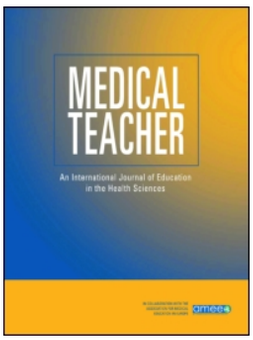

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Workplace-based communication skills training in clinical departments: Examining the role of collegial relations through positioning theory

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ABSTRACT

Introduction: Studies suggest that the workplace is a key to understanding how clinical communication skills learning takes place and that medical communication skills need to be reinforced over time in order not to deteriorate. This study explored the perceptions of doctors in four hospital departments who participated in a workplace-based communication training project. Its specific focus was the relationship between collegial relations and learning communication skills.

Methods: The study applied a qualitative design using an ethnographic methodology, i.e. interviews and observations. Positioning theory was used as the theoretical framework.

Results: Training communication skills with colleagues in the actual workplace setting was valued by the participants who experienced more sharing of communication challenges, previously understood as something private one would not share with colleagues. However, collegial relations were also barriers for providing critical feedback, especially from junior doctors to their seniors.

Conclusion: The position as "colleague" both reinforced the communication skills training and hindered it. The communication skills educational model had a flat, non-hierarchical structure which disturbed the hierarchical structure of the workplace, and its related positions.

Introduction

The theme of this article is workplace-based communication training in for doctors in clinical departments. Medical communication skills training (CST) is by now an integral part of the pre-graduate curricula in most medical schools, and communication is recognized as a key clinical skill, for example as seen in the CanMEDS framework (Tavory and Timmermans 2014). However, CST is rarely systematically incorporated into postgraduate training except in select specialties (van den Eertwegh et al. 2013; Junod Perron et al. 2015), and it is even rarer in continuing medical education (Rotthoff et al. 2011; Silverman 2011). This lack of follow-up training is problematic as research documents that medical communication skills need to be reinforced over time in order to be maintained (Aspegren 1999; van Dalen et al. 2002).

Another challenge is the setting of the CST. Both empirical and theoretical studies point out that to understand how doctors learn communication skills, it is paramount to take the workplace and clinical setting into consideration. Thus, what is learned in the classroom, it not necessarily directly transferable (Lave and Wenger 1991; Brown and Dickson 2010; Bombeke et al. 2012; Junod Perron et al. 2014). Several studies report discrepancies between the formal curriculum and what is observed and learned in the clinical setting (Malhotra et al. 2009; Essers et al. 2012; Rosenbaum and Axelson 2013); and it is suggested that more effort be paid to bridging the gap between formal curricula and workplace reality, for example by paying attention to the teachable moments in the workplace (Rosenbaum and Axelson 2013). However, training communication skills in the workplace setting is a challenge. In a review, Junod Perron et al. (2015) found barriers for workplace training in relation to trainees, trainers, and organizational structures.

The present article explores these barriers in detail. Its specific focus is how collegial relations play a role, and how relationships, hierarchy, and learning interact when doctors are training communication skills in the workplace.

The article is based on a large educational research project with two parts: (1) development and implementation of an educational model for CST for doctors in the workplace, and (2) a qualitative study on the participants' experiences and the barriers and resources for this type of training in the hospital setting.

Practice points

- Workplace communication skills' training is a valuable contribution to continuing professional development.
- Situating communication training in the workplace enable doctors to share challenges otherwise understood as something too private to share with colleagues.
- The position as "colleague" both reinforces the communication skills training and hinders feedback.
- Educational models with a flat, non-hierarchical structure disturbs the hierarchical structure of the workplace.

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Supplemental data for this article can be accessed here.

Conceptual framework

The educational project

In the educational project, a workplace-based CST model for groups of doctors was developed and implemented at four Danish hospital departments (Pediatrics, Neurosurgery, Gynecology, and Respiratory medicine). In Denmark, systematic post-graduate CST mainly takes place through mandatory courses for all residents. Since 2004, all new doctors have attended a 5-d CST course as a part of their 1st year internship. Although the course mirrors clinical reality by involving experiential teaching, e.g. video supervision and role-play, it is held outside the clinical setting.

The theoretical basis for the educational project was Lave and Wenger's (1991) concept of "situated learning", which is very influential in medical education, pointing out how learning happens in social contexts and as part of "communities of practice" rather than being a process of transmitting knowledge from the workplace or through classroom teaching to the individual. It follows from this insight that in CST focus should be allocated to how learning can take place in clinical practice, not only in the classroom. Furthermore, Billett (2004) proposes the concept of "workplace affordances" and emphasizes how the workplace must afford opportunities and support in order for individuals to learn in the workplace. The educational model (see below for a detailed description) was developed in line with this framework by situating training in the clinical setting and with the aim of giving doctors the opportunity to share and discuss communication challenges as part of a department's practice and culture.

Positioning theory

The theoretical background for the study is positioning theory, as developed by Harré and Moghaddam (2003). Positioning theory is an analytical tool for understanding intentional interactions in social episodes "under a local moral order, and the local system of rights and obligations" (Harré and Lagenhove 1999a). Positioning theory is the theoretical lens because it captures the interactions that surround communication training and how being colleagues influences these interactions. It has previously been used to analyze midwifery (McKenzie 2004), gerontology (Allen and Wiles 2013), oncology (Williams et al. 2015), and healthy eating habits in schools (Brock and Christiansen 2014). Here we use positioning theory to understand the interactional dynamics in learning situations in the workplace.

In the following, we briefly describe the theory and its three core analytical concepts, known as the positioning triangle, i.e. (1) the position, (2) the action, and (3) the storyline (see Figure 1). A position is defined as a cluster of rights and obligations to perform certain actions (Harré and Lagenhove 1999b). Any social environment has a range of positions that people may adopt and in which they may try to locate themselves, or may be pushed into, or move away from, break with, etc. Positions are dynamic and changeable. The description of a position thus involves reflecting on certain patterns of behavior in a particular social episode, and may include an analysis of what common expectations shape a specific and limited part of everyday life (Harré and Slocum 2003).

The second concept, i.e. action, includes both speech acts and other actions. Any significant social action, movement, or speech must be interpreted as a certain kind of action. A handshake, for example, is only an intended action in a particular social episode. Whether it expresses "greetings", "goodbye", "congratulations", "confirming a contract", or something completely different is understood only in relation to a specific social episode and its cultural norms, i.e. its local moral order (Harré and Moghaddam 2003).

The third concept, the storyline, orders the episode. Social episodes do not develop randomly but rather follow already established patterns of movement, which is the underlying moral and social order, like orders of narrative conventions. Some storylines are quite conventional and short. For example, a "storyline" could just be "teacher–learner". Storylines summarize how individuals are expected to act and how one may understand their actions in particular situations. "The teacher", for example, has the right (and obligation) to talk in a teaching situation, and we do not expect the learner to interrupt or talk to an equal extent; if the learner acts in this way, we will interpret this as an action that somehow breaks with or changes the storyline, e.g. that the learner tries to position the teacher in a certain way. Thus, in order to understand and interpret actions, we must relate them to the storyline within which they unfold (Harré and Moghaddam 2003). Several storylines may be at work simultaneously in the same episode.

Methods

The educational model

The aim of the present project was to develop an educational model enabling CST to become part of the clinical educational portfolio and working culture (Høst and Møller

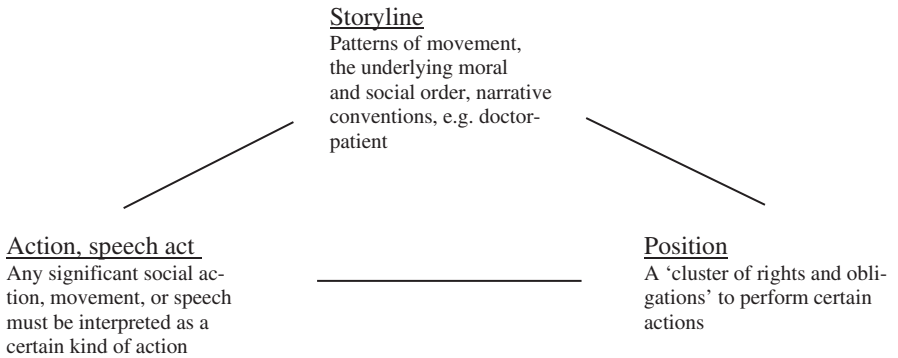

Figure 1. The Positioning Triangle.

2014). The training took place in the clinical setting. It comprised teaching sessions which introduced participants to a communication framework based on the Calgary–Cambridge Guide (Kurtz et al. 2006). The training was based on a drip-by-drip principle, with short training sessions lasting 30–60 min once or twice a week over a long period. All training periods began with 3–4 sessions introducing key communication skills and roleplay. This was followed by a period of video supervision. In the video supervision, one doctor would show approximately 5 min of a video-recorded patient consultation to colleagues in the department. This would be followed by 25 min of group feedback and peer reflection (Ladyshewsky 2013). The feedback model employed was based on agenda-led outcome-based analysis (Kurtz et al. 2006), which allows for learner centeredness and equal opportunity for providing feedback for all participants.

Data collection

The present ethnographic study draws its data from interviews and observations. Semi-structured interviews were conducted with participating doctors by the first author (see Interview guide in Supplementary Appendix 1). The interviews explored the doctors' experiences with the training. The interviews were video recorded and transcribed verbatim. Supporting observational notes were written after selected training sessions. These were used repeatedly to refine the interview guide and to relate the interview themes to concrete events in the training sessions.

Participants and setting

We conducted interviews with selected doctors from each department. The interviews were conducted by the first author. The first author was a facilitator in the training, and thus had knowledge about concrete situations. The interviews took place in hospital offices in the departments after periods of training. We used the principle of maximal variation in order to obtain different perspectives, including both junior and senior participants, as well as doctors who had participated more or less actively.

Ethics

The study was exempted from ethics approval according to the Act on Research Ethics Review of Health Research Projects. The local research committee was notified and the Danish Data Protection agency approved the study. All participants volunteered to participate, they received oral information about the project, and a written consent was obtained. All transcripts were anonymized. As patients only participated indirectly in the research project, they were exempted from giving written consent. They did give oral consent to participate in the video supervision, and all recordings were deleted after training sessions.

Data analysis

The data material was thematically categorized (Braun and Clarke 2006) by the first author, who read the material and identified main themes and sub-themes. Subsequently, a research assistant read the material independently, and alterations and final validation of themes were made of assistant and first author together. This was followed by a theoretical analysis of one of the main themes, i.e. that of collegial relations (see Supplementary Appendix 2 for an overview of main themes). One case was selected to supplement the thematic analysis with a more in-depth study of a training session. This case was chosen, because it condensed the complexity of collegial relations and was thus seen as a "paradigmatic case" (Flyvbjerg 2006). The theoretical framework for the analysis was positioning theory. The analysis was undertaken by the first author in an iterative process between theory and data material, which has been described as an abductive approach (Tavory and Timmermans 2014). Each training session was viewed as a social episode with storylines, and the different positions the episodes provide for the doctors were analyzed (see Supplementary Appendix 2 for an example of the data analysis). Qualitative guidelines were followed to ensure transparency (Tong et al. 2007; O'Brien et al. 2014). Quotations that most accurately illustrated the sub-themes were selected and translated from Danish into idiomatic English.

Results

The educational model – implementation

Between the pilot phase in 2012 and 2016 in total, 121 doctors were part of the training. The training sessions took place in the clinical setting during designated teaching sessions. Each department had a long-term intervention period lasting from 1 year of training as the minimum to $2\frac{1}{2}$ years of intervention. Typically, training took place once weekly for 4 weeks; then there was a 4-week break, which was followed by 4–6 weeks of video supervision and collegial feedback once every week, and so on. Between 5 and 25 doctors attended each training session. This variety was due to the organization of the project, which was an offer to all doctors working in the departments at the time. 10–15 doctors would participate in an average session. Two external facilitators planned and undertook the training (one of which is the first author).

Qualitative analysis

As seen in Table 1 we conducted 41 interviews, which provided 255 pages of transcript. In the following analysis of the data material, we first present the underlying storylines with imbedded positions. Second, we present a case narrative that sheds light on how collegial relations come into play in the training. Finally, we explore the different themes related to being a colleague in CST.

Storylines and positions in the educational concept

The group feedback model has a storyline of feedback-giver and receiver. Hence, in a training session, the person showing a video-recorded consultation is obligated to receive feedback. In turn, the group of colleagues has the right to give feedback. Hence, the model affords equal right to all group members to provide feedback.

Table 1. Overview of data collection in the four departments.

	Pediatrics dept.	Neurosurgery dept.	Gynecology/ obstetrics dept.	Respiratory medicine dept.	Total
Individual interviews	13	10	7	11	41
Trainees	7	4	0	7	18
Specialists	6	6	7	4	23
Pages of transcript	84	49	43	79	255
Observations of training sessions	6	3	3	3	15
Duration of session	30–60 min	60 min	60 min	60 min	
Number of project participants, i.e. doctors employed in each department	29	23	31	38	121

Table 2. Overview of storyline, positions, and actions in the case narrative.

	Mary	Jonathan
Storyline	Feedback: giver–receiver Colleague–colleague. Collegial alliance	Change from colleague-colleague to competitors. Collegial attack
Positions at play	I share an interesting consultation with my colleagues	Disloyal and non-collegial attack from Mary
Action of showing video recorded consultation	Together as colleagues, we share ideas about how to handle angry and unfair reactions from patients A challenge for all of us	Humiliation witnessed by all colleagues Threat to professional identity
Positioning patient and understanding patient speech act	Unjust and grumpy – not a real criticism of doctor	Reasonable patient criticism that I must take into account and consider in terms of changing my communication
Understanding of situation	A situation where "we" learn together how to communicate with complaining patients	A situation where "I" am exposed as lacking communication skills in front of a collegial collective

Case narrative

In this social episode, we meet two junior doctors, Mary and Jonathan, who are both in their specialist training and work at the same department. Jonathan is bilingual; Danish is his second language. The communication training has been running for some months (Table 2).

The particular situation unfolds during a 30-min. video supervision, just after a morning conference, where Mary shows a recorded consultation of herself and a patient in the outpatient clinic and her colleagues give her feedback. Approximately 15 doctors participate in the training session in the conference room, among them Jonathan. An external project consultant (first author) facilitates the session.

Mary tells that she has chosen to show this video because she finds it difficult to deal with patients who complain a lot and show poor compliance. The patient is a middle-aged woman with asthma who is a smoker. Throughout the consultation, the patient makes many complaints about the healthcare system, the high costs of her asthma medicine, etc. Halfway through the conversation, she makes a negative comment about the doctor she met in the previous consultation, complaining that she did not understand anything of what the doctor tried to tell her because of his accent. After the video sequence, the colleagues provide feedback to Mary about handling a complaining and frustrated patient. The session ends.

During the session, however, Jonathan, who is in the room and part of the training, realizes that he is that very doctor about whom the patient complains. He is silent throughout the training session. Mary, knowing that he is the doctor in question, realizes that there might be a problem. Later the same day, Mary asks Jonathan whether he was upset about the video; she suggests that they should talk about it, but Jonathan answers that he is too upset to talk to her. A couple of days later, Jonathan agrees to talk to Mary about the incident and they reach a mutual understanding, where Mary apologizes.

Positioning analysis

This narrative sequence shows how several storylines work simultaneously. In an interview, Mary explains why she chose this video:

> *Well I thought that it was a really good patient for this type of communications skills training. The patient was… well angry because she had so many symptoms relating to a very poorly controlled asthma. She was angry about many things and blamed everyone else: the authorities for not covering her medical expenses, the hospital for not providing the medicine for free, and so on. Then came her remark that she could not understand what the other doctor said. To me that was just a comment like all the others, just as unfair, and just as much a part of her being angry. Therefore, it never occurred to me that Jonathan would feel hurt by it.*

For Mary, the basic storyline is feedback-giver and receiver. She brings the recorded conversation she finds best suited for the training session, i.e. the video that provides the richest learning opportunities for her colleagues. The quote also identifies another storyline, namely colleague-colleague. She positions herself as being member of a collegial collective that shares and discusses how "we" deal with frustrated and complaining patients. She interprets the patient's complaint about the colleague as typical of a particular patient type; and just as unfair as the rest of the complaints.

Jonathan, on the other hand, understands the episode from quite a different perspective, as he expressed in the following quote, for example:

> *And, of course, I was shocked, I really was … In fact, I remember, afterwards I was working at a ward with several patients. I was so shocked that I could not figure out how I should talk to the patients. (…) I just thought, "Oh no, everything I do is wrong!" Because the patient's criticism was really fierce. And I did not know where to begin or what to say. I was just sad about it, right. It was hard to watch it and observe that all my colleagues were sitting there and watching it as well. I think that everyone knew it was me.*

We witness how in the beginning Jonathan understands himself within the same type of colleague-colleague

storyline as Mary. However, Mary's action of showing the patient's complaint about him changes the situation; now it is one of potential conflict. He is in a room full of colleagues where one colleague does the un-collegial thing of exposing a patient's criticism of him. He feels exposed as lacking communications skills by Mary. This highlights the moral dimension of positions as a cluster of rights and obligations. Mary's choice of this case breaks with the obligation to act as a good colleague by exposing another colleagues "in public" as unskilled. And this is what Jonathan experiences:

> *If it had been me, I would never have presented that video. If it was a good colleague, someone that I liked, I would not have presented that. But Mary chose to present that very one … She said she had recorded many videos. But she decided to show this very one! In the situation, I just wondered, "Why did she choose that one?"*

To Jonathan, the act of showing the video is a collegial attack rather than an act of sharing learning material with colleagues. He implicitly begins to position Mary as someone who dislikes him or has hostile motives. This points to another storyline inherent in this episode, namely competitor–competitor. Trainees in specialist training compete as they struggle for employment in the department. And in the position as a competitor or opponent, one has different rights than as a colleague.

In addition, different from Mary's basic understanding of the collegial collective, we see how a doctor–patient storyline is at play. For Mary, the episode involved a question about how "we" as doctors sometimes face unfair complaints from patients – both about the system and about other colleagues. It also shows how "we" as colleagues share ideas about handling that situation, even though we consider the complaints to be irrational. To Jonathan, the meaning of the action is different. To him, the patient's (speech) act is not an irrational insult towards him, but a serious criticism that he must take into account and from which he must learn.

Summary of case narrative analysis

This analysis shows that a general challenge with this type of training is that the social episode unfolds within several storylines that may potentially alter the meanings of the colleague's actions: What from one perspective is an action of sharing a piece of one's intimate sphere with colleagues in order to collectively learn from one another, is from another perspective an action of being a poor colleague, i.e. a competitor deploying unfair means. It is a story about how a safe educational situation suddenly becomes unsafe; a narrative unfolds where friend becomes foe and one's colleague an opponent, not an aid.

Collegial relations and training communication in the workplace – analysis

In the following, the storylines and positions at play in the entire material will be analyzed (Figure 2).

The position as colleague: Obligations and rights

The key storyline is colleague–colleague. This is a moral order where doctors are collegial professionals in the sense that they share professional tasks, i.e. treating patients. Colleagues are expected to show loyalty to one another and respect; a key feature being that the doctors are working "on their own" when talking to patients, without colleagues witnessing what happens in their consultations. One doctor expresses this in the following way:

> *One does the ward round in one place, and the next colleague is in another place. Then we meet and discuss if there are problems, but we don't really see each other working. (Specialist)*

This is the case for doctors at both senior and junior level in the four departments. It shows the doctor's vested right of being a decision-making authority and his or her right to work autonomously.

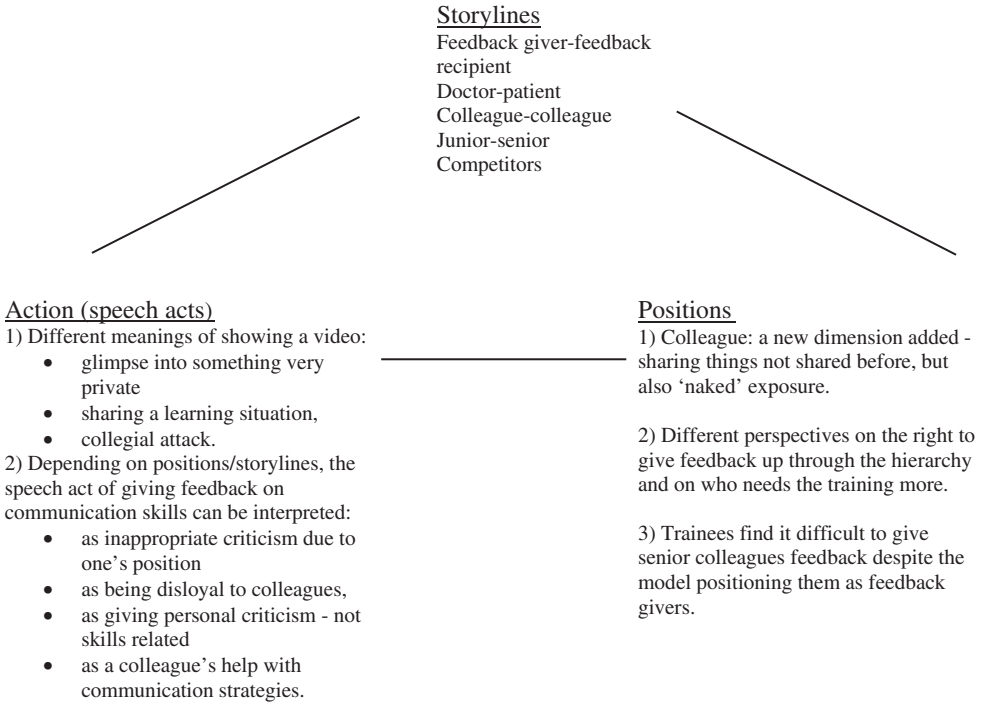

Figure 2. Overview of key findings in the positioning analysis: storylines, positions, and actions in the workplace-based CST.

The position as colleague appears to be both a barrier and a resource for the communication training. First of all, doctors find it overwhelming to show video recordings of consultations to their colleagues. It is a dominant theme in the data material that the position's right to work alone is linked to a sense of privacy. Training using video supervision affronts this privacy; one feels exposed. A specialist expresses this:

> *It is so revealing. You can't really hide. It is different from a morning conference where you can choose not to say anything or you can just make a quick remark and then be quiet. Similarly, in the context of the outpatient clinic: there, I am the one in charge; in charge of the patient, the relatives, and the nurses. And everything is just revealed… it is! (…) Of course, it is also a very intimate situation for the patients, but it's my intimate sphere that is suddenly recorded by a camera and exposed to a group of colleagues.*

As seen in the quote, the feeling of being exposed and even, as some doctors call it, "naked" when showing a video, creates barriers for this type of training. Not only poor communication skills, but also medical errors, suddenly become visible to all. Doctors, both junior and senior, express that showing a video-recorded consultation is tantamount to letting colleagues "peek into something very private".

Returning to the quote above, the way the doctor opposes the position as "colleague in the communication training" to the other two types of social episodes, i.e. "the morning conference" and "the outpatient clinic", highlights how the position changes. Communication training makes visible how private the doctors actually feel the situation is, and training challenges this right. For a few doctors, it was so overwhelming that they declined to show a video.

Furthermore, participants experience that the collegial relation in itself hinders constructive criticism. As one specialist says: "Giving critical feedback is a bit difficult. We have to work together afterwards". Giving critical feedback on communication skills conflicts with what is understood as an obligation as a colleague: It breaks with being loyal, because styles of communication are perceived as tied to identity; and it is felt to be inappropriate for colleagues to comment on identity. At the same time as the position is a barrier, sharing communication challenges with colleagues is also highly valued by the participants. It is repeatedly mentioned as a resource for new ways of learning and cherished as a rare opportunity to see how colleagues handle situations and learn from them.

> *I think it has been great to see how my colleagues handle different types of conversations. I have learned a lot about my own way of communicating from that. And it has been great fun! (Trainee)*

In addition, in some departments, the very fact that training takes places among colleagues enables doctors to discuss and share problems concerning communication in general, also outside the training sessions. As one specialist expresses:

> *The training also has a positive effect on when we talk about patients and care in general. It makes it easier to bring communicative skills into the conversation and ask: "How could we do better communication-wise?" Now we have a mutual frame of reference that makes us capable of that. That's good. (Specialist)*

In this way, training communication skills in the workplace can create a new dimension of what being a colleague is, in the sense that what is expected from each other alters: aside from medical issues and treatment options, one is now able to consult colleagues about how to talk to patients. The doctors report that normally this kind of sharing and discussion of communication issues would not exist.

Senior–junior positions

Another storyline or moral order at play is senior–junior colleague. This storyline is tied to hierarchical departmental structures and is related to supervisor–supervisee positions, registrar-attending physician positions, etc. Thus, related to this storyline is the distribution of rights and obligations about who are expected to teach whom, i.e. senior doctors are expected to teach and provide feedback to junior doctors who are obligated to receive and implement feedback, not *vice versa*.

CST does not follow the hierarchical positions between junior and senior. First, the model of feedback is not aligned with positional hierarchy because all participants are expected to provide constructive feedback, not only senior to junior. Second, due to the specific Danish context where all residents have participated in mandatory CST courses since 2004, junior doctors may have received more training than their senior colleagues. These two elements are illustrated by different junior–senior perspectives on the training.

Many trainees voiced that giving feedback to their seniors was challenging. Some feel that they held back although they had suggestions for changes. This is witnessed in the following trainee quote:

> *We're probably just a little shy. Especially if you have to give feedback to a colleague like Paul who is a senior doctor and has been a doctor for many years – or any other specialist. I think it's easier that they provide feedback to us young doctors than the other way around (Trainee).*

In contrast, most senior doctors find that the feedback model works and that participants at all levels of the hierarchy participate freely and feel able to share all thoughts and suggestions for change. They experience no problems with junior doctors holding back. As expressed by a specialist:

> *To me, in that room of training, in there, the hierarchy is obliterated. When you walk into that room, you have to be prepared that the hierarchical limits are, like, wiped out and disappear. In there, we are equals. In that forum, everyone is allowed to have their say and all opinions count. (Specialist)*

This discrepancy between junior and senior doctors concerning the role of the hierarchy show that hierarchical structures are easier to set aside for the ones in power (i.e. the senior doctors) than it is for the less powered, and paradoxically junior doctors abstain from giving critical feedback to their seniors. Thus, even if Denmark is a culture with a low power distance (Hofstede and Hofstede 2005), the participants are unable to suspend the reality of the hierarchy in training situations, and hence the discrepancy between junior and senior perspectives on the possibility of offering feedback. This discrepancy is repeated in a pattern about who needs CST most. Overall, a vast majority of

the participants express that they gain much from the training. However, the material shows a pattern where junior doctors think that, in general, senior doctors need the training more than they do, due to their lack of formal training. However, several senior doctors also think that junior doctors benefit more from the training due to their lack of experience (although a few perceive the junior doctors as better educated than themselves). In this way, there is a positioning of "the others" as having poorer communication skills than one self.

Collegial competitors

Among trainees, there is a storyline of competitors which is not seen at the senior level. In departments where participants are a mix of specialists and trainees, the trainees may have to compete with their colleagues for long-term positions. This was seen in the case narrative and is confirmed in the material. An example is that some find it difficult to provide constructive criticism, especially to senior doctors, out of fear of being perceived as overcritical:

> *It [competition] plays a role, even though people don't talk about it. But it plays a role to know that if you are the kind of person who complains and criticizes, it might influence where you are able to get a position afterwards. (Trainee)*

Summary of findings

The analysis shows that speech-acts in the training situations can be understood in various ways by the participants because several storylines and positions are involved: the same action of showing a video-recorded patient consultation to colleagues can both be understood as being part of a collegial collective and as a collegial attack.

A core theme was that no matter how much the participants appreciated that the training took place among colleagues and no matter how much they valued the new dimensions of what one could share with colleagues, this very element also introduced challenges due to the multiplicity of storylines: Simultaneously with the training session storyline of feedback-giver and receiver, other storylines and positions existed and hindered feedback (colleague-colleague, junior-senior colleague, and collegial competitors), partly due to that fact that the traditional hierarchy was disturbed by a feedback model that distributed the right to provide feedback equally between the participants. Thus, the data material shows that there are several storylines at play and that these influence how the training unfolds.

Discussion

This study offers insight into the social interactions shaping how workplace-based CST actually unfolds. Positioning theory reminds us about the dynamic and changeable nature of meaning in social episodes (Harré and Lagenhove 1999a), and we found that it was a useful lens for understanding the social interaction in workplace-based training at a "micro"-level. Positioning theory allows us to grasp why situating CST in the workplace is not a neutral exercise, but changes the way in which doctors normally interact as colleagues. This theoretical framework thus allows us to fill the gap in the research on transfer of communication skills to the clinical setting (van den Eertwegh et al. 2013); and it offers us a more detailed understanding of how doctors construct meaning in learning situations and how external input influences this process (Teunissen et al. 2007).

The dynamics of the learning situations can be characterized as reciprocal movement: On the one hand, a variety of collegial aspects influence how learning takes place, for example who is and who is not in a position to provide feedback. On the other hand, the training alters what colleagues normally are expected to do, that is to share communication challenges with one another. Our study thus shows a reciprocal movement where training and collegial structures affect each other; and in this type of learning situation, it is not always easy to know who has the right and obligation to do what.

Our study adds to the existing research on clinical CST by shedding new light on how positions create resources and barriers for workplace-based CST. It confirms that trainees value CST as part of their clinical training (Hutul et al. 2006), and it adds that this is also the case for specialists. However, both junior and senior doctors position "the other group" as the one in most need of the training, which is in line with studies reporting that trainees regard supervisors as poor role models as regards communication skills (Essers et al. 2013).

The present study supports the general assumption that more learning activities, both communication skills and in general, should be situated in the workplace reality to duly capture the complexity of the local contexts. However, our study also shows that this is not a simple task due to the socio-cultural nature of this setting (Paul et al. 2013; Junod Perron et al. 2015), especially not when learning activities involve feedback structures that challenge the learning hierarchy among colleagues. This also points out that locally based facilitators should receive training enabling them to handle the complexities involved in video supervision and collegial feedback. Our findings may have implications for other areas of workplace-based training where the teaching methodology breaks with the traditional hierarchical structure in the clinical setting – both in terms of employing a feedback model that invites constructive criticism from all parties regardless of their place in the hierarchy, but also in training competences and departing skills to all members of a department in contexts where the otherwise more experienced senior doctors do not have the same level of formal training as their junior colleagues. These findings may help in organizing workplace-based training in other of the CanMEDS competencies, e.g. cooperation and teamwork, professionalism, etc.

This study shows how workplace-based educational projects in post-graduate and continuous medical education must take into account the multiplicity of collegial positions in order to succeed. This is definitely the case for CST because it is understood as relating to collegial identity. Yet, implications may also befall on other areas where despite being novices in the workplace context, the trainees actually have more updated knowledge about specific areas than their seniors, and where feedback structures do not follow the normal hierarchy, e.g. types of team training, simulation training, etc.

The findings of this study must be understood in the particular Danish educational context, with the key feature of a "flat" medical hierarchy and a low power distance. Workplace-based training initiatives in other contexts

should consider the characteristic features of the local hierarchy and the positions related to it. Positions and storylines may vary across countries, although some kind of hierarchical structure seems to exist in all hospital settings.

Even though our findings are limited to the four departments and the particular learning cultures of the four specialties in question, the patterns of hierarchy and collegial positions are generally seen in departments. Furthermore, the number of interviews gives weight to the findings, which are a general concern across specialties. The findings are limited to the specific domain of communication skills and its specific feature of being perceived as a competency somehow related to identity. Future research using the positioning theory framework in other areas of workplace-based training would provide a deeper understanding of the kind of positions at play when competencies are learnt. Taking the complexity and particularity of workplace learning contexts into account, our study should be supported by further research into other specialties, as well as research with a focus on positioning between doctors and other health professionals. This would give a broader picture of how learning in the workplace takes place.

Conclusions

The clinical setting enhances collegial feedback; and training with colleagues in the actual workplace may very well change the culture resulting in further sharing of communication challenges hitherto understood as something private. However, collegial relations may also constitute barriers because of the existence of hierarchical structures and their related positions; these hierarchies and positions may be disturbed by an educational model with a flat, non-hierarchical structure.

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Glossary

Positioning theory: Is an analytical tool for understanding intentional interactions in social episodes "under a local moral order, and the local system of rights and obligations". Its three core analytical concepts, known as the positioning triangle, i.e. (1) the position, (2) the action, and (3) the storyline. A position is defined as a cluster of rights and obligations to perform certain actions. An action, includes both speech acts and other actions. The toryline is the underlying moral and social order that orders the episode (Harré and Harré and Lagenhove 1999a, 1999b).

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