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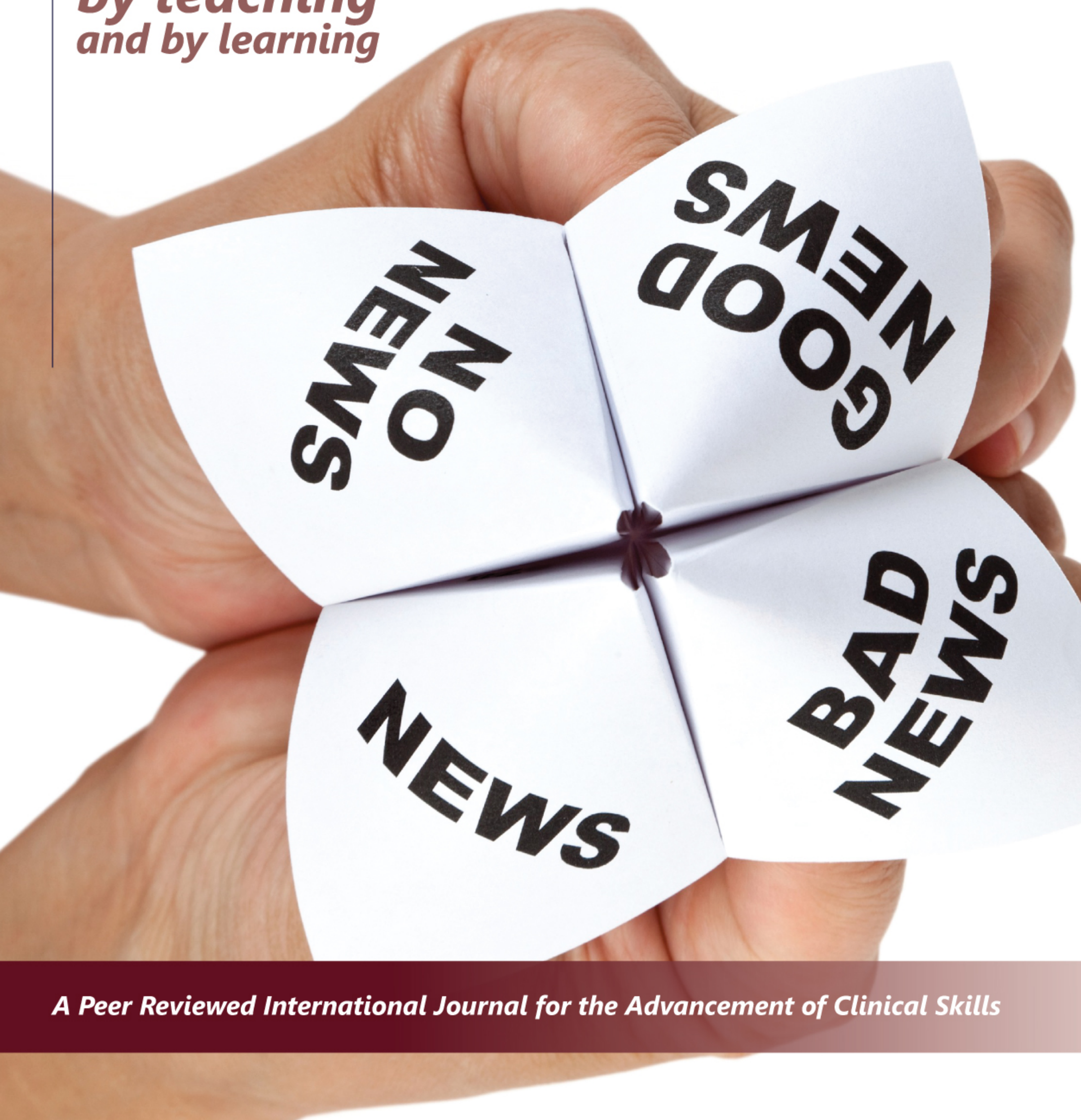

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Contents

Foreword

Welcome to the latest edition of the International Journal of Clinical Skills (IJOCS), Volume 8, Issue 2, March 2014.

There is no doubt that high standards of communication by health care professionals can lead to better patient outcomes and satisfaction. Informed by theoretical perspectives from workplace learning, the Head of Clinical Communication at St George's Medical School, University of London, explores how clinical communication is taught, learned and practised. Is the clinical workplace the legitimate location for teaching and learning clinical communication? This interesting paper proposes a new way of understanding learning in this context.

Can bad news be delivered without destroying hope? Canadian researchers, Dr Lawrence Martis and Dr Anne Westhues, present an informative study which examines the process of breaking bad news in India. Physicians who ground their practice in a biomedical model of care are likely to adopt strategies that result in non-disclosure or partial disclosure of clinical bad news. However, a social determinant of health perspective helps physicians to use strategies to conserve hope among patients without withholding truth about their health condition.

The Trust Quotient and Johari window are tools that can help in understanding, measuring and improving trustworthiness. It follows that greater trust in health care professionals is associated with increased patient satisfaction and improved clinical outcomes. This paper describes a case scenario to illustrate the Trust Quotient and Johari window – tools which should be increasingly utilised by doctors and healthcare workers to measure and improve their trustworthiness.

As always, your feedback is invaluable for the continued development of the International Journal of Clinical Skills – the only peer reviewed international journal devoted to clinical skills. E-mail: feedback@ijocs.org

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Clinical communication in the clinical workplace

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Keywords

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Medical education
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Curriculum design

Abstract

Introduction:
This qualitative study investigates the subject of 'clinical communication' and how it is taught, learned and practised in one London medical school and hospital. It is informed by theoretical perspectives from workplace learning.

Methods:
Five clinical communication teachers and five fourth year medical students took part in a series of interviews and ward observations. Teachers were interviewed about their teaching practice; they were asked to observe students in the clinical workplace and were asked to reflect upon whether these observations had informed their teaching practice. Students were interviewed about how they had learned and subsequently practised clinical communication in the clinical workplace.

Results:
Results suggest that teachers wished to develop a more authentic and integrated teaching practice focused on the clinical workplace. Students seemed able to apply the clinical communication skills they had been previously taught to the clinical workplace, but the patient centred philosophy underpinning these was lost.

Discussion:
Conceptually, the research shifts focus to the clinical workplace as the legitimate location for teaching and learning clinical communication in the later years of the curriculum and proposes a new and expanded way of understanding learning in this context and ends by suggesting practical ways in which this could be achieved.

Introduction

As a clinical communication (CC) teacher in a London medical school I was curious to find out whether our curriculum was effective. I also wondered whether the teaching practice of our team of CC teachers had an impact on the education of students. To investigate these matters, the qualitative study discussed in this paper was carried out as part of a professional doctorate in

education (EdD) at the Institute of Education in London informed by the research question: How does the practice of clinical communication teachers affect the integration of clinical communication skills into the emergent practice of medical students?

This paper briefly describes the background of clinical communication as part of medical education and the emergence of clinical communication teachers. It goes on to offer workplace learning, and in particular the theoretical construct of recontextualisation, as the theoretical underpinning to this study, before describing the the methods and presenting results and conclusions.

Background

Historically all occupational learning, including medicine, was workplace based [1] where learning was delivered via an apprenticeship model. A major achievement for clinical communication as a subject is that it has now come of age and is taught, learned and assessed as part of the core curriculum of all medical schools in the UK [2]. Most medical schools now use simulation with real or simulated patients as part of this learning [2]. However, a desire to place CC education into the curriculum to a time before medical students developed bad habits [2] resulted, in many cases, in its placement in the early years of the curriculum, as well as being taught in a simulated setting e.g. 'front loaded' [3] to a time before students had much experience of working in the clinical workplace with real patients [4]. Early years education is of course important as it prepares students to work with patients safely, but it could now be argued that CC in the early years of medical education is taught in an educational vacuum that has less connection to the real clinical practice of a doctor and that simulated teaching methods may simply provide a simulation of learning, rather than of real life [5].

In the undergraduate context, teachers of CC have also changed, coming from a variety of professional backgrounds e.g. psychology, sociology, linguistics, anthropology, education etc as well as from medicine, nursing and dentistry [6]. Teachers themselves may not be part of the clinical workplace any longer, but bring with them a rich understanding of other professional discourses.

Clinical communication knowledge

All knowledge has a context in which it was originally generated [3] and clinical communication knowledge in the medical school context is 'codified' knowledge (i.e. theoretical knowledge taken from specific academic disciplines, usually in published form) [7] that is generic, not necessarily specific to medicine and is drawn from a mixed behavioural / social science / medical evidence base which may be distant from its original disciplinary origins. In the clinical workplace which is geared towards the care of patients [8] and where 'situated' knowledge is predominant (i.e. knowledge or working practices used to get the job done and rarely published in an academic sense) the CC that is learned by students in the medical school may be viewed as impractical and disconnected from real life by practicing doctors because of time constraints and pressures of the service. Students are often advised that these CC practices should be reserved for exams rather than real clinical practice [9, 10]. This difference in knowledge cultures between teachers in the medical school and clinical workplace may mean that they do not have shared learning goals for students, and therefore students may experience a 'disintegrated learning context' where opposing values of learning CC exist between their teachers [11]. A more in-depth exploration of the literature and underpinning ideas for this study appear in a companion paper [4, 12].

Workplace learning

The clinical workplace has a powerful effect on student learning [13, 14] and theories from the workplace learning field offer an expanded way of understanding how learning takes place in this arena.

A working definition of this learning is, *'About the relationship that exists between the individual learner and the group processes that are situated in the workplace. Workplace learning looks at how the individual, social and cultural processes of working affect learning in the workplace context'*, Adapted from Evans et al [3].

Workplace learning theories have become popular because of a concern that formal courses of professional education that appear at the beginning of a course of study no longer fit the learner for practice in the real workplace world [1]. The theoretical construct of Recontextualisation was developed by Evans, Guile and Harris [15] and aimed to inject 'fresh thinking' into the challenge of integrating theory and practice in work based learning to overcome the theory-practice gap. Recontextualisation proposes that knowledge is recontextualised in four ways:

- ***Content recontextualisation;*** Knowledge in the programme design environment – i.e. identifying codified knowledge from its primary disciplinary sources and selecting it for inclusion in the CC curriculum, i.e. decisions about what is important for students to learn.

- ***Pedagogic recontextualisation;*** Knowledge in the teaching environment, i.e. the codified knowledge is selected, contextualised to the curriculum and teaching methods are designed to deliver it to students.

- ***Workplace recontextualisation;*** Learners acquire situated knowledge by a mixture of modelling, teaching and feedback by doctor teachers in the clinical workplace. Clinical placements facilitate students to recontextualise and modify CC knowledge, attitudes and skills in the authentic clinical workplace, mediated by workplace culture and practices.

- ***Learner recontextualisation;*** How learners make sense of these processes and formulate personal strategies to bring together all forms of learned knowledge and skills to the clinical workplace and recontextualise them to create new CC knowledge, skills and insights in the authentic workplace and assimilate these into their emergent clinical practice.

Recontextualisation provides a new framework for examining how knowledge changes between different domains and how students develop and move their knowledge and learning around and between contexts.

Methods

Qualitative research does not set out to discover objective truths, but seeks to provide a view of the world that may help in understanding particular phenomena, it is necessarily therefore subjective.

This qualitative study was carried out by interviewing five clinical communication teachers (with backgrounds in psychology, psychiatry and social work) on two occasions from one London medical school, plus five senior medical students. The CC teachers also observed medical students on the hospital wards interacting with patients and staff, and wrote reflective accounts of their observations.

Forty 4th year medical students were selected randomly using their student numbers and ensuring a gender balance, they were then invited to take part and nine students responded positively initially, but four did not make it to interview. Students were therefore partially self-selecting.

Ethical approval was obtained from both the NHS Research Development committee and a London Research Ethics Committee.

The epistemological view of any researcher should be compatible with the theory and the methodology used to collect and analyse data in research [16, 17] and therefore Rubin and Rubin's Responsive Interviewing [18] methodology was adapted for the semi structured interviews and interview schedules. For the semi structured ward observations Gillham's Observation Techniques [19] were adapted, which sat well beside the individual interviews, providing a structured and consistent approach which addressed reliability issues, whilst giving a different view of the situation i.e. allowing observation of the performance of students in the clinical workplace analysed through the eyes of expert observers (the CC teachers) in the field [20].

The research sequence

A first semi structured interview with each teacher was conducted. Each teacher observed senior medical students on the wards during a clinical placement on two occasions and wrote up a reflective account of their observations. A second semi structured interview with each teacher was conducted to discuss the reflective accounts and their observation experiences. A semi structured interview with five senior students was conducted. A total of fifteen individual interviews were carried out with the teacher and student participants, nine ward observations were undertaken and nine teacher reflective narrative accounts of the ward observations were collected over a four month period. All interviews were sound recorded and transcribed verbatim and reflective accounts were word-processed. Data were managed using Atlas Ti. To match the methodology used for data collection the Responsive Interviewing Data Analysis method by Rubin and Rubin [18] was used for thematic analysis of the data. Data were analysed in two stages:

Stage 1: recognising concepts, themes and events - The data were coded and analysed by the principle researcher in the early analysis stage after each interview and reflective account until saturation of themes was achieved.

Stage 2: making sense of codes and building theory - The emergent themes were analysed with two independent researchers until consensus was reached and theory was built.

Limitations

This study was based in one UK medical school and is therefore not representative of any other schools. It was carried out on hospital wards and did not examine other clinical workplaces. Due to resource constraints this study did not explore the views and perceptions of doctor teachers in the workplace. It was also not possible to sample the views of CC teachers from other medical schools or a wider selection of medical students. Also, because of resource constraints a representative sample of students was not obtained and this may have introduced selection bias into the study, although this is not a term usually used in qualitative research. Lastly, the pre-existing relationships between the researcher and the research participants may have influenced this study and introduced bias in many subtle ways which is always a risk with 'insider' research.

Results

Results will be presented under the four domains of Recontexualisation for clarity. Illustrative quotes will be coded in the text and appear in full in Table 1. Only selected results and data will be shown, due to space limitations.

Table 1: Quotes from the interviews

CR = Content recontextualisation
PR = Pedagogic recontextualisation
WR = Workplace recontextualisation
LR = Learner recontextualisation
T = Teacher quote
S = Student quote

Code	Content recontextualisation quotes
CRT1	*'My theoretical knowledge is lacking – I think I have forgotten most of it. I think you must mean theory about the subject (CC) rather than the teaching? I don't really know about that'*
CRT2	*'Theory comes from evidence, but the evidence tends to be a lot about how we teach I suppose, rather than what we actually teach. When you think about it like that - where does CC come from?*
CRT3	*'It's [CC teaching] about putting the patient first, it's really about being patient centred, but giving doctors and students the skills to do this'*
CRT4	*'In the classroom we've got time to do simulations, there's no pressure, there's no rush, we're not saying you've got five minutes to talk to this patient because then you've got to go and clerk five more, or then you've got to go and check those bloods or go on a ward round. Those are the real pressures that the students feel when they're doing their wards'*

Code	Pedagogic recontextualisation quotes
PRT5	*'Talking like this made me realise I've got absolutely no grounding to my teaching. I feel very theory-less. I feel incomplete, because I think there's now more of recognition that there should be theory to things, theory to the research we do and the, yeah, teaching we do.'*
PRT6	*'I think mine is quite a sheltered view because I don't see patients every day. I think that is something that could probably inform my teaching practice a lot more and I do kind of wish I had more experience with patients'*
PRT7	*'What they're [the students] having to do is learn two different types of skills in the way that they understand communication skill almost as separate. They do the clinical skill and then they do the communication bit but they can't combine them together*
PRT8	*'Probably the younger doctors they see have been trained [in CC] but the older ones maybe haven't so they don't model what we teach, so students probably model what they see.'*
PRT9	*'You get that sense [from students] of, "What?" You know, you're not a doctor, you're not in there, you're not doing it, how can you teach it?*

Code	Workplace recontextualisation quotes
WRT10	*[During the bedside teaching] 'there was no direct interaction of students or doctor with patients. Does the patient feel included? It appears not much. They were forgotten in the middle of all the clinical talk'*
WRT11	*'She [the student] just asked him if he lived alone, nothing else. Nothing about his job or his life. Nothing about his housing or his social life. As far as she was concerned he was "the Jaundice patient". She couldn't see past his illness to his real life.'*
WRT12	*'There was no empathy shown to the patient about the pain of kidney stones that had clearly been excruciating. The patient described such terrible pain that she had to go to hospital and then the student asked "what kind of stones were they?"*
WRT13	*'The Consultant, although it was clear he was in charge, it was unclear as to what the students were expected to do / know when they were at the bedside.'*

Code	Learner recontextualisation quotes
LRS14	*'I remember learning [in the classroom] how to take a clinical history and signposting, summarising, all that stuff. They showed us all the parts that make up the history and I still use them today'*
LRS15	*'I just never thought how important (CC) was and maybe if I gave it a bit more attention at the time I would have got more out of it, the first two years. I wish someone had told me, you know, those are the things you should focus on, communication skills and clinical skills. I wish someone had told me that'*
LRS16	*'I went [on the wards] with my "tool kit" of CC, you know, the ones we were given in the [teaching] sessions and I watched what the doctors did and then I tried joining them together and practising with patients'*
LRS17	*'I find the best place, actually, to learn history taking and, sort of, communication, is, has been in clinics where I can watch what the doctors do and try the things out for myself'*

LRS18	*'There are many examples out there of what is good and so sometimes I do get a bit confused about what is the right way of doing things. Of course, inherent in this are the much spoken of ways of doing things on the ward and doing things in the medical school where there's almost a different standard'*
LRS19	*'Not sure I always build rapport with a patient, it depends, if somebody's watching you [a doctor] they just say, "Oh, skip that part, just go and do it, blah, blah, blah. Don't waste time and so I do what they say 'cause I don't want to seem different "*

Content recontextualisation

The teacher participants felt that the primary disciplinary origins of CC knowledge have become obscured and have been uncoupled from their academic roots. Current models used in the teaching and learning of CC may mean that the genesis and attribution of CC knowledge has become obscure to some extent and this may have contributed to CC becoming a practical, but academically rather rootless subject [CRT1].

Teachers were unable in some cases to differentiate between the origins of CC and the teaching methodology used to deliver it to students. The boundary between content knowledge (content recontextuaisation) and process teaching (pedagogic recontextualisation) may have become blurred. Teachers therefore confused what was taught with how it was taught because some models of CC amalgamate the two areas [CRT2].

Teachers had a clear conceptualisation of the importance of learning and teaching CC in medical education, much of it centred on the benefit to patient care and wellbeing. At its core, CC teaching and learning is about the practical application of knowledge that is driven by a philosophy which values the importance of patient centeredness in the doctor / patient relationship [CRT3].

The patient centred focus of CC teaching and learning goes beyond a simple skills agenda, but may not be clearly articulated by teachers or learners and therefore may constitute a hidden curriculum. There may be a dichotomy between the codified CC knowledge of the medical school which is patient centred in focus, and the situated knowledge of the clinical workplace that is more bio-medically focused [CRT4].

This clash of codified and situated knowledge may affect the types of knowledge that medical school and clinical workplace teachers select to include in teaching and this may lead to a disintegrated learning environment for students.

Pedagogic recontextualisation

The motivation of CC teachers to teach the subject was strong and linked to their wanting to improve health and patient satisfaction as well as their enjoyment of teaching. The teacher participants were able to talk about the pedagogy that underpinned their teaching in informed and sophisticated ways.

They often referred to 'the literature' on teaching CC and the 'Calgary / Cambridge' guide, an important guide in the UK which provides the evidence and rationale for teaching CC and which also proposes a pedagogical steer for how the subject is taught in medical education [21, 22] [PRT5].

Teacher participants were aware that they had scant experience of being on the wards and all wanted to know more about the clinical workplace and understand the work there better [PRT6].

They were concerned that CC teaching and learning was separate from other clinical skills learning and felt there should be better integration [PRT7].

Teacher participants felt that students sometimes saw CC modelled in a different way by some doctors on the wards and that this could be confusing and challenging for them [PRT8].

With one exception, teacher participants felt that not being a clinical doctor invalidated their status and teaching in the eyes of students [PRT9].

Workplace recontextualisation

The teacher observations of students on the wards were revealing, highlighting some interesting issues about the clinical workplace. All said they learned a great deal about the wards that they had not known before and, without exception, wanted to do more of this in order to develop CC to be more authentic in their teaching.

There was a strong feeling that the CC skills the students had learned in the classroom were, more or less, being used on the wards, but that there was an absence of patient centred focus to the communication they observed e.g. students did not seek to understand the patient or their life in relation to their illness. Teachers felt that because the CC curriculum was front loaded it was difficult to address this deficit in a timely way during teaching sessions [WRT10].

An example of this was that often students did not elicit or took a scant social history from the patient, therefore not exploring the impact of illness on the patient's life [WRT11, WRT12].

Teacher participants saw lots of clinical teaching happening on the wards by doctors of all levels of seniority. This ranged from ad hoc teaching to more formalised teaching at the patient's bedside. Teachers perceived a mixed standard of teaching quality, some very effective in their view, and some less so [WRT13].

Teacher and student participants both perceived that CC was modelled differently by some doctors, and these opposing models could lead to a fragmented learning experience for students.

Learner recontextualisation

During the interviews medical student participants clearly remembered the CC teaching they had received during the early years of their course, particularly when teaching was in small groups and involved filmed role play with actors and feedback. They also identified and described the CC skills they used and could give explicit examples of where they used them on the wards with patients [LRS14].

They saw this teaching as preparation for working in the real clinical world, and felt they had not fully appreciated its importance at the time, but looked back during clinical placements and understood its value [LRS15].

Student participants agreed that the authentic clinical workplace was where they really learned CC, especially when working with patients. They seemed able to recontextualise CC and described clear strategies for applying the CC they had learned in the classroom and elsewhere to the clinical workplace. Most felt that practising and reflecting on their CC with patients and, most importantly, watching qualified doctors at work, as well as receiving feedback from qualified doctors and from peers about their emerging practice, were the most important strategies they used for learning [LRS16, LRS17].

There was sometimes a dissonance between the CC student participants had learned in the classroom with that modelled by qualified doctors they saw, particularly, in their view, by those who were more senior and had been qualified for a number of years. The bio-medical focus of the clinical workplace was an issue for the students [LRS18, LRS19].

Discussion

I wanted to end this article by drawing together some points for discussion from the results and to make suggestions for change in clinical communication teaching and learning for the future.

Teachers of clinical communication

I believe it is important for CC teachers to be more explicit about the patient centred focus that informs their teaching. This must be honestly discussed and presented as an important principle of teaching. Their teaching role is separate, but complementary, to their clinical colleagues. Closer working partnerships and collaboration would increase the power of both.

The origins of clinical communication

An important step in the development of clinical communication as a subject will be the re-discovery of the disciplinary origins of its knowledge base to give depth to the academic rigour of the subject and further strengthen the arguments for its use in the clinical workplace. A textbook of this nature would allow greater engagement with the subject and would be valuable for future research by providing a wider theoretical base.

The medical education curriculum

The teaching of CC must span the whole curriculum so that in addition to giving students basic knowledge and skills in preparation for working with patients, it is able to support and scaffold students during the important developmental clinical years to enable them to embed appropriate patient centred attitudes into their emerging clinical practice.

The clinical workplace

Clinical communication education must focus on the needs and challenges of the clinical workplace in order to prepare students for practice as doctors. This could be done in many ways such as co-teaching, or by situating some CC teaching in the authentic workplace and by co-design and review of the CC curriculum.

CC education must also go beyond the undergraduate curriculum to the postgraduate arena as well. This would be helpful in developing the practice of both junior and senior doctors, who may not have undertaken communication training, for example, due to the passage

of time since qualification or qualification in an overseas institute that does not have a CC curriculum component.

Conclusion

Clinical communication education in the UK is in the main 'front loaded' to the early years of the medical school curriculum. Simulated learning of clinical communication is more effective when linked to authentic practice in the clinical workplace. Teaching and learning of clinical communication should span the whole undergraduate curriculum. Teachers of clinical communication should be united in a shared educational aim to avoid a 'disintegrated learning experience' for students. Clinical communication education should continue into the postgraduate arena.

Declarations

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There are no financial or other interests to declare for this submission.

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References

1. Hager P. (2011). Theories of workplace learning. In Malloch M, Cairns L, Evans K, O'Conner B N (Editors), The SAGE handbook of workplace learning. Pages 17-32, London, UK, SAGE Publications Ltd.

2. Hargie O, Boohan M, McCoy M, Murphy P. (2010). Current trends in communication skills training in UK schools of medicine. Medical Teacher. 32(5):385-391.

3. Evans K, Guile D, Harris J. (2011). Rethinking work-based learning: for education professionals and professionals who educate. In Malloch M, Cairns L, Evans K, O'Conner B N (Editors), The SAGE handbook of workplace learning. Pages 149-163, London, UK, SAGE Publications Ltd.

4. Brown J. (2012). Perspective: clinical communication education in the United Kingdom: some fresh insights. Academic medicine: journal of The Association of American Medical Colleges. 87(8):1101-1104.

5. Bligh, J, Bleakley A. (2006). Distributing menus to hungry learners: can learning by simulation become simulation of learning? Medical Teacher. 28(7):606-613.

6. Brown J. (2008). How clinical communication has become a core part of medical education in the UK. Medical Education. 42(3):271-278.

7. Eraut M. (2004). Transfer of knowledge between education & workplace settings. In Rainbird H, Fuller A, Munro A (Editors). Workplace learning in context. Pages 201-221, London, UK, Routledge.

8. Illeris K. (2011). The fundamentals of workplace learning : understanding how people learn. In working life. Page 179. London, UK, Routledge.

9. Malhotra A, Gregory I, Darvill E, Goble E, Pryce-Roberts A, Lundberg K, Konradsen S, Hafstad H. (2009). Mind the gap: learners' perspectives on what they learn in communication compared to how they and others behave in the real world. Patient Education Counseling. 76(3):385-390.

10. Brown J. (2008). Do the clincal communication skills learned by medical students transfer from the classroom to the clinical environment:an analysis of the experiences and perceptions of fourth year students. In dept of lifelong and comparative education institute of education. London, UK, University of London.

11. Evans K. Guile D, Harris J, Allan H. (2010). Putting knowledge to work: A new approach. In nurse education today, special issue on leadership in learning. Volume 3, Pages 245-251. London, UK, University of London.

12. Brown J. (2012). Through the looking glass: clinical communication. In the clinical workplace. London, UK, Institute of Education University of London.

13. Silverman J, Wood D F. (2004). New approaches to learning clinical skills. Medical Education. 38(10):1021-1023.

14. Heaven C, Clegg J, Maguire P. (2006). Transfer of communication skills training from workshop to workplace: the impact of clinical supervision. Patient Education and Counseling. 60(3):313-325.

15. Evans K, Guile D, Harris J. (2008). Putting knowledge to work. In teaching & learning research briefing. London, UK, Institute of Education.

16. Crotty M. (2003). The foundations of social research. In meaning & perspective in the research process. London, UK, SAGE Publications Ltd.

17. Foddy W. (1993). Constructing questions for interviews and questionnaires. In theory and practice in social research. Page 228. Cambridge, UK, Cambridge University Press.

18. Rubin H J, Rubin I. (2005). Qualitative interviewing : the art of hearing data. Edition 2. Thousand Oaks, USA, SAGE Publications Ltd.

19. Gillham B. (2008). Observation techniques. In structured to unstructured. Page 112. London, UK, Continuum.

20. Robson C. (2002). Real world research. In a resource for social scientists and practitioner-researchers. Edition 2, Page 599. Oxford, UK, Blackwell.

21. Silverman J D, Kurtz S M, Draper J. (2005). Skills for communicating with patients. In Jan van Dalen, Frederic W Platt (Editors). Edition 2, Page 262. Oxford, UK, Radcliffe Medical.

22. Silverman J D, Kurtz S M, Draper J. (2005). Teaching and learning communication skills in medicine. In Jan van Dalen, Frederic W Platt (Editors). Edition 2, Page 367. Oxford, UK, Radcliffe Medical.

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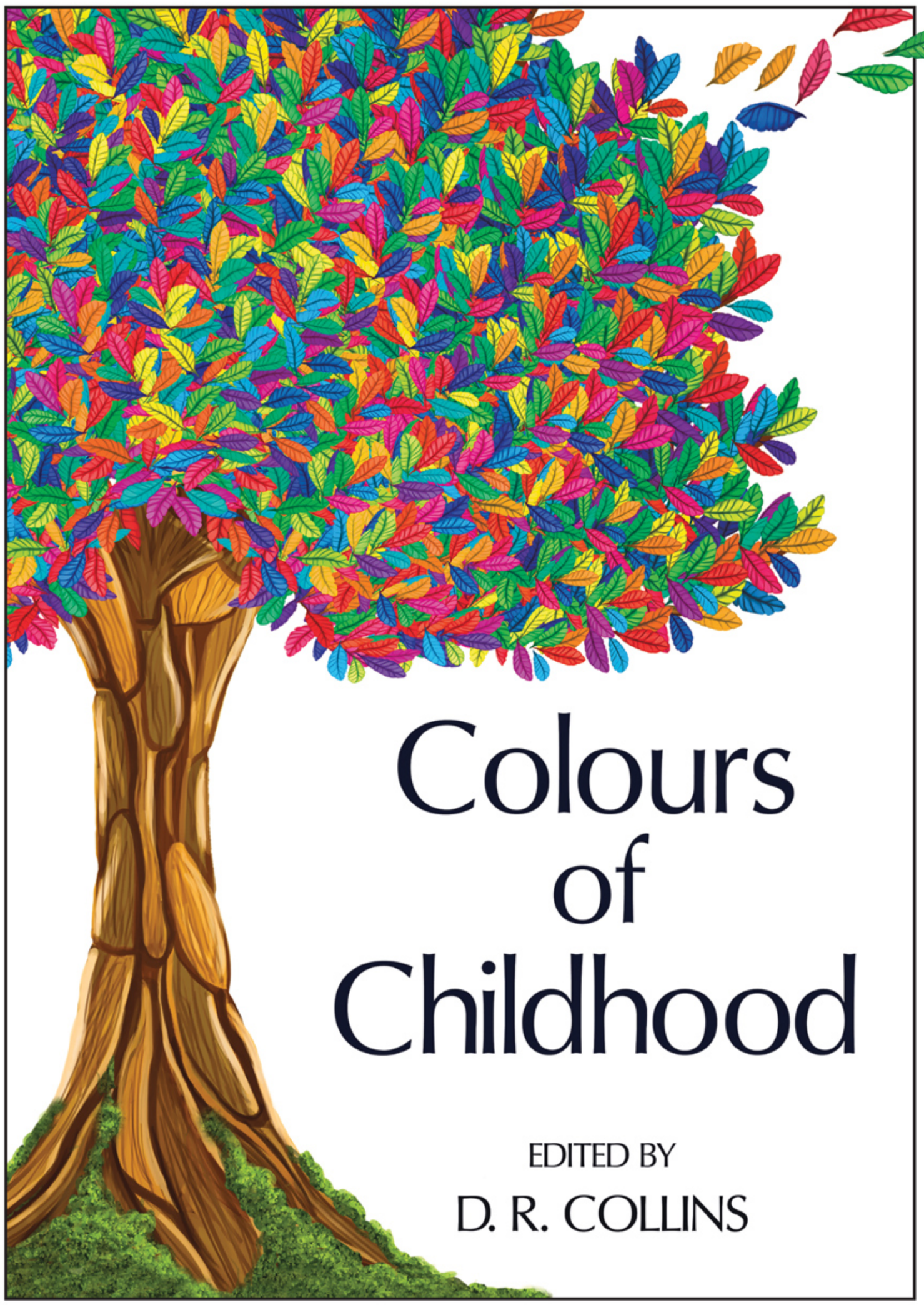

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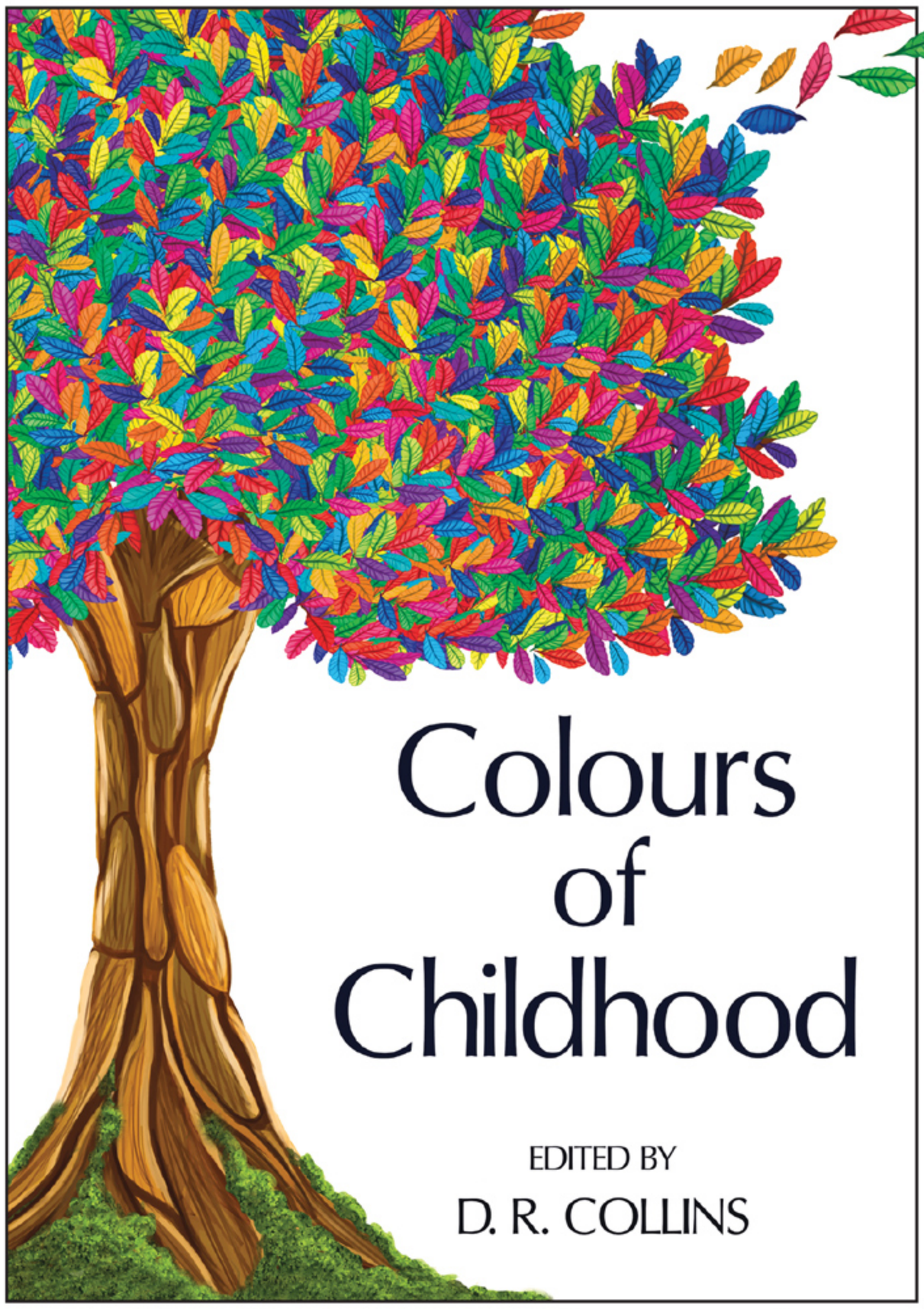

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We all have hopes and dreams, many of these in childhood. But life's twists and turns can make or break a future. **Colours of Childhood** is a tribute to childhood and its many colours. It includes contributions from over one hundred people from all walks of life; they include religious leaders, royalty, sporting personalities, actors, politicians and musicians, just to name a few. Over a hundred poems accompany the contributors' messages, with each poem giving a distinctive insight into childhood and much more. The full-page colour illustrations throughout the book provide a thought-provoking background to the poems. Childhood should be a time to be carefree and happy – but not all of us are so lucky. This unique anthology depicts also human determination and courage, as well as the urge to love and help others. It gives us hope for a better, more united world. What were your childhood hopes and dreams? Wherever life leads you, **Colours of Childhood** is sure to inspire you and brighten your way.

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