

FI2   Psychiatry definitely.

MI   Especially child psychiatry.

FI   They don't necessarily go to the patient and see them, but they all discuss what the social worker found, etc.

MI   I think often the doctors can't really help for not being patient centred. Like for instance, and sometimes it's just the system that lets them down as well. For instance, when we were on obs and gynae the one evening they had to start doing caesarean sections for patients who are likely going to need it in a few hours just to get the labour ward like empty, or to empty it up, and that is not necessarily the best, or like a patient centred thing, but they didn't really have a choice. So I think sometimes the system, I'm pretty sure we're going to talk about that some more, but sometimes the system forces you to.

IV   Yes, absolutely, and I think now that you are mentioning that, it's a bigger thing, but I think that's why I've decided to focus on the doctor patient relationship because there are many other things that you don't have control over, and that single part is something that an individual has control over. Have you seen where doctors work directly with patients within that relationship, that people also become like you said, overwhelmed by many things and have lost their passion?

FI   I think time is very scarce, and that is the primary thing. I mean, there is the stereotypical idea of surgeons only wanting to cut and not caring, but the reality is if they did spend the amount of time that we would like on every patient, they would never finish their work. That's

the first thing. The second thing is if they really got involved emotionally, I think there are two concepts to the patient orientation.

So on the one hand doing what's best for the patient, that should never be compromised, but really having a relationship with your patient, it is ideal and that is ultimately what we strive for, but we are also human. I think if you are a surgeon and you have so many patients, it is just not physically possible for you to be emotionally involved with all of those patients.

Secondly, it might even compromise your decision making. So it's not always that you should be 100% emotionally invested in your patients because you will not survive it, and no one else in your life will get any attention or emotional input from you because you are exhausted from doing it with all the patients.

IV   So basically to go back to our definition, the definition I like very much about patient centeredness is where they say it has two components. Basically what you said, the one is sharing and the other one is caring. Within those two I think we can put all the things that you have spoken about when you interact with a patient. If you don't have a lot of time, you can only do a bit of those, of both of those. Now, just to take us back to when you first started to learn about patient centeredness in your curriculum, think back long, first, second year, where did you start learning about this?

MI 2   Also probably going back to the whole thing of knowledge, skills and attitude, and that also may be back tracking on this a bit now. Doctors have the skills, if they're qualified, they have the knowledge, but the attitude, I mean, like Minette said, we are overworked, you sit in an alley of maybe 50 patients.

If I can just give you an example, the other day in a certain clinical where a specific Sister, the doctor, although they want to see the patients, they want to recall them, they want the file, but there is this sort of attitude problem with her not wanting to be told by this person, and although it's for the best outcome of the patient, that we need this file, we need to send this patient for tests, but this attitude problem.

IV   I like the idea that you have about those three things. So let's get back to that. So they're pretty much hammering you with knowledge, okay, and skills together with that. There are a lot of skills, and the attitude thing is a difficult thing to teach and assess. Patient centeredness would almost fall into that category, although attitude alone isn't enough. It needs to cultivate into an action, otherwise the patient won't know that you are patient centred.

So do you think the problem with people that become so hard and they say they get compassion fatigue, do they lose the attitude, or is it just the time that prevents them from doing something? So, what I'm trying to say is even you people sitting here, you know what patient centred is, and it seems like you pretty much believe if you work with patients in that way it will be the best? So the attitude is there, you believe in that, you want to do that, but do you get to the action of that?

FI   I have already noticed a change for me [group agrees] between my first year and now. Because your emotional response, you immediately, I mean I think I first came into contact with it before I started studying medicine by being treated by doctors and feeling like you're not – I don't want to say respected, it's not that – but you do get doctors that seem like they care more about their patients, and you want to be a caring doctor. But you just become, you sort of develop emotional callouses because it's too much.

MI 2   Especially now.

FI   Yes, especially now. I have noticed for example now in neurology we had an older 'oom' that was sort of pre-dementia, and I was immediately irritated with him, and afterwards it actually shocked me that previously I would have had empathy, I would have felt sorry for him, I would have imagined him in the context of his family, the fact that he should be respected, but at that stage I was just thinking I actually don't have time to now help you dress and move from your bed to your chair, because our ward round was halfway and we still have X amount of patients to see.

FI2   And you're leaving at six.

FI   Yes.

IV   So, I can see you people nodding your heads. You have a similar...

MI   I want to add something to what ??? says. I think it's a coping mechanism.

FI 4   It is, definitely.

MI   Because unfortunately Tygerberg is not the best functional place on earth, but I don't want to call it dysfunctional, but when you have to in this dysfunctional state, you have to keep your attitude together, you have to cope, because everything is not super, everything is not perfect. You can't see every patient with the same empathy that you want, that the textbook said you must be, because otherwise you will not complete the 100 patients of the day. So I

wouldn't say I become emotional or 'afgestomp' or emotionally blunted, but it's sort of a coping mechanism where you have to...

FI 4   Protect yourself.

MI   You must still show empathy to the patient, treat him the best possible way you can, but protect yourself, because in the government sector, it's not the private sector where you see five to ten patients a day maybe. Here you see a lot, and you have to cope with it but still treat the patient according to the attitude and the knowledge and the skills.

FI2   But warranting for the same fact, you know, there also needs to be an attitude and an approach towards doctors. I have also encountered things where you get a patient that's so appreciative and things, and it just takes one patient a day to just turn your whole attitude around. You know, you put so much effort in and then the person is ungrateful.

MI   It seems like it's an entitlement.

FI2   Yes, there also needs to be sort of doctor orientated... [laughs].

FI   I know what you are saying. They are upset with the bad service that they are getting here.

FI3   I just want to add something. I think we get taught in our curriculum that you have to have empathy, this is how you take a history, this is how you work with a patient, but then you also get to ward rounds and whatever, and I understand time is an issue and there are a lot of patients, but then what we get from the doctors doing the ward rounds is like no, I don't want to hear anything about the family, just tell me what's wrong with the patient, and then we kind of copycat, take that on.

IV   Role modelling.

FI3   Yes.

FI   There's a big gap between what they teach and what they do. [Agreement]

FI3   Yes, and then we like adapt to the doctors and we don't have class anymore.

IV   What you are saying is so true, because I've heard it from many people. Now, I'm just wondering, so there is a gap between what you are being taught and what you see. Especially if you are a young third year, that is crucial. Now, where do you think can we try and find solutions? Is what we teach unrealistic, or are the people that do those bad things, are they ones who are wrong, or it is a bit of both?

FI3   I think it's the hospital system that's unrealistic, to be honest, because there's just not enough doctors to patients.

FI   The patient to doctor ratio is just not...

MI   Like I said, I don't want to say dysfunctional, but it's not functional, perfect. Like the whole design, we know Tygerberg was designed in a very old era, but the functionality...

IV   Is it better in other hospitals?

FI   No, I don't think so.

FI2   I also don't think so.

FI   I don't think it's a Tygerberg thing, I think it's a State thing.

MI   With the speed that patients move through the system, how can a child that will need a back operation because she's got a skew back, and it's an emergency, can only get a date in April? I mean, something is wrong here, and it's a tertiary centre, and it's the biggest hospital in the Western Cape, but they can only give her a date in April. So, I don't know if it's a lack of budget or too many patients.

Addendum 10

Transcribed interview example

(clinician teacher /lecturer interview)

<u>**Internal 2015**</u>

<u>**Speaker Key**</u>

IV   Interviewer

MI   Male Interviewee

IV   So I'm just going to start to talk about patient centeredness in a very broad way, and just how you think it can happen in the curriculum. So, just to start off, the literature is not clear about the definition, and that's like a whole part of my literature review, what does patient centeredness mean. So, maybe if I can start off to ask you two things. The one is how do you think it is, what do you understand when you hear this word, and the second thing maybe to your speciality, because there are also differences between how does a paediatrician maybe see this, the physician or a family physician or whatever. So, maybe first just your personal understanding of the term, and secondly your discipline, how you pick it up.

MI   Yes, so look, from what I remember about patient centeredness, my understanding was the whole history and examination really revolves around the patient, and it wasn't only regarding the patient's main complaint or what the medical problem was, it was also the psychosocial component that one needed to look at, and also what the patient wanted out of the consultation, because what the doctor wants out of the consultation and what the patient wanted out of the consultation. So, that is my general understanding of it.

IV   Yes, it picks up what many of the definitions say.

MI   Yes, so that whole bio psychosocial model approach to the patient. Now, in terms of what we do, or what I do on my ward rounds, I expect the student to have done that when they have taken the history and examined the patient. Unfortunately in F1 where the turnover of patients and the patient numbers are just so many, we just can't spend a lot of time on each of the components of the bio psychosocial.

So we tend to, or in my speciality, general medicine and nephrology, we tend to concentrate on the bio part of the psychosocial model, because at the end, and unfortunately that is what we want as doctors, we want to get down to the nitty-gritty and get it done with and sorted out because we need to get to the next case. But that is just the stress under which we are working at the moment, or the pressure under which we are working at the moment.

IV   You mentioned F1 specifically, and I completely understand why. I'm just asking, in other wards maybe, is it different?

MI   So, once the patient gets out of F1 and they start going to the general medical wards, or the nephrology ward where I also work, then things tend to change a bit in terms of we know what the medical problem is, we start concentrating on home circumstances, so the social component. We actually spend a lot of time in nephrology with the social worker, because there is actually a lot of social issues related to managing a nephrology patient.

IV   Yes, absolutely, so you need to work with them.

MI   So we work very closely with the social worker, and the emphasis then for the doctor is still on the medical problem, but we tend to now concentrate on the social circumstances and the psychological components and so on. The reason for this, I think in nephrology is, we have a very small number of patients, and we see them all the time. It's unlike other disciplines, where you see the patient, you get them better and they go. We have a long term relationship with the dialysis patients, so we know them very well. So, because of that relationship, we tend to start concentrating on other aspects of the patients, because we can, that's the thing.

Unfortunately when it comes to medical students, they don't actually get exposure to this because they don't really spend time in A7, which is the dialysis ward. Medical students don't rotate through nephrology, unfortunately.

IV   So they more see the acute things.

MI   So they will tend to just concentrate on the acute medicine, emergency, F1, rather than on the other aspects. Even when the patients are in general medical wards, because there is so much pressure on we need beds, we need beds, F1 is overflowing, can you please discharge patients in the ward, even then the students can't spend time on the social aspects. Usually what I do, [chuckles] unfortunately what I do when I'm working and I see maybe a stroke patient, I always refer the patients to the social worker and I ask them to deal with that component because I just don't have time myself to deal with that aspect.

IV   But you acknowledge that area is there.

MI   We acknowledge that area is there and we always refer, because I always tell the doctors and the students on the rounds, at the end of the day this patient needs to go home, and if he has had a stroke, or she has had a stroke, and they are unable to attend to their usual activities or daily living, then somebody needs to be able to do that, and if they don't have family, then they need to go to a facility where they can actually get that kind of care. So we always get the social worker involved soon after that.

IV   Thanks very much for that, it makes sense. A couple of things that I'm just thinking now from the medical student's perspective, now the student, and this happens in all the disciplines, they usually get to the patient, they examine the patient with the history taken, and then they present to the doctor.

MI   Yes, that's right.

IV   Where the focus is usually bio, as you say.

MI   Yes.

IV   Now, the fact that the student examines the patient and history taking, do you get chance to watch them doing that part?

MI   So, a good question, and personally, I don't know about the other firms and consultants, but I generally ask the students, when they are presenting they tell me the JVP was elevated, and I tell them so show me how you examine the JVP. So I try to spend time to as least on each patient, or when there is an opportunity to do so, for them to demonstrate a clinical sign. Otherwise you never know, and usually what happens is you end up asking them in the end of block OSCE, and then the things they do is completely different to what you know, and then you ask them, but has no one ever had a look at how you examine a patient, and I think that is a big area that's lacking. You see, if you have 12 patients that you have to get through, and you still have to go onto a clinic thereafter...

IV   But you see, you as a consultant obviously have a lot of things happening underneath you. Do you think there is somebody lower in the hierarchy maybe, and I'm referring to the registrars, that could help?

MI   Not only the registrars, the interns as well, because they are also doctors, and the just got through the medical school system. So, I depend a lot on my registrars to be able to, because the students present to them first, and then later on when I come and do rounds, then they

present to me. So then I ask them to show me. So I do depend on the registrars to – how can you say – to check the student's clinical signs, even if they don't ask the student, to confirm that yes, the apex beat was displaced, yes, there is AS3 gallop, or yes, there was bibasal crackles.

I tend to, so they need to confirm that the signs were present, I tend to look at technique, because technique is poor, that's the feeling I've been getting from all the medical students, and sometimes the technique is there but the interpretation isn't there.

IV   Yes, but what I picked up in your ward round, which was very nice for me, maybe you're aware of the technique that's called the one minute preceptor, because you are using that.

MI   Yes.

IV   Because I know also some people have been using it out of luck.

MI   Out of natural... yes.

IV   Which was very nice when the students say it's X, then you say to them why do you say it's X, which I think is very nice.

MI   I tend to do that because I want to make sure that they are sure about what they are saying.

IV   You can see the way they think, regardless whether it's right or wrong,

MI   That's right. I always tell the students it's better to be right for the wrong reasons than to be wrong for the right reasons. Sorry, no, I always tell them... what do I always tell them? [Laughs] It's better to be wrong for the right reasons than to be right for the wrong reasons, that's what I always tell them.

IV   That's true, because sometimes they will guess the right thing, but they don't understand how they got there.

MI   That's right, and a big thing that I do on my rounds is I always tell them I'm not interested in detail. As a doctor, even me as a specialist, specialists don't actually know much more than other people. It is just that they have seen the same thing over and over and over again, and experience has made them to be the consultant. I always tell them a story about what's the difference between a grandmaster chess player and a novice chess player? Then they obviously can't tell me, and I tell them, they did a study, I always tell them this study, because I try to motivate them to start examining more, they need to examine more patients. So I tell

them what they did in the study was they used a chess book and they strategically place the pieces on the board, and then they compared the grandmaster to the novice.

Obviously the grandmaster outplayed the novice, because he has seen those positions over and over and over again. Then what they did was they took the chess pieces and they just put them at random. They didn't use a chess book, they just put the pieces at random, and then there was no difference between the grandmaster and the novice. The reason for that was because the grandmaster has never seen it before, like the novice.

IV   He had to figure it out himself.

MI   So the only reason a grandmaster, or I always tell them the only reason a consultant is better than a registrar, or is better than a student, is because the consultant has seen it over and over and over again. So, I tell them please, you have to be proactive. You can't only examine patients when you are on call. It doesn't work that way. The more you see, the more you examine patients, the better you will get at it. So on none call days in the ward you must ask your friends in other firms, do you have interesting patients that I can come and examine. Whether the students take my advice is another story.

IV   Even if it's one or two that do, then at least you have done it there.

MI   Yes.

IV   Do you think there is a commitment to promote patient centred care in your department?

MI   Hmm, that's a difficult one.

IV   Or even in other departments. If you can speak wider it's fine, but do you get the sense that there is a commitment to it?

MI   Look, I can only speak for general medicine and nephrology. In nephrology, definitely. There is no doubt about it, because of the reasons I mentioned earlier. In general medicine, I'm going to speak from my own firm, I try to become patient-centred. In fact, just two days ago I did a discharge round with my students and registrars and so on, and there was a patient with lung cancer which was metastatic. I noticed that the registrars tend to just go through the next, it's like a protocol. He's got cancer, identify what type of cancer, and then we need to stage it and then he needs to be referred, and oncology eventually.

So I said no, no, no, this is not how you manage this patient. You give the patient the option. You put the ball in the patient's court. You tell him we can do this, you are going to get chemotherapy, radiotherapy, you're going to feel bad, your quality of life is going to get worse,

but we may be able to prolong your life. So you may have quantity of life, but you may not have quality of life, that's the difference. Or we can stop everything right here, right now, and you can do home and spend the rest of the time with your family. In fact, the patient was so happy to get these options, and he actually wanted to know, if I go for the chemotherapy, how much longer will I live.

IV   Shame, so he started asking questions.

MI   Correct. So then I said I don't want you to feel pressurised to give an answer now. I said this in front of the students and the registrars, because I just wanted them to start, instead of being this protocol thinking, individualise. Then I said I don't want to pressurise you to give an answer now, think about it overnight, speak to your family when they come tonight, and then you can give the registrar an answer. So, the point here is... so I do try.

IV   That maybe brings me to the next thing, and that is, is it true that some situations and some patients, like you explained now, lean itself towards this?

MI   Yes, definitely.

IV   And one should be taking that opportunity, because you might get another consultant who didn't even take that opportunity.

MI   Yes, that's right.

IV   Okay, but let's say now you have somebody like yourself who is sensitive to those things, when you see the opportunity you grab it as a learning situation

MI   I do, and that's what I did there.

IV   Yes, wonderful. Now, I'm just trying to think about the reality and the context, because the textbook would say do this, and it's a long list of things, and we know what reality is. So in between I am trying to understand, patient centeredness is this big thing, like we said, and it's not always possible to do all of this, but is there minimum criteria?

MI   Yes, I think so.

IV   And what do you think that is? Even in those busy places where you don't have time for this, and sometimes you have a patient that doesn't really understand, or whatever, I mean there are many scenarios. But would you say there is a minimum that any good doctor should really be doing, because I mean there are people out there that are bastards, to say the least.

MI   Yes, that is true.

IV   And it doesn't make it right. If we have like the new generation of young doctors coming up, what would you suggest?

MI   Okay, so I definitely think there is place, even in the acute setting. So for example I did ward rounds in F1 I the EU, the emergency units, the people who do shift work on Wednesday nights, and I noticed for example every time they presented a case to me they would say this is a male patient with whatever, and I always stop them and say what is the people's name? I mean, that is basic.

IV   Basic, but so important.

MI   Basic, but so important, and I always say call the patient by his or her name. Don't make the patient feel like a number, they're a person, an individual. Would you like me to say, your mother is lying here, this is a female patient with lung cancer, in front of the whole room here? No, you want me to close the curtains, be tactful.

IV   Just those basic things, acknowledging that it's a person.

MI   Yes, and even the way, because unfortunately in F1, which is an emergency department, I always tell the doctors be tactful in what you say around the patient, because patients are lying literally next to each other like this, and the other patient can hear what you are saying about this patient.

IV   Yes, they are listening because they're waiting for their turn.

MI   So they hear you saying HIV and cancer, so I say try to be a bit more tactful. Sometimes people don't want other people to know what's wrong with them. So, I always say for example if it's a cancer patient, they always laugh at me, the registrars, I always say rather say a non-benign lesion, you know. That sounds a bit more tactful than saying this patient has got lung cancer and there is nothing more we can do for the patient [chuckles], that type of thing.

IV   I think that is very valuable, as you said. Now I'm just thinking, within that thing that you are sensitive could like a potential problem, because now the patient doesn't understand.

MI   Correct.

IV   So is there a mechanism in place, and time wise, I mean do you have time to go back to the patient?

MI   Yes, in fact there isn't time to go back to the patient. So usually what I do is once we are done with our medical discussion, I usually tell the doctors, or I do it myself, I say in laymen's

terms, once they have moved on to the next patient, they know they must wait for me because I will just tell the patient quickly look, you've got cancer, it looks like lung cancer.

IV   You speak softly to them.

MI   I speak softly to the patient, one-on-one.

IV   That's wonderful.

MI   And I tell them this is what we are going to do next. We are waiting on x-rays or we're waiting on scans or whatever. So there is time for stuff like that.

IV   And it's just that connection you make that makes the patient feel he's not just a number.

MI   Yes, exactly. So I do do that, and there is time for that. There is always time to just spend one minute to tell the patient what is wrong with them.

IV   Yes, absolutely, but now that you are saying that, I have seen now because I've been to a couple of people, there are people that do it and there are people that don't do it. What do you think are the factors that differentiates that somebody regards that one minute, that you say, we don't say you have to do it for half an hour, and some won't do it and they have that same one minute, what do you think?

MI   I want to tell you. I think it's a personality thing, it's an individual thing. It comes from within the person. So I know what it's like when I was a medical student and you know, we used to go with our family members to other hospitals, what it's like to be the family waiting for the doctor to see the patient.

IV   So you can still remember that.

MI   Yes, of course, and I remember that and I always knew but we want to know what's going on, you know. When we ask the family member, who is the patient, what did the doctor say, they say no, they didn't tell me anything. So, I know what that's like, so I've got personal experience.

IV   Did you have a loved one that was regularly going to the hospital?

MI   Yes.

IV   You see, absolutely.

MI   That I had to go with, because I was now the medical student in the family, and I always had to go with.

IV   That must have been an experience for you.

MI   I remember feeling, I remember working at one, or not working, I went with my grandfather to a clinic and he had an atrial fibrillation. I was a fourth your medical student at the time, studied here at Stellenbosch, and the doctor was a community service doctor. She actually spent time to come and talk to me specifically because obviously the grandparents and the parents, the family are all proud, you're studying medicine.

So the doctor was actually a graduate from Stellenbosch University, and she was so happy to hear I am from Stellenbosch and all this, and she actually spent time to show me the ECG, she thinks he's in heart failure. I think it also made it easier on the doctor because I could then explain to them what the problem was. I actually appreciate that back then, and I'm following it through now. So that's why I say, it's individual.

IV   It's personal experiences that you bring.

MI   Yes, and personality. Some people are just not talkers.

IV   Yes, but now on that same token, is that now giving those people the carte blanche to be rude?

MI   No. No, no, there is no excuse for being rude. You are working with people; you need to treat people with dignity.

IV   And I think this is where professionalism comes in.

MI   Yes. You need to treat people with dignity. I still see doctors opening up the patients and exposing the whole body, and I try to give an example, I say I'm going to listen to the heart now, what should I do? I open up the blanket, I only... I don't even lift up the shift. I put my stethoscope under and I listen. But other people are not like this [chuckles].

IV   I love what you say now, and that's what the literature says, because role modelling is a key thing.

MI   Yes.

IV   But, if you just role model, that's interesting in a new article that I have seen, they say it can work for some people, but some people won't even see it. So if you don't make it over to them, like saying for example can you see I'm not lifting the shift because this is a female...?

MI   I tell them.

IV   I mean, that's wonderful.

MI   Yes, I tell them.

IV   Keep on doing that because I have had other doctors now who do good things, and then I look at them, and there was this one situation, the students were on their phones, I don't know, maybe they were Googling the condition. Maybe they weren't, it doesn't matter. The bottom line was they didn't see what she was doing. Afterwards I said to her what you are doing is so wonderful, but maybe just next time point it out to them, because they need to know it. So it's very good that you actually point those things out, because some of them it goes in here and out the other ear and they didn't even realise. They just maybe think you're thinking it's cold, and it's more than just that.

MI   Yes, correct. That is so, yes. So even in F1 where the patients are lying next to each other, you can still treat patients with dignity. But like I said, I think a lot of it is personality. Like I said, some people are able to talk to people, and others are not.

IV   What about gender? Have you picked up anything there, that you think some can be more or less?

MI   No.

IV   Not in your experience?

MI   No. One would think that females would maybe be a bit more...

IV   There is some literature, but it's not.

MI   I don't think so. I have seen some bad nurses [laughs].

IV   The other component is age.

MI   Yes, I think age is a big component.

IV   Do you agree with that?

MI   For students and for consultants.

IV   Because students used to say in the interviews for me the consultants are more patient centred, and they got the feeling that the registrars are so stressed out, that it becomes the least of their priorities to be patient-centred.

MI   That's right yes.

IV   But then you still get registrars that are patient-centred. Is that where personality comes in?

MI   Correct. So I think those, unfortunately again in medicine and F1 where the emphasis is on the acute medical problem and just the numbers of patients that you need to see before the ward round starts, you want to get the blood tests done and the x-rays done and the this and the that, unfortunately the registrars, they do, they are running around like headless chickens. So they don't tend to worry about patient centeredness at the time. I think once the patients are in the ward and they are in a less stressed environment, then they start concentrating on the other aspects. But yes, I think age plays a big role. The more mature you are and the more experience you have, the more you tend to treat patients with dignity.

There was something else I wanted to say. Oh, in fact I've noticed it from the medical student's perspective, and I've been telling Razien Davids, we should actually allow more students to come in this route to medicine, is the students that come from high school into medicine, directly into medicine, and if I compare them to the students who did one or two years of BSC first and then did medicine, it's like chalk and cheese. The students who did BSCs are just so much more mature in the way they look, the way they approach the problem, the way they think, it is completely different.

IV   Unbelievable, and they really want to do it as well.

MI   Yes, and they really want to do it. They didn't get in first time into medicine. They had to work to get there, so they are more appreciative of being, of having the privilege of studying medicine. I told them, I think the university really needs to change their criteria in terms of how many, because they only allow a handful of BSC students to come through.

IV   Yes, they should take more of those.

MI   I think they need to increase that number.

IV   These 18, 19 year olds, I mean they're children.

MI   Yes, exactly. Exactly.

IV   Then, just one or two things, I know you are also in a hurry, so the teaching of patient centeredness, any suggestions from your side how one can aim, like we have a clean slate, we have a new curriculum and we can add things, how can we drive that point?

MI   The teaching of it?

IV   And everything that goes with that.

MI   Yes. I think the way we have been doing it in the past, and I'm talking about what I was exposed to as a medical student, in real life that doesn't really materialise. The family medicine department is really the ones who have been driving the whole patient centred approach, and unfortunately that is just not very practical because we just, unfortunately, don't have time. There is not enough time to spend to tackle those other aspects. So, I think they need to individualise what they... it has to be patient specific. It depends on the condition and what the main problem is.

Like I mentioned to you a cancer patient or a stroke patient versus somebody who just comes in with a pneumonia. There the emphasis would probably be on the treatment of the pneumonia. What led to the pneumonia may be important in terms of the social and the other aspects, For example the patient has HIV and you now need to disclose that information to the patient, and now they have got a pneumonia and that was just the presenting disease. So it depends on the situation and the patient itself. You can't do it on every single patient.

IV   But what you can do on every single patient as you said is to recognise them as a human being.

MI   Correct, and treat them with dignity when you examine them and so on, and at the end a one minute feedback session to the patient, in layman's terms. Those are small things, but it can amount to big things, and that's what I try to do on rounds.

IV   Then the assessment, because students tend to say to me in the interviews like for example we see that doctor, he does it and we like it, I want to be like that, but then they say, come the clinical presentation thing they do, they want to spend a bit of time on that and then they actually don't get marks for it, and the marks really drive them. Some of them suggested that on that rubric that whoever gives them marks there should be things added to that so that those students who don't think of it should also be forced to think, did you give the one minute feedback for example afterwards to the patient. I mean, obviously realistic things. Do you think there is a space for that? How do the rubrics work that you assess your students on?

MI   Well, nobody uses a rubric when we do assessments. It's a thumb suck thing. I like rubrics, I think it's something the university needs to look at more, especially the Department of Internal Medicine, because it de-emphasises trapdoor signs, you know, you didn't find the misplaced apex beat, now you fail the case. No [laughs]. So, you fragment the marks, so you can give for history and examination and all those things. So I think yes, that is something we should consider in terms of...

IV	But the ward mark, how do you give that? [IV laughs] Is it some of that? Is it trying to catch that?

MI	Yes, it's not in a rubric format, but it's divided into a) and b) and a) would be was the student enthusiastic, was he on time, did he show interest, and so forth and so on, what was his character or his behaviour on ward rounds. So you need to think of all of these aspects when you're looking at his picture.

So I always tell the students please, I need to give you a ward mark at the end of this, and the only way I can give you a good ward mark is if you show interest on rounds. You have to present cases. If I can't remember your face when I am looking, then it means you were keeping to yourself, you were hiding behind your friends and so on, on ward rounds. So they need to make an effort to make themselves known.

IV	Do they generally do that when you say that, try to make yourself seen?

MI	For example, I've got two students now, two SIs. In fact, they have now been two weeks into their rotation for the seven week SI rotation, and I was very concerned about them because they just haven't been performing the way I would have expected an SI to perform at this stage of the game. So I actually called them into my office, just the three of us, and I asked them to explain to me why they are performing the way they are, and then a whole story came out about one of the students.

IV	Is it personal things?

MI	Personal things. So then I could understand a bit more, but at the end of the day you need to pass, and I can't give you marks if you haven't performed.

IV	That must have meant a lot to that student.

MI	I hope so.

IV	That you actually went onto a personal level, and seeing that you care for them.

MI	Yes, so then I told them about, ag, I just tried to motivate them to please, you need to study all the time, you can't study two days – I always tell the students this – you can't study two days before the time for an internal medicine exam. To become a doctor takes six years. If medicine was a weekend degree then it would have been two days, but it takes six years, so you have to learn every day. But anyway [laughs], so I do tell them before the time already what I expect of them.

IV   I always get very – I must just say that – very good feedback for you. The students have been saying in the interviews, they have been mentioning you. They have been saying yes, we want to be like him [MI laughs], and I mean really, that is a feather in your cap. It's environment that you are in, and that role modelling, the students are seeing that.

MI   I'm glad. We never get feedback [laughs], so I don't know.

IV   That's what the students said.

MI   That's good to know.

IV   But apart from that what I have done, I went to your department head.

MI   Yes, Prof Irison.

IV   I emailed him and I said to him I'm doing a study on patient centeredness, he must now think in the curriculum and give me any name of somebody that I can contact if I want to get a sense of what does internal do in patient centeredness, and he gave me your name. So it came from both sides.

MI   That's good to know. Look, I spend a lot of time teaching, and I put a lot of effort into it. It started when I was an undergrad already, when they had this tutor mentor programme, I was a tutor. I started then already, but I try to, I always tell the registrars you need to know your topic well if you want to teach medical students because you can't teach a sixth year the way you teach a third year. You have to be able to pitch it at the leave of a third year, at the level of a fourth year, fifth year and sixth year.

So you need to be able to teach the same topic in the amount of detail you would a sixth year, that you would teach a third year, but not at that level, because their understanding of basic science and pathophysiology of disease is not that of a sixth year medical student. But to be able to pitch it at different levels, you need to know the topic well.

IV   Yes, but even beyond that, that is a complete, I think, I won't call it a gift, because I think maybe some people can learnt it, but it's valuable to know where the students are. I think you can do that very well.

MI   Yes, I try to.

IV   But even beyond that, because that would be the first tick, like this is a good clinical teacher, but for my study, I am looking beyond a good clinical teacher in content, and looking at this clinical teacher in his whole like role, does he convey the message to the students,

because he knows the clinical knowledge, but is he giving it over to the student, and this is a patient and you have to acknowledge that this is a human being, that patient centeredness.

MI   That's right, yes.

IV   So it's really that part that you are probably not even thinking of, because you are focussed on teaching them the content in a nice way, which you do, and these other things you're probably not even thinking of.

MI   It's just second nature that you would expect people to know.

IV   Yes, but I think from a curriculum point of view, we need to flag to the students what he is doing wrong. Like if we exposed them to a teaching session now and you say this is the outcome. So the outcomes, after he is done with you, you must know diabetes, what and what, and one of them must be how do you treat a patient with respect.

MI   Yes, I agree.

IV   So, they must look for that as well in between, and I think that's where it falls flat. Often we will stop after those signs.

MI   That is correct, yes.

IV   So with I want to do, and I'll be in contact with you in the next year when I write this up, because I the end when I hopefully come to – I won't say a new model because I don't want to be so like forward to say I'm going to write over the family medicine books, because that's not what I will do, but it's almost just to give context to what they are doing. The students said to me in the interviews we know what it is, but we can't use it.

MI   That's right, you can't use it.

IV   And I mean what does it help?

MI   That's pointless, yes.

IV   So we must help to make something that is still, even if we don't call it patient centeredness, you call it maybe good clinical practice or whatever, but what should every person, every doctor do to patients.

MI   Yes, I agree, and just that said, patient centeredness, it's easy to write it on a piece of paper, but it's really taught at the bedside, unfortunately. You can read it and understand it, but if you can't apply it at the bedside, it means nothing. So, I think there is this dissociation between what we are teaching students at the bedside and what they are reading. I have personal

experience with that patient centred thing and the bedside, and it just doesn't click, unfortunately. If you can come up with something better than what we are currently have, that would be great.

IV   So we have to help the students to apply that, because maybe that whole thing of family medicine, not that I'm saying it's wrong, it's just that there is a day and a time for everything.

MI   That's right.

IV   And there might be a situation where you can use all of that, wonderful.

MI   Yes, definitely.

IV   But in between, we don't give them tools, so now suddenly they, the one student said to me when I'm in the hospital I don't greet the patients, and he's a good student. He's a really good guy. So he hasn't got the ability to transfer that and pick out so what is the essential thing that I must always take with me.

MI   Yes, greeting the patients, saying their names, acknowledging them.

IV   So, thank you very much. I am going to obviously think about this, but I would love to speak to you again at a later stage.

MI   Not a problem.

IV   Maybe we can test a little shorter model that is workable.

MI   Not a problem. I like what you are doing.

IV   Thank you very much for your time.

[End of sound file 00:39:47]