OCHER
Oslo Communication in Healthcare
Education and Research

4th OCHER workshop on Clinical Communication Research

January 14-16, 2015

The Oslo Communication in Healthcare Education and Research (OCHER) group

Program

Start:	Wednesday 14 January, 10:00
End:	Friday 16 January, 16:00

Venue: **Thon Hotel Triaden**, Lørenskog, Norway
Address: Gamleveien 88
1476 Rasta
Telephone: +47 66 10 97 00

International guest lecturers and group discussants:

Marla Clayman, MPH, PhD, assistant professor, Northwestern University Feinberg School of Medicine, Chicago, US.
http://fsmweb.northwestern.edu/faculty/FacultyProfile.cfm?xid=16723

Clayman has a background in cognitive sciences and both her master and PhD from the fields of health behaviour and health education. She has for several years focused her research on shared decision making, particularly in cancer patients.

Anssi Peräkylä, sociologist, professor, University of Helsinki, Finland.
http://blogs.helsinki.fi/perakyla/in-english/
Peräkylä is professor of sociology at the University of Helsinki. He is also the vice director of the interdisciplinary Center of Excellence in Research on Intersubjectivity in Interaction at the University of Helsinki, and a practising psychotherapist. He is engaged in conversation analytical research on psychotherapy and on emotional processes in social interaction; his earlier research topics include also primary care medical consultations and AIDS counselling.

Jan C. Frich, MD, PhD, professor, Dept. of Health Management and Health Economics, Institute of Health and Society, University of Oslo.
http://www.med.uio.no/helsam/english/people/aca/jancf/index.html
Jan Frich is a neurologist, health services researcher, and former Harkness fellow in health policy and practice. His research has centered on patients' experiences, quality of care, and clinical leadership. He has an interest in the interface between user and systems.

Local faculty: Pål Gulbrandsen, Arnstein Finset, and Jan Svennevig, University of Oslo

Working languages: English, Scandinavian

	Wednesday January 14		
Time	**Activity**	**Plenary room / Room A**	**Room B**
1000	Plenary	Introduction, mutual presentation	
1045	Break		
1100	Keynote 1	**Anssi Peräkylä:** How is psychotherapy done through social interaction: a conversation analytic perspective	
1200		Discussion	
1230	Lunch		
1315	Groups	**Session A1** **Conversational analysis**	**Session B1** **Basic measurement issues**
		Davidsen & Fogtmann	Steinsbekk & Ammentorp
		Svennevig	Geiger et al
1425	Break		
1435	Keynote 2	**Marla Clayman:** The context of patient decision-making: Some knowns and unknowns (about what shared decision is and what it is not, measures we have and measures we miss)	
1535	Break		
1545	Groups	**Session A2** **Emotions and empathy**	**Session B2** **Elderly 1**
		Ørnes et al	Sundling et al
		Vatne	Sundler et al
1655	End Group		
1715	Walk to Pål's house for get-together	The walk is 15 minutes. Shoes should stand snow.	
2000	Dinner at hotel		
	Thursday January 15		
0830	Groups	**Session A3** **Information exchange 1**	**Session B3** **Training issues 1**
		Indseth & Gerwing	Andenæs et al
		Ofstad	Liethmann et al
0940	Break		
0950	Groups	**Session A4** **Electronic help**	**Session B4** **Adolescents 1**
		Waidtløw et al	Thomsen et al
		Brembo et al	Mellblom et al
1100	Break		
1110	Keynote 3	**Jan C. Frich:** Communicating with systems of care: implications of new digital realities on clinical communication research	
1200	Lunch		
1245	Groups	**Session A5** **Training issues 2**	**Session B5** **Information exchange 2**

		Boga & Haaland	Gerwing et al
		Heyn	Lie et al
1355	Break		
1405	Groups	**Session A6** **Shared decision-making 1**	**Session B6** **Health concepts and practice**
		Kasper	Hafskjold et al
		Cold	Berntsen
1515	Break		
1530	Keynote 4	**Anssi Peräkylä:** Emotion in social interaction: studies on face, prosody and physiological responses	
1630	Break		
1640	Groups	**Session A7** **Adolescents 2**	**Session B7** **Elderly 2**
		Strøm et al	Gorawara-Bhat et al
		Korsvold et al	Vesterager Kristensen et al
1750	End group		
1900	Dinner at hotel		
	Friday January 16		
0830	Groups	**Session A8** **Late cancer**	**Session B8** **Training issues 3**
		Schaufel et al	Ege Møller
		Derks	Haaland & Boga
0940	Break/ Check-out		
1010	Keynote 5	**Marla Clayman:** Do we know it when we see it? Challenges in measuring shared decision-making	
1110	Break		
1120	Groups	**Session A9** **Victims**	**Session B9** **Shared decision making 2**
		Willumsen	van Dulmen
		Høyvik	Gregersen et al
1230	Lunch		
1245	Groups	**Session A10 Patient activation** (all in room A)	
		Wolderslund et al	
		Skirbekk & Finset	
1355	Break		
1405	Keynote 6	**Pål Gulbrandsen:** Surprise!	
1440	Break		
1450	Plenary	Collaboration and way forward	
		Round up and evaluation	
1600	End		

Abstracts

Session A1: Conversational analysis

The voice of depression

Annette Sofie Davidsen[1], *Christina Fogtmann*[2]

[1]Research Unit for General Practice and Section of General Practice, University of Copenhagen
[2]Department of Scandinavian Studies and Linguistics, University of Copenhagen

According to the ICD 10 diagnostic criteria depression is defined by agreed symptoms such as lowering of mood, reduction of energy, and decreased activity. We want to explore how these symptoms relate to the ways patients diagnosed with depression describe and construe their symptoms in consultations with GPs and psychiatrists and how these descriptions are occasioned interactionally and responded to by the physicians.

Our data consist of 29 consultations between physicians and patients diagnosed with mild to moderate depression. To account for interactional aspects we apply conversation analysis. However, to analyse how patients construe their experiences of symptoms we include a functional grammar of language, rendering it possible in addition to identify and account for grammatical patterns in patients' accounts of symptoms.

One of our findings is that patients, when construing their symptoms, often describe that an increased activity is going on in their heads/brains without the patients themselves having any influence or control. Thoughts or brain activity are grammatically realized as the acting parts and the patient as one to whom a characteristic is ascribed. The patient describes him- or herself as being empty, heavy or tired; or as somebody who lacks something, for example feelings.

We will present some analyses and results and we would like to discuss the methodological challenges in our study.

Dialogue and dominance in Marte Meo-counselling

Jan Svennevig

This paper reports on a counselling session between a Marte Meo-therapist and a couple with a small child. The counselling concerns child care, and the participants watch a video recording of a meal in which the mother feeds the toddler. Marte Meo-therapy is a psychological methodology which aims at identifying and strengthening positive interaction patterns between family members by the use of video recordings of everyday interactions. The analysis is based on a conversation analytic methodology, and seeks to describe the interactional patterns between the counsellor and the parents as they watch the video clip and comment on what goes on in it. The analysis focusses on two conflicting orientations in the conversation, dialogue and dominance. It shows how the counsellor contributes to dialogue by inviting and acknowledging the parents' descriptions and viewpoints. On the other hand, it also describes practices by which the counsellor, in subtle ways, directs the conversation towards certain topics and conclusions. This is mainly done by the use of acknowledgements and reformulations of the parents' contributions.

Session B1: Basic measurement issues

Translation of the Communication Assessment Tool (CAT) to Danish and Norwegian

Professor Aslak Steinsbekk, Institutt for Samfunnsmedisin, NTNU, Norway
Professor Jette Ammentorp, Enhed for Sundhedstjenesteforskning, SDU, Denmark

Background
In 2007 Makoul et al. published a questionnaire that patients uses to assess how they experience their communication with the physician / treatment provider (Makoul et al. 2007). The name is the Communication Assessment Tool (CAT) and it has 15 statements scored from 1 to 5 (poor; fair; good; very good; excellent). Due to general high scores, the proportion answering excellent is reported. The process of developing CAT was very thorough and it has have been used in several studies.

There are plans for doing an international comparative study to validate CAT. The have led to interest from Norway and Denmark to participate. As earlier studies have shown that there can be substantial differences when questionnaires are independently translated to the Nordic languages, a project was started to coordinate the translation to Norwegian and Danish

Aim
The aim of the project was to translate the Communication Assessment Tool (CAT) to Norwegian and Danish, make the Norwegian and Danish as similar as possible and to validate them

Methods
A back and forth translation with validation

The back and forth validation were done by having two persons for each language independently translate from the original American version to Norwegian and Danish. Then separate Norwegian and Danish versions were made based on the translations and these were given to others to see if they were understandable. Afterwards the two versions were compared to make them as similar as possible both regarding content and language. The revised Norwegian and Danish versions were subsequently translated back to English by a new person for each language. The translated versions were compared and the final versions are made.

The validation of the questionnaire will be done by having them completed by patients in order to be able to check the psychometric properties. This concerns properties like missing, flooring/ceiling effect, factor analysis and internal consistency (Cronbach’s alfa).

Results
A number of changes in the language were done when comparing the translated Norwegian and Danish versions. Also a few minor errors in translation was noticed. No further changes were needed in the questions themselves after having translated the revised Norwegian and Danish versions back to English. Some changes was made to the introductory text, partly due to the translation and partly due to the practical aspects related to setting. As the work is ongoing, further results will be presented at the OCHER workshop in January 2015.

Conclusion
The Norwegian and Danish version of the Communication Assessment Tool is expected to be an important addition to be used in future studies of interventions targeting patient – provider communication.

Reference
Gregory Makoul, Edward Krupat, Chih-Hung Chang. Measuring patient views of physician communication skills: Development and testing of the Communication Assessment Tool. Patient Education and Counseling, Volume 67, Issue 3, 2007, 333 – 342

Cross-validation of SDM measures: DEEP-SDM and MAPPIN‘SDM

Friedemann Geiger, Katrin Liethmann & Jürgen Kasper

Background

In the past, several instruments have been proposed which aim to assess SDM processes. They often differ with regard to the targeted indicators of SDM. Even more important, they differ with regard to the targeted subjects (doctors, patients, dyads) who may show attempts to initiate SDM.

Developed independently and simultaneously, the recently introduced instruments DEEP-SDM and MAPPIN‘SDM include several corresponding target indicators of SDM which are neglected in other instruments, e.g. judgment of information quality/evidence-based patient information. And they focus the dyad as the relevant unit of analysis. However, DEEP-SDM implements a content analysis approach while MAPPIN‘SDM stresses observable behavior. In addition to an observer perspective, MAPPIN‘SDM also includes self-report scales for doctors and patients.

Objectives

This study aims to cross-validate DEEP-SDM and MAPPIN‘SDM and to relate DEEP-SDM to the MAPPIN‘SDM self-report scales and the compound measure $\mathrm{SDM}_{\mathrm{MASS}}$ to determine similarities and differences between both measures.

Methods

In a German multicenter RCT, video-taped decision processes from 152 consultations led by 38 doctors have already been analyzed with MAPPIN‘SDM. They will we reanalyzed by independent and blinded raters by use of DEEP-SDM. Correlations between both instruments will be calculated.

Therefore, DEEP-SDM has to pass through a translation-back translation process to have a reliable German version. Inter-rater reliabilities will be checked.

Further ideas

- To re-evaluate the communication training by use of DEEP-SDM which had been evaluated in the RCT
- To re-evaluate relations of DEEP-SDM to further endpoints of the RCT (decisional conflict (Dyadic DCS), uncertainty (UP24)

Session A2: Emotions and empathy

Medical students' empathic communication: Emotional, cognitive and behavioural reactions to emotional behaviour of simulated patients

Knut Ørnes(1) *,Hanne-Lise Eikeland* (1)*, Per Hjortdahl*(3)*, Arnstein Finset*(2)*og Reidar Pedersen*(1)

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Bakgrunn: Flere studier har vist at empatisk håndtering av emosjoner kan ha positiv effekt på helse hos både pasient og lege. Paradoksalt nok rapporterer også flere studier at nivået på empati hos legestudenter synker under studiet, men da undersøkt ved hjelp av spørreskjemaer. Det finnes derimot få dybdestudier på hvordan legestudenter under klinisk opplæring håndterer både egne og pasienters følelser i kliniske situasjoner.

Målsetting: Målet med studiet er å få ny innsikt i empati hos legestudenter gjennom å studere kommunikasjonsprosesser under kliniske møter mellom legestudenter tidlig i sin kliniske opplæring og simulerte pasienter instruert i å uttrykke følelser verbalt og nonverbalt. Ved hjelp av videoopptak av simulerte konsultasjoner, semi-strukturerte kvalitative intervjuer samt registreringer av psykofysiologiske data forsøker vi å svare på; (1) hvilke erfaringer og refleksjoner gjør legestudenter seg under ytring av følelser hos pasienter og hva mener de selv påvirker deres atferd ovenfor pasienten, (2) hvilken faktisk atferd utviser studentene ovenfor de simulerte pasientene, (3) finnes tegn til emosjonell psykofysiologisk aktivering hos studentene under pasienters uttrykk av følelser og (4) hvilket bidrag kan en slik bruk av flere metodiske innfallsvinkler til å belyse emosjonelle-, kognitive- og atferdsmessige reaksjoner hos legestudenter gi til forståelsen av empati hos legestudenter?

Design, metode og materiale: Elleve simulerte konsultasjoner mellom 3.-års legestudenter og simulerte kroniske pasienter (skuespillere) ble gjennomført i 2011 og tatt opp på video. Hver legestudent ble bedt om å ta opp sykehistorie på en kronisk syk pasient (uten å vite at de faktisk møtte en skuespiller) mens det ble gjennomført kontinuerlige målinger av elektrisk hudledningsevne (EDA) hos begge individer. Etter konsultasjonen ble en semi-strukturert intervjuguide brukt til å intervjue både simulerte pasienter og skuespillere om deres versjoner om hva som hendte under videoklipp fra konsultasjonen der følelser ble spilt ut av den simulerte pasienten. Kvalitativ analyse vil bli gjennomført av intervjuene av legestudenter og simulerte pasienter, og konversasjonsanalyse og koding av kommunikasjonsatferd vil bli gjort av videoopptakene. Målingene av EDA hos legestudentene vil sammenlignes med studenters egne fremstillinger av hva de opplevde under følelsesuttrykkene samt med funn fra studentenes fremviste atferd under følelsesuttrykkene.

Vitenskapelig betydning: Overordnet hensikt med studien er å få innsikt i hvordan vi bedre kan forberede legestudenter på utfordringene ved å møte den emosjonelle dimensjonen av pasienters livssituasjon, både med hensyn på egenmestring hos studenter og atferd de fremviser ovenfor pasienter.

Emotional dialogue and pro-social communication in support groups for siblings of chronically ill children

Torun M. Vatne
Frambu resource centre for rare disorders

In 2012 psychologists from Frambu resource centre for rare disorders and the department of Psychology at the University of Oslo have developed and pilot tested a manual based group intervention for siblings of children with chronic diseases or disabilities and their parents. An important part of the intervention is to provide opportunities for siblings to share emotional experiences and support each other. To be able to develop guidelines for group leaders to optimize the group climate and promote interaction between group participants, more knowledge about emotional and pro- social communication within support groups for children are needed.

Aim: To conduct a descriptive study to explore how children and group leaders respond to children's expressions of negative emotion during group sessions expressions. Further, to describe to describe the communication sequences following children's expression of emotion I groups to identify prominent patterns.

Method: In 2012 support groups sessions for siblings of a child with a rare disorder conducted at Frambu were videotaped. The groups were led by a psychologist or education specialist together with a facilitator. Data in this study consist of video recordings of 33 group sessions, lasting from 30-90 minutes. The subjects are 56 children aged 6 to 17. The communication the group sessions have been coded using VR-Codes. We are planning to select highly emotional sequences for further content analysis to identify prominent patterns.

Results: The study revealed that group leaders frequently respond by providing space for further disclosure of the emotional experience. Other children rarely respond to expressions of emotion, but when they do they tend to reduce space for further disclosure. Preliminary results when it comes to prominent communication patterns following highly emotional sequences will be presented during the workshop.
In addition to presenting and discussing the results of this study during the workshop, the author would like to discuss the development of a study exploring how children wish to be met by others when revealing emotionally difficult experiences in group sessions.

Session B2: Elderly 1

Communication in optometric practice: The Person-Centred Communication with Older Persons in Need of Health Care (COMHOME) Study

Vibeke Sundling, Gunnar Nygaard, Linda Hafskjold, Hilde Eide
Buskerud and Vestfold University College

In 2050, thirty per cent of the population will be 65 years and older1. The prevalence of visual impairment increases with increasing age because of normal age loss, ocular disease and complications of systemic disease such as diabetes and stroke. Additionally 5% of older people are unnecessarily visually impaired because of uncorrected vision2-4. Reduced vision negatively affects activities of daily living, quality of life and general health 5-13. Optometrists are the largest profession in vision and eye care in Norway and perform more than 1 million eye examinations a year 14. Few studies have systematically studied communication with older people in need of health care15-17 and to the best of our knowledge no studies involves optometrists18.

The aim of the study is to develop knowledge about person-centred communication in the optometric encounter.

The study will include a sample of private practicing optometrists (n=10) in Drammen and Hallingdal and 5 of their encountering older patients living at home (n=50). The optometric encounter will be videotaped. The optometrist will be asked to report self-efficacy in communication and the patients will be asked to report the doctors' communication skills.

Evaluation of optometrist self-efficacy in communications skills, empathy, and mindfulness will be collected using Ammentorp19, Jefferson Empathy Scale20, 21, and Langer 14 items scale22. Information about recognition of patient emotion cues will be collected using the Patient Emotion Cue Test23. The optometric encounters will be video-taped and the communication is planned to be analysed using Four Habits Coding Scheme (FHCS), Roter Interaction Analysis System (RIAS) 24 and the Verona Coding Definitions of Emotional Sequences (VR-CoDES)25. Patient reports on optometrists’ communication and preference of communication will be collected using the Four Habits Patient Questionnaire 26

We appreciate input and discussion at OCHER on aspects of importance to explore in the material.

A qualitative exploration of communicative challenges in home care of older persons

Author(s) details

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Hilde Eide, Professor at Buskerud & Vestfold University College, Norway.
Inger K Holmström, Professor, Mälardalen University, Västerås, and Department of public health and caring sciences, Uppsala University.

Background:
Communication is a basic competence in all health care. Few studies have systematically examined communication between older persons in need of home care services and care providers. Studies have mainly focused on doctors' communication, mostly in hospital settings. Central challenges for health care providers in home care are the complexity of both the care and the communication. With few exceptions, little is known about the communication of caring encounters that take place in the homes of elderly people, and what the communication is about. To increase older peoples' participation and to improve the care of older people in home care more knowledge is needed on how to facilitate person-centered care and communication. There is a lack of research on communicative challenges in the context of home care, and on how to deal with challenging communicative situations.

Aim:
To analyze communicative challenges in the context of home care of older persons.

Methods:
This qualitative study reports from the Swedish findings of an international research project (COMHOME), where data has been gathered on communications with older persons in home care services in Norway, Sweden and Netherlands. We used selected tape-recordings from a data set comprising of approximate 250 tape-recordings on conversations between older persons and care providers during home visit. Tape-recordings with specific situations where the elderly person was identified as particularly vulnerable and careers' communication skills come to a head were selected from the data material.

Findings:
Preliminary results suggests that care providers have to face communication challenges not related to the task at hand. In different ways they are confronted with various situations not always easily handled at the home of the elderly. For example they have to deal with pain and health problems, needs for conversations and interactions, as well as worries and concerns of the older person that the care providers are unable to solve. Further results will be presented and examples given from situations of communicative challenges.

Discussion
The results will be discussed in relation to person centered care.

Session A3: Information exchange 1

Who will do what and when? Analyzing the nuts and bolts of proposed tasks in doctor patient interactions

Thor Indseth and Jennifer Gerwing

Introduction: To adhere to a treatment plan, patients and physicians must secure mutual understanding of what tasks should be done, when, and by whom. Our primary objective was to explore how physicians' and patients' utterances cumulate in making tasks actionable. We met this objective by defining a measure of how complete and clear task formulations are. Our main research questions were: how many treatment related activities are presented and discussed? And are the proposed tasks sufficiently complete and clear for the patient to do them? We aim to use the analysis developed here to contribute to training programs.

Method: 12 videotaped clinical interactions were selected from a corpus of 497 from a hospital in Norway. Each of the six specialist physicians interacted with a patient who was a native-Norwegian speaker and one who had limited Norwegian proficiency . Using microanalysis of face-to-face dialogue, analysts located sequences in which tasks were proposed and categorized them by topic (e.g. tasks about medications, appointments, paperwork, etc.). Tasks were then analyzed for completeness and clarity, including both physician and patient contributions.

Results: There were 90 proposed tasks, 78 of which were selected for qualitative analysis. Using word count as proxy for time and effort; proposed task discussions took up approximately half of the talk, with physicians contributing more than patients (.75 vs. .25). Even though all formulations about the same task in the interaction were included, sometimes crucial information was still missed (e.g., "when" to perform the task was never mentioned). However, more often, the accumulated task formulations were lacking in clarity (e.g., "when" was expressed ambiguously). Whether the patient was a native- or non-native Norwegian speaker made no difference to the completeness or clarity of task formulations.

Discussion: The time spent discussing tasks to be done in the future demonstrated that these physicians appeared to be aware that discussing what should be done is important. However, the detailed analysis of task formulations demonstrated their lack of awareness for how to contribute core information clearly enough that the tasks were actionable. For this presentation, we will show examples of borderline cases (for proposed tasks, complete and clear respectively) and open up for feedback and discussion on where to draw the line.

Quality of information exchange in patient-physician encounters during hospital admissions due to chest pain – project outline

Eirik Ofstad

Background: With more than 150 000 referrals each year, chest pain is the most frequent reason for admission to Norwegian hospitals. After having undergone a battery of resource-heavy and potentially harmful clinical tests, about 25% of chest pain patients are discharged within 48 hours with the unspecific ICD10 diagnosis: chest pain. For other patients, information gathered upon admission governs the subsequent in-hospital trajectory. Despite a decrease in mortality in Norway, cardiovascular disease - commonly presenting with chest pain - is still the leading cause of death, lowering the threshold for clinical tests like stress-ECG, CT, MRI and angiography. Information provided to patients while in hospital likely governs their perception of their own health, level of anxiety and adherence to medical advice and prescriptions.

Objective: To increase knowledge of processes of information exchange and decisions in chest pain admissions and their outcomes (e.g., clinical tests, timeliness and precision of diagnosis and subsequent management, hospital stay duration, patient adherence to medical advice and prescriptions, and levels of patient and physician uncertainty, empowerment, and satisfaction).

Data: Videotaped patient-physician encounters capturing all patient-physician encounters during hospital stays due to chest pain in 10-20 patients. In first group of patients, encounters will be followed by immediate qualitative interviews with the participants. In the second group of patients, encounters will within the same day be followed by sessions where the participants each will watch the video together with the researcher integrating the observation with a qualitative interview. Relevant surveys may be considered. Patient records will be assessed.

Analysis: Videos will be considered coded with relevant instruments (DICTUM, VRcodes, other?). Transcriptions of coded segments of the encounters and interviews will be subject to qualitative analysis.

Questions:

1. Does this project seem sensible to pursue?
2. What do you think about the project outline?
3. What makes it promising?
4. What should be altered?
5. What is missing?
6. Which methods for data collection (interviews, surveys, video interviews) should be considered?
7. Which methods for qualitative data analysis should be considered (coding scheme, qualitative approaches etc)?
8. Which outcomes are important to measure and how?

Teamwork practice: coordinating through talk, movement, and embodied conduct in emergency teams under simulation.

Ellen Andenaes[1], *Gøril Thomassen*[1], *Stine Gundrosen*[2]

[1]) Dept of Language and Communication Studies, Norwegian University of Science and Technology Medical Simulation Centre
[2]) Dept of Circulation and Medical Imaging, Norwegian University of Science and Technology

As the use of interdisciplinary teams in healthcare increases, so does the recognition that team performance is crucial for patient safety and quality of care. Emergency teams are faced with complex challenges in stressful situations, where coordination and communication are critical for the optimal care of the patient (Small et al, 1999). Simulation offers a welcome opportunity for training professionals to perform in emergency situations with no risk to patients.

In simulated settings, as opposed to clinical ones, observation and recording may be planned in advance, and with no risk of compromising patient anonymity. Therefore, simulation also presents ample opportunities to do empirical ground work needed to develop robust analytical tools which can later be used to investigate clinical communication. The aims of the present study are

1) to develop analytical tools that can capture the dynamics and complexity of emergency team communication, and 2) to provide an empirical basis for comparing communication under simulation with communication in clinical situations.

The data for the study is from simulation sessions where six different teams work one identical scenario. The full-scale simulations took place in situ in an emergency department at a university hospital, and videotapes of the scenario were transcribed and analyzed according to principles of activity-based discourse analysis (Sarangi, 2010).

Emergency care is a highly charged decision making context, and several factors interact to produce a high degree of complexity in the communication: there are many participants, talk overlaps and overlays with distributed medical work, parallel talk occurs frequently, and communication is multimodal. The latter point accords with clinical research demonstrating how teams coordinate not only through talk but also through embodied conduct and the alignment of team members' bodies, tools, and patient's body (Hindmarsh and Pilnick, 2002, 2009; Goodwin, 2007; Manser, 2009.) While it is easy to privilege talk in communication training, Husebø, Rystedt, and Friberg (2011) conclude that non-verbal communication necessary for coordination should be included in briefing and debriefing sessions in simulation-based team training.

Keywords: team communication, emergency medicine, simulation, discourse, multimodality

References:

Hindmarsh, Jon and Alison Pilnick, 2002: The tacit order of teamwork: Collaboration and embodied conduct in anaesthesia. *Sociological Quarterly* 43/2: 139-164.
Hindmarsh, Jon and Alison Pilnick, 2007: Knowing Bodies at Work: Embodiment and Ephemeral Teamwork in Anaesthesia. *Organization Studies* 28: 1395.
Husebø, Sissel E., Rystedt, Hans and Febe Friberg 2011: Educating for teamwork – nursing students' coordination in simulated cardiac arrest situations. *Journal of Advanced Nursing* 67(10), 2239-2255.
Manser, Tanya 2009: Teamwork and patient safety in dynamic domains of healthcare: a review of the literature. *Acta Anaesthesiol Scand* 53: 143-151.
Sarangi, Srikant 2010: Healthcare interaction as an expert communicative system: An activity analysis perspective. In J. Streeck (ed.) New Adventures in Language and Interaction. Amsterdam: Benjamins: 167-197.
Small, Stephen D. et al 1999: High-fidelity Simulation Team Training for Emergency Medicine. *Academic Emergency Medicine*, 6,2: 312-323.

Feedbackanalysis

Katrin Liethmann, Friedemann Geiger & Jürgen Kasper

Background/ State of research

There is a lack of Shared Decision Making in clinical practice. Therefore, we developed the training program doktormitSDM for doctors to enhance their SDM skills, piloted and pretested it with a pre-post-measurement and evaluated the training within a multicenter randomized controlled trial (IT'SDM trial, N = 38) (Geiger, Liethmann, Hoffmann, Paschedag & Kasper, 2011). The training consists of three components: (1) Manual, introducing SDM skills, (2) Video tutorial, demonstrating an SDM consultation, (3) Two 15 min. face-to-face-feedbacks after analysis of an own consultation. The RCT showed a training effect (t-test, $p \leq .05$) in the endpoint variable $\mathrm{SDM}_{\mathrm{MASS}}$: The intervention group had a higher increase in SDM competencies during the training compared to the waiting control group. The long term effect was marginally significant (t-test, $p = .06$) (Liethmann, Kasper & Geiger, 2014).

Objectives

The training is proven effective. But we don't know, why. Further studies analyzing the intervention aim at identifying the active components.

Method ideas

Content analysis is taking place based on complete records of the face to face feedback sessions (N = 76) with regard to (1) The extent topics of theoretic relevance are discussed in the consultations, (2) Communicative patterns used by the trainer when providing feedback, and (3) Relationship patterns between trainer and participant. Analysis could be structured using the MAPPIN'SDM (Kasper & Liethmann, 2013) but also the Rating Inventory of Solution oriented Interventions (Honermann, Müssen, Brinkmann, & Schiepek, 1999).

Questions

We want to discuss,

- Which further variables should be taken into account to influence the success of the training.
- How to investigate the feedback sessions at the best, e.g. which instruments are useful or should be developed.

Geiger, F., Liethmann, K., Hoffmann, F., Paschedag, J. & Kasper, J. (2011). Investigating a training supporting shared decision making (IT'S SDM 2011): study protocoll for a randomized controlled trial. *Trials 2011.* 12:232.

Honermann, H., Müssen, P., Brinkmann, A. & Schiepek, G. (1999). *Ratinginventar Lösungsorientierter Interventionen (RLI). Ein bildgebendes Verfahren zur Darstellung ressourcen- und lösungsorientierten Therapeutenverhaltens.* Göttingen: Vandenhoeck & Ruprecht.

Kasper, J. & Liethmann, K. (2013). Manual for training and coding: *$\mathit{MAPPIN'SDM}_{revised}$. Multifocal approach to the 'sharing' in SDM*. Hamburg: Institut für Kommunikation in der Medizin.

Liethmann, K., Kasper, J. & Geiger, F. (2014). *Investigating a Training Supporting Shared Decision-Making (IT'S SDM). Multiperspective results from a multicenter RCT.* European Association in Health Care, Amsterdam.

Session A4: Electronic help

E-LEARNING - ONE WAY OF BRUSHING UP COMMUNICATIONS SKILLS
- a pilot study in a Pediatric Department in Lillebaelt Hospital, Denmark

Karin Yde Waidtløw, Research Assistant, MHSc
Supervisors: Jette Ammentorp, professor & research leader, Poul-Erik Kofoed, professor

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Background:
The use of computer mediated learning has increased significantly over the past years and is now being used widely as an alternative to traditional face-to-face learning. However research studies show that the efficacy of e-learning depends on a wide range of variables, and that some topics and areas are more suitable for this kind of learning style than others.
Based on a communication course developed by The Danish Medical Association, an e-learning brush-up course has been developed and tested in 2 wards in the Pediatric Department of Lillebaelt Hospital. The main purpose of this study is to investigate how the self-efficacy in a group of health professionals (22 nurses and 10 doctors) will be maintained and strengthened in the most appropriate way.

Purpose of the study:

- To investigate if the employees' self-efficacy is being maintained and/or strengthened through the e-learning brush-up course.
- To learn about the participants experience and outcome of the e-learning brush-up course.
- To be used for the further development of an e-learning course which will be covering the entire Lillebaelt Hospital

Method:
Quantitative method: The 32 employees participated in a questionnaire survey: 1 questionnaire was sent out prior to the e-learning course, and 1 questionnaire was sent out immediately afterwards.
Qualitative method: 14 employees (11 nurses and 3 doctors) participated in 3 different focus group interviews.

Preliminary results:

- The statistical analysis of the questionnaire survey is still in preparation.
- The preliminary results of the focus group interviews show that the participants have a predominantly positive attitude towards the e-learning course in the ward that has a supportive management, whereas the attitude was predominantly negative in the ward with a less supportive management. This affected the participants experience of and outcome of the e-learning course.

Development of a web-based decision and support tool for patients with hip Osteoarthritis

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Background: Osteoarthritis (OA) of the hip is a prevalent source of pain and disability in elderly individuals and there are not currently any therapies that are known to stop or reverse the progression of OA. Treatment includes self-management and surgical joint replacement in suitable individuals. Patients describe a constant struggle to make minimal use of drugs and maximum use of other management strategies such as resting and avoiding activities, motivated by the belief that OA is something that comes with age and that exercise increases the wear and tear of the joint.
Providing patients with the information they want at the time they want it remains a challenge.
Patients' needs for information may be underestimated, or alternatively, the amount of provided information may be overestimated. Information must be tailored to patients' literacy skills and meet their varying needs, as the experience and impact of OA symptoms changes over time- in line with the fact that OA is a chronic degenerative condition.

Purpose: To empower these patients possibilities for better self-management and active participation in the decision making process, this research aims at developing a web-based support tool. This tool is meant to provide its users with tailored evidence-based information and serve as a self-evaluation tool as they are asked to keep track of their experiences, values, self-management strategies and symptoms over time. This track-record is hoped to aid communication between the patient and GP, improve self-management and support shared decision making in practice, as perceived by the patient.

Methods: This paper will describe the development process of the web-based support tool. Results from 13 individual qualitative interviews are to be used as reference point when building up a prototype in close collaboration between patient representatives, web-designers, clinicians and researchers. This prototype will be tested and modified in a controlled setting until its design, content and functionality is proven to satisfy the target groups' needs.

Our focus on the OCHER-workshop: This is no easy and straightforward task and we are in need of critical, but constructive input and discussions from fellow researchers and clinicians to increase the likelihood that this will be a success.

1. How do we secure that the tool really is targeting the patient needs (from a person-centred perspective)?
2. How do we engage the clinicians to take an active role in the follow-up of the study participants?
3. How do we measure/evaluate effects? Methods? Focus on shared decision making, personcentred
outcomes…?

Session B4: Adolescents 1

Coaching of adolescents with poorly controlled type 1 diabetes. A randomized controlled study.

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Health Services Research, University of Southern Denmark[1] and the Department of Paediatrics, Kolding Hospital, Denmark[2].

Objectives: Studies have shown that a different approach to help adolescents with poorly controlled type 1 diabetes is needed, and alternative methods such as coaching have been mentioned as a possible tool. Very few studies have investigated the effect of such an intervention. Two pilot studies using coaching on patients with type 1 diabetes have shown promising results and a review on studies using life-coaching on patients has demonstrated the need of further studies. This study is a randomised controlled study investigating whether coaching, offered to adolescents between the age of 15-25 with type 1 diabetes and poor metabolic control , can improve the metabolic control, their self-efficacy, self-determination and quality of life.

Methods: A total of 120 patients will be randomised to either 12 coaching-sessions with a professional coach, or to 12 telephone-sessions with their regular diabetes specialist nurse. The intervention-period will be 18 months. A questionnaire investigating self-efficacy, self-determination and quality of life, will be performed prior to the intervention, after 6 months , at the end of the intervention and again 12,36 and 60 months after the end of the intervention. HbA1c will be analysed in STATA to determine differences between the two groups. Focus-group-discussions with a group of patients, a group of parents/spouses and a group of health-care-professionals will be used to investigate whether the questionnaires covered all aspects, or if there are issues we did not predict to be of importance.

Results: None

Discussion: Any suggestions on how to include reluctant adolescents in this study that could have a major impact on treatment in the future?

Talking about late effects: A video-based observational study of routine follow up between paediatric oncologists and adolescents patient.

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PURPOSE: To investigate 1) to what extent topics of potential late effects were discussed at routine follow-up consultations with adolescent childhood cancer survivors and 2) to what extent paediatric oncologists (hereafter oncologist) provided information about late effects.

PATIENTS AND METHODS: Routine follow-up consultations of 66 adolescents (mean age 15(12–20)) by oncologists (n = 10) were video recorded. Patients had been treated for Leukaemia (72.7%), Lymphoma (21.2%) or a benign haematological disease (7.6%). A rating tool, called Levels of Information about late effects scale, to code potential topics of late effect and information level were developed.

RESULTS: Topics related to potential late effects were discussed in 85% of the consultations of which 71% were initiated by the oncologists. The oncologists did not relate or provide any information about late effects 41% of the times. Topics were explicitly linked to the cancer, treatment or late effects 30% of the times and information was provided 29% of the times. Patient-reported topics (e.g. pain, fatigue, and psychosocial topics) were given less information compared to physical topics (e.g. cardiovascular complication, hormonal problems, fertility). There were marked individual differences between oncologist in terms of how many topics related to potential late effects were discussed and on what level of information were given.

CONCLUSION: Follow-up consultation with adolescents after childhood cancer can be improved by an increased awareness for potential late effect topics, regardless of characteristics, especially when it comes to patient-reported topics. There is a need to reduce individual differences between oncologist by develop a frame for how and when to inform about late effects.

Session A5: Training issues 2

Communication skills process training for providers: Challenges in evaluating patient outcomes

Mwanamvua Boga (1) Ane Haaland (2)

Background

In a communication skills training programme in Kenya, we evaluated outcome on providers' knowledge, skills, behavior, using self-reported tools and external evaluation. Focus has been patient centered care, with three relationship factors explored (*provider-patient, provider-colleague, provider-self)*, leaving out provider-community. All results, and much anecdotal evidence, show patients receive better care: Providers practice skills with more awareness and respect; have higher self-confidence and job satisfaction.
However, we don't have objective evidence from patients – how do they experience care: What's "making a difference" to how they feel about their stay in, or visit to, hospital.

Methods

How to develop method for evaluating outcome:
a) On patients: Experiences and opinions about the quality of care, in this complex situation:

- Hospital has 200 providers. In 5 years, 126 have been trained, some in every ward.
- Patients are met and treated by many different professionals. One cannot assume they meet/are treated by physician
- Exit surveys: Danger that patients will fear being identified; will not say anything "negative" for fear of being "mistreated" next time: Many do not trust public service
- Patients have low expectations of being treated well, and may have difficulties assessing the service – if using quantitative tools
- We do not have a baseline

b) On providers, using objective criteria? Can e.g. days away from work, before and after training, be indicator of better job satisfaction and lower burnout?
How do we know providers are doing what they say they are doing? If they are doing it, are patients seeing and feeling it? Are managers seeing it, realizing importance?

c) What is a useful theoretical framework for such an evaluation? Is realist evaluation a possibility? RE analyses why change occurs, or why not, in which conditions, and is said to improve our understanding of causal processes. RE aim: strengthen external validity.
Other frameworks?

Development of nursing students´ communication skills

Lena Heyn, RN, PhD

Background: Previous studies indicate that communication skills can be taught. Such training is costly and time consuming, but is applied to curricula of most medical and nursing schools in Norway today. Yet, several studies indicate that communication skills decrease during the years of medical school. It is unknown if the same effect apply to nursing students.

Aim: The aim of this study in planning is to investigate nursing students` development of communication skills throughout their studies.

Method: Students will be videotaped when role-playing in two time points of their studies; year one (T1) and year three (T2). The videotapes will be coded using the Verona Coding Definition of Sequence analysis (VR-CoDES).

Analysis: The videos from T1 will be compared to the videos from T2 using regression analysis.

Implications: This study might provide knowledge that will be useful in planning at what time point during nursing school communication skills training should be implemented.

Session B5: Information exchange 2

Caller responses to first-aid instructions: A methodological foundation for investigating information exchange in clinical encounters

Jennifer Gerwing, James Gerwing, and Meredith Allison.

In emergency calls, callers receive instructions for first aid (e.g., moving the patient into a safe position, conducting cardiopulmonary resuscitation). Two-way communication is critical: Callers must carry out instructions, but operators must adjust their instructions to the callers' demonstrated understanding. When callers are non-native speakers, a language barrier impedes this two-way communication. We designed this project to investigate the relationship between how callers respond to instructions and how effective those instructions are. We quantified the extent to which operators adjusted their instructions to caller responses, relating this coordination to the success of the instructions.

The aims of this project necessitated simulated dialogues, in which both dialogic processes and caller's subsequent actions were recorded. We videotaped seventeen dyads consisting of native-English-speaking "operators" and non-native-English-speaking "callers". Operators instructed callers how to put a "patient" (a doll with articulated limbs) into a safe position. Participants were free to respond and interact with each other, but they could not see each other. The videotaped dialogues linked the interactive processes they used to establish mutual understanding with observable evidence of caller understanding.

We used *microanalysis of face-to-face dialogue* to conduct a reliable, functional analysis to show what caller responses projected from the operators' next turn. For example, a caller's display of accurate understanding of an instruction projected operator confirmation that the understanding was correct; a display demonstrating inaccurate understanding projected that the operator initiate repair. We discovered ten distinct, functional categories of caller responses. We then quantified the extent to which operators' next turn "fit" what the caller utterance had projected, producing a coordination proportion for each dyad.

We aim to use this method as the analytical foundation for investigating processes of information exchange in face-to-face clinical encounters, exploring whether patient engagement is only useful if health care providers tailor their subsequent contributions accordingly.

How do we measure the quality of given information? - A preliminary exploration of the information about late effects provided during routine follow-up consultations in a pediatric oncology clinic.

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Background.

Being treated for cancer at a young age places you at significant risk of developing late effects, (serious) health problems caused by the cancer treatment. Childhood cancer survivors need information about their risks of late effects to manage their health optimally, but many lack such knowledge. Little guidance exists as to what constitutes "good" information. Here we aim to investigate the quality of the late effects information provided by paediatric oncologists during routine follow-up care consultations.

Methods.

Routine follow-up consultations with 66 adolescents (mean age 15(12–20)) by pediatric oncologists (n = 10) were video recorded. Patients had been treated for Leukaemia (72.7%), Lymphoma (21.2%) or a benign haematological disease (7.6%) and were consecutively recruited. A rating tool, called Levels of Information about late effects scale, to code potential topics of late effect and information level were developed. This, however, did not capture the "quality" of the information provided. We therefore used different qualitative analyses to explore this.

Results/discussion.

When a topic related to late effects was discussed in the consultation, the oncologist provided information about late effects 60% of times. However, the extent or quality of the information provided ranged widely, from relating the topic of conversation to late effects or the treatment to detailed explanations of underlying mechanisms of why certain late effects could occur. The oncologist could also discuss a current problem or symptom that could potentially be a late effect at length, but without relating it to late effects or the treatment. We found judging the quality of the information provided very challenging to do. Different approaches to rating the quality of the information provided will be discussed.

Session A6: Shared decision making 1

Using patient support corps to implement SDM in clinical practice

Jürgen Kasper

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Background

Although sometimes proven effective [e.g. Liethmann et al.] training doctors' communication skills to strengthen patient involvement into medical decision making seems difficult to implement. This might be due to traditional role structures, time efforts and logistic barriers. Besides provision of training to health personal and evidence based information to patients, establishment of referral routines for patients into a SDM process seems important [Elwyn 2013]. A new approach introduced by Jeff Belkora [2014] seems capable of these challenges. Patients get three-fold decision support by trained medical students (patient support corps). Before a decisional consultation with the doctor, the patients' understanding of medical information and their personal values are explored by an interviewer and transferred into the consultation via a protocol. The latter accompanies the patient during the consultation and provides a take home protocol. The method allows for patient support but also works as sustainable training of medical students and indirectly of doctors too.

The project aims at evaluating the use of patient support corps in Norway.

Methods

The method will be piloted at the University Hospital of North Norway with patients making one of a group of medical decisions, which recently have been addressed by an internet based decision aid (DA: prostate cancer, pancreas cancer, obesity). Patient support corps are supposed to work as an implementation strategy of these decision aids.

A training of advanced medical students will be implemented within regular curricula and in accordance with the Belkora training. Moreover, an on call service is organized. Evaluation will use a controlled trial randomizing patients into either the DA- or the DA-plus support corps-group. Primary outcome is the communication quality in the consultation. Secondary outcomes are the patients' decisional conflict and an informed choice measure.

Shared decision-making

Søren Cold, University of Southern Denmark

What goes on when different doctors are involved in information and decision-making?

A qualitative study of information and decision-making in breast cancer.

A sample of women surgically treated for breast cancer are followed through the consultations with - first the surgeon and afterwards the oncologist, to elucidate to what extent shared decision making is incorporated in the consultations, and how the two specialties play together in that context.

A skilled interviewer will follow the woman through this journey and tape the consultations and afterwards perform an interview of the woman.

Session B6: Health concepts and practice

Person Centred Communication with older persons in home health care - nurse assistants' communication

Linda Hafskjold[1], *Sandra van Dulmen*[1,2,3], *Dorte V Kristensen*[1], *Iren Ruud*[1], *Vibeke Sundling*[1], *Hilde Eide*[1]

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Background: In this study home health care visits are audiotaped in order to explore how older persons express their concerns and how health care providers respond. Nursing assistants and nurses perform overlapping tasks making the nurse assistants' competence an essential part of the quality of home health care services. As there are no studies of nurse assistants in home health care, we focus in this part of our study on this group.

Population and data collection:

- 4 home health care institutions in Buskerud (Drammen and Ål)
- Data was collected December 2013 – April 2014
- A minimum of 5 home visits was audiotaped for:
  20 nurses (85% female) and 20 nurse assistants (90% female)
- 275 visits were recorded (54% with nurse assistants)
- Including 63 patients aged 65 years or older (75% women)

Focus for the discussion at the OCHER seminar:
At the moment we are coding the visits with nurse assistants with the VeRona COding Definition of Emotional Sequences (VR-CoDES). The average duration of the visits is 18 minutes (SD 14 minutes). We are at the moment establishing inter-rater reliability for two new coders and experience challenges that are different form another sample (the A-hus physician sample) where we also recently established inter-rater reliability.

A sample of 18 visits with nurse assistants was extracted to train two coders. The visits lasted for an average of 14 minutes (SD 12 minutes). 8 visits have no cues or concerns and in the remaining 10 visits only cues have been identified so far. Most of the cues are cue b and 60% are health provider elicited. At the seminar we will present and discuss the challenges in establishing inter-rater reliability in this setting and preliminary results from the analyses

What are the goals of care in multi-professional contexts?

An analysis of how different health concepts may affect communication in care

Gro Berntsen, NST Universitetssykehuset Nord-Norge

Introduction: Unrecognized implicit variation in underlying health concepts may hamper communication, cause misunderstandings, contradictory goal setting, fragmentation and disruption of care. We therefore asked the following questions:

- Are health concepts, sampled from the health service research literature, and their related goals for care, contradictory, complementary or overlapping?
- Can a health-concept typology help negotiate clear and unambiguous goals for care?

Theory/Methods: We identified health concepts from reviews and systematic searches in Google Scholar, Medline and Web of Science® on the terms: “health concept” and “quality of care”. A strategic sample of 64 publications were thematically coded into 14 different health concepts. We made pairwise comparisons of concepts to determine whether they were contradictory, complementary or overlapping, and groups of concepts accordingly.

Results: We grouped concepts into 4 themes: “Supernatural health”, “Health is absence of disease”, “Health is a resource for function” and “Health is individually defined”. As modern care precludes the supernatural, we used the three latter themes to build a three-layered model of health to support communication and goal setting:

> *Health is 1) normal structure, function and homeostasis of human biology, which 2) support the necessary, usual, expected and personally desired functions needed to 3) uphold those aspects of life judged as essential by the individual.*

This health model provides a theoretical basis for person- and goal-oriented care. It underlines that biology, function and identity are closely and mutually linked.

Conclusions: The goals of care are often implicit, which may cause miscommunication and confusion. It is imperative that both lay and professional providers of care make goals of care explicit, and that interventions align with “what is important” to the patient.

Session A7: Adolescents 2

Dental anxiety and its effect on the life of dentally anxious adolescents (16-18 years)

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Post.doc. Ingrid Ruud Knutsen. Institute of Health and Society. Department of Health Sciences. Faculty of Medicine, University of Oslo
Professor Tiril Willumsen. Department of Pediatric Dentistry and Behavioural science. Faculty of Dentistry, University of Oslo

Background

Prevalence of dental anxiety in the population indicate that even though we have better equipment and more focus on communication and prevention of dental anxiety, we still have many young adults who develop dental anxiety in their childhood(1). The etiology is multi-factorial (2). To understand dental fear and anxiety we need to understand the individual patient's experiences of the fear response systems and how these mechanisms act as barriers for coping with dental treatment. The fear of doing something you've never done before is a normal bodily reaction, but going from fear to anxiety and phobia is a pathological pathway(3).

Aim

Our aim is to obtain a deeper understanding of experiences related to dental anxiety and avoidance of dental care among adolescents, and to learn more about the experience of and the effects from dental fear treatment.

Material and methods

The study will include adolescents, 16-18 years old, attending the Public Dental Health Service (PDHS) in Norway. The participants will be recruited from a list of patients referred to a dentist competent in dental anxiety treatment. Inclusions criteria will be (i) The participants report experiences of high dental fear and (ii) are judged by the referring dentist to suffer from high levels of dental fear and in need of dental fear treatment(4). To measure dental anxiety the Modified Dental Anxiety Scale (5) will be used both before and after dental anxiety treatment. The study design indicates approximately 10 participants.

Patients will be interviewed about their feelings and experiences in regard to their dental fear and anxiety, the effect it has on their daily life, and other aspects of fear and anxiety that are important to them. We will also focus on what treatment they feel is helpful and what they do to manage dental treatment. Each interview is estimated to last about one hour. The interviews will be recorded and transcribed to paper by the author. The transcriptions will be thoroughly assessed and recurring subject and meanings will be noted. The resulting data will be divided into corresponding themes and sorted hierarchic.

1. Astrom AN, Skaret E, Haugejorden O. Dental anxiety and dental attendance among 25-year-olds in Norway: time trends from 1997 to 2007. BMC oral health. 2011;11:10.
2. Klingberg G. Dental fear and behavior management problems in children. A study of measurement, prevalence, concomitant factors, and clinical effects. Swed Dent J Suppl. 1995;103:1-78.
3. Carlsson SG, Wide Boman U, Lundgren J, Hakeberg M. Dental anxiety - a joint interest for dentists and psychologists. Eur J Oral Sci. 2013;121(3 Pt 2):221-4.
4. Bernson JM, Elfstrom ML, Berggren U. Self-reported dental coping strategies among fearful adult patients: preliminary enquiry explorations. Eur J Oral Sci. 2007;115(6):484-90.
5. Humphris GM, Morrison T, Lindsay SJ. The Modified Dental Anxiety Scale: validation and United Kingdom norms. Community Dent Health. 1995;12(3):143-50.

Breaking bad news to adolescent and young adult cancer patients in emotional turmoil

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Purpose: How oncologists deliver bad news to adolescents' and young adults (AYAs) who display strong emotional reaction is scarcely studied. The task is challenging because of AYAs vulnerable developmental stage and proneness to negative emotions. We therefore report observations of communicational practices from two such consultations.

Methods: Using an explorative design we audio-recorded and transcribed consultations where oncologists delivered the diagnosis of cancer to AYAs. We chose two cases displaying different examples of strong emotional behavior (anger and sadness), and conducted an inductive qualitative content analysis.

Results: Three communicational practices were identified. First, that the oncologists' changing use of personal pronouns was characteristic of the communication. An impersonal we-mode was typically used to explain medical assessments and a personal I- and you-mode when they gave empathic statements. Second, the oncologists' ability to endure the patients' emotional behavior seemed important in an empathic response; and third, there was as a process throughout the consultations in which the oncologists got the patients to acknowledge the upcoming treatment.

Conclusion: We identified three communicational practices not previously described in this clinical setting. The oncologists' switching between different personal pronouns can be seen as a way to address medical issues as well as the patient perspective. Further, enduring the patients 'emotional behavior and getting the patient to acknowledge the upcoming treatment as a process broaden the current understanding of how to deliver bad news to AYAs in emotional turmoil by highlighting ways to do empathy in such challenging clinical situations.

Session B7: Elderly 2

Verbal and Nonverbal Communication of Concerns in Older Adult and Physician Clinical Encounters

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Background
Most studies examine verbal and nonverbal (NV) aspects of communication independently. The present research explores the conjoint unfolding of older patients' verbal and NV dimensions alongside physicians' verbal and NV communication.

Methods
The study sample, N=26, is extracted from AHUS videotaped dataset and categorized into three age groups: young-old, middle-old and old-old. Each tape is coded in three major steps. First, the entire tape is coded for eye contact (EC) and other NV dimensions using five EC codes: 1) looking and talking; 2) looking and not-talking (listening); 3) not-looking and talking; 4) not-looking and not-talking; and 5) brief glance. The first two convey "full attention," and the last three connote "partial attention." Other NV codes include: a) smiles/laughs; b) gestures; c) lean-forward; and d) modifying environment (e.g. chair moved). Second, the tape is reviewed to identify patients' verbal expressions of negative emotions, as defined by the Verona Coding Definition for Emotional Sequences (VRCoDES). Third, NV dimensions and verbal cues/concerns are input into NVivo 10.0 program, and are in process of being analyzed for emerging patterns for physicians, patients and physician-patient communication.

Preliminary Results
Eye contact emerged as a salient nonverbal dimension. Patients spent most time "looking and talking" (77%) compared to physicians (51%). Two types of encounters have so far been identified wherein: 1) verbal cues/concerns and NV eye contact were congruent-- 'providing space' for patient; 2) verbal/nonverbal were incongruent, i.e. verbal 'reduced' and nonverbal 'provided' space for patient. We intend to further explore whether, and if so, how and which nonverbal code criteria supplement patients' verbal cues/concerns—'providing' or 'reducing' space.

Point of Departure for discussion at the OCHER workshop
We are currently in process of completing the analysis, and look forward to presenting preliminary findings on simultaneous coding of nonverbal and verbal dimensions in physician-older patient interactions, as well as challenges encountered.

Communication practice in Norwegian home health care

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Aim. The aim of the study is to describe the communication practice in Norwegian home health care visits between the old patients (age ≥ 65 years old) and the nursing assistants. What kinds of topics are they talking about and is it possible to interpret the communication as person-centered.

Background. In Norway as well as in the rest of Europe the populations still get older. Norwegian health policy aims to ensure that the elderly should be active participants in their lives. The oldest remain even healthier because of higher living standards, economics, higher education and better health. One of the Norwegian health policy goals is a person-centered approach to elderly care. Communication is an important part of the person-centered approach. Few studies are from home health care services.

Design. An observational study with a descriptive exploring design to capture the communication between the nurse assistants and the patients.

Methods. From four different home health care institutions, twenty nursing assistants audiotaped five home visits each. In these article data from ten visits are included. That means that seven different nursing assistants are included in addition to ten different patients. All the patients included receive home health care service and have given their content to participate in the study. All four home health care institutions are included.

Results. The nursing assistant always initiate the conversation when they enter the home of the patients and they always initiate the ending of the visits. The patients primary initiate talks about own health. Additionally the patients often ask for specific health providers or for the next home health care visit. The patients care for the nursing assistants and for others. Both of them often choose courtesy topics to start the conversation or to continue the talks while the nursing assistants are performing the tasks. They confirm the patients when possible and include patients and next ones in how they are performing the tasks. The nursing assistants do not often initiate talk about the health of the patients or follow up the topic. Both parts use humor in their conversation.

Conclusion. The patients are asking for predictability and continuity in the home health care service. They communicate that they worry about own health. The patients care for the nursing assistants and care for own family and other persons in the neighborhood. The nursing assistants usually use a person-centered approach in the way they greet the patients and enter the homes of the patients but they do not often follow up the patients concerns about own health. They use an inclusive way of communicating while focusing on the tasks to perform.

Session A8: Late cancer

End of life or soon healthy? A qualitative study on hope in lung cancer patients under palliative chemotherapy or radiation therapy.

Margrethe Aase Schaufel, Ingrid Miljeteig, Øystein Fløtten.

Bakgrunn

Meistring kan forståast som ”kognitive og oppførselsmessige forsøk i konstant endring for å hanskast med spesifikke ytre og/eller indre krav som blir oppfatta som utfordrande eller å overgå personen sine ressursar”(1). Opplevinga av meistring er eit sentralt element i alle område av menneskelivet, og spelar ei viktig rolle ved sjukdom (2). Meistring kan òg forståast som positiv responsforventning, i motsetjing til håpløyse, definert som negativ responsforventning (3). *Håp* er assosiert med meistring og spelar ei viktig rolle hjå pasientar med alvorleg sjukdom (4,5). Håp hjå alvorleg sjuke har vert skildra som “ei multidimensjonal, dynamisk livskraft karakterisert av ei tillitsfull men usikker forventning om å oppnå eit framtidig gode som, for den håpande personen, er realistisk mogleg og personleg betydingsfullt” (6). Sjølv om ein har fått diagnostisert ein kronisk sjukdom, vil mange pasientar håpe på å bli friske, at ny teknologi eller medisinar vil dukke opp og at dei kan få leve eit ”normalt” liv (7). Legar kan hjelpe pasientar å omdefinere og styrke håp sjølv når dei må hanskast med tap og negative kjensler (8), men det trengst meir kunnskap om korleis dette kan gjerast i ein lungeonkologisk setting. Vi vil undersøke kva for håp pasientar som får kjemo- og/eller stråleterapi i palliativ intensjon har for behandlinga, og korleis legar og sjukepleiarar opplever og hanskast med dette.

Problemstillingar

1. Korleis opplever lungekreftpasientar under palliativ kjemo-og/eller stråleterapi håp?
2. Korleis opplever og hanskast lungesjukepleiarar med dette?
3. Korleis opplever og hanskast lungelegar med dette?

Metode

For å kaste lys over problemstillingane vil vi utføre tre empiriske delstudiar: individualintervju med lungekreftpasientar og fokusgruppeintervju med sjukepleiarar og legar som arbeider med lungekreftpasientar. Vi vil nytte kvalitativ metode til undersøking av empirifeltet for å kunne bruke deltakarane sine erfaringar til å auke forståinga vår av humanistiske, sosiale og kulturelle sider ved problemstillingane (9, 10). Målet er å utvikle kunnskap som kan medverke til ei breiare forståing av menneskeleg handling og opplevingar i ein sosiokulturell samanheng. Intervjustudiar kan seie noko om erfaringar og korleis ulike fenomen blir opplevd, om meining, haldningar og verdiar, om tankar, kjensler og motivasjon bak ulike handlingar. Eit kvalitativt design kan ikkje brukast til å predikere og forklare fenomena sitt omfang eller fordelingar.

Referansar

1. Lazarus RS, Folkman S. Stress, appraisal and coping. New York: Springer Publ. Co.; 1984, s 60.
2. Malterud K, Solvang P. Vulnerability as a strength: why, when, and how? Scand J Public Health Suppl. 2005 Oct;66:3-6.
3. Ursin H, Eriksen HR. The cognitive activation theory of stress. Psychoneuroendocrinology. 2004 Jun;29(5):567-92.
4. Felder BE. Hope and coping in patients with cancer diagnoses. Cancer Nurs. 2004 Jul-Aug;27(4):320-4.
5. Herth K. Fostering hope in terminally-ill people. J Adv Nurs. 1990 Nov;15(11):1250-9.
6. Dufault K, Martocchio BC. Symposium on compassionate care and the dying experience. Hope: its spheres and dimensions. Nurs Clin North Am. 1985 Jun;20(2):379-91.
7. Delmar C, Boje T, Dylmer D, Forup L, Jakobsen C, Moller M, et al. Achieving harmony with oneself: life with a chronic illness. Scand J Caring Sci. 2005 Sep;19(3):204-12.
8. Evans WG, Tulsky JA, Back AL, Arnold RM. Communication at times of transitions: how to help patients cope with loss and re-define hope. Cancer J. 2006 Sep-Oct;12(5):417-24.
9. Malterud K. Qualitative research: standards, challenges, and guidelines. Lancet. 2001 Aug 11;358(9280):483-8.
10. Malterud K. The art and science of clinical knowledge: evidence beyond measures and numbers. Lancet. 2001 Aug 4;358(9279):397-400.

Problem presentation in the cancer follow-up consultation: How an orientation on ‘exiting the sick role’ affects uptake of complaints

Author: Elin Derks

In cancer care, the importance of good physician-patient communication is increasingly being recognised. Especially with a disease like cancer, patients are faced with major uncertainties, complex medical information and decision-making, and continuing concerns about disease recurrence. Research has shown, however, that physicians tend to limit discussion to biomedical concerns (in particular concerns that are known and can be treated), while psychosocial concerns get short shrift (Fine et al., 2010). In the past decade, many interventions have been developed to increase the discussion of psychosocial problems – but so far, their impact on discussion and uptake of complaints has been limited. This study investigates problem presentation in the cancer survivorship phase. Up to five years after treatment patients come back for follow-up consultations, in which their recovery is monitored and they are examined for signs of recurrence or metastasis. It is in this post-treatment phase that physician and patient may differ the most in their perspective on the disease. Where the physician sees treatment success, the cancer survivor is often dealing with the physical and emotional impact of treatment and a lingering fear of recurrence (Epstein & Street, 2007). In this presentation, we will look at an interactional phenomenon in the cancer follow-up consultation that may further hamper discussion of psychosocial complaints. In their conversation, both physician and patient seem to be oriented to treatment success, signs of recovery and patients’ own efforts to get well. That is, where most medical interactions are focused on *entry to* the ‘sick role’ (Parsons, 1951), the cancer follow-up consultation seems to be focused on *exit from* this role (cf. Beach, 2013). Often this orientation on ‘exiting the sick role’ is co-constructed by physician and patient. In some cases, however, this orientation seems to function as a physician strategy to close down discussion of complaints. Both phenomena, and their likely impact on uptake of complaints, will be discussed.

Beach, Wayne A. 2013. Patients’ efforts to justify wellness in a comprehensive cancer clinic. *Health Communication* 28(6): 577-591.

Epstein, R.M. and Street, R.L. Jr. (2007). *Patient-centered communication in cancer care: Promoting healing and reducing suffering*. National Cancer Institute, NIH Publication no. 07-6225. Bethesda, MD.

Fine, E., Carrington Reid, M., Shengelia, R., and Adelman, R.D. (2010). “Directly observed patient-physician discussions in palliative and end-of-life care: A systematic review of the literature.” *Journal of Palliative Medicine 15*(5): 595-603.

Parsons, Talcott 1951. *The social system*. New York: Free Press.

Session B8: Training issues 3

Situated learning and collegial structures in communication skills training for doctors - A qualitative study of four hospital wards.

Jane Ege Møller

Since 2004 post-graduate medical communications training in Denmark predominantly has taken the form of short mandatory courses separated from the clinical work. Theories concerning situated learning, transfer, and communication skills training, however, suggest that this type of training may be more effective if it was integrated in everyday clinical practice.

Thus, this project developed and implemented a communication skills training concept for doctors in four different hospital departments (i.e. neurosurgery, gynecology, pediatrics and lung medicine) in Denmark. The concept built on the Calgary-Cambridge Observation Guide, and involved role-play, video supervision, collegial feedback and facilitator training.
A qualitative study was undertaken applying ethnographic methodology. Methods involved were observations and interviews with participating doctors (n=36). The qualitative study investigated how this type of training was received and perceived.

This paper explores a key theme in the data material, namely, the role of collegial culture and disturbance of hierarchical structures. The material shows that even though all the participating doctors express a positive attitude to the training, there are differences in terms of level of experience and rank. Junior doctors find it challenging to give constrictive criticism to senior colleagues, and sometimes they abstain from doing it. At the same time they find that senior doctors could benefit more from the training, due to their lack of prior training. On the other hand senior doctors express that this kind of training is more beneficial to the junior doctors, because of their lack of experience. Thus it seems that collegial relations influence how one perceives the training and gives and receives critique. This paper will discuss these findings in more detail.

At a theoretical level the paper discusses the concept of situated learning as described by Wenger and Lave (1991) related to these empirical findings.

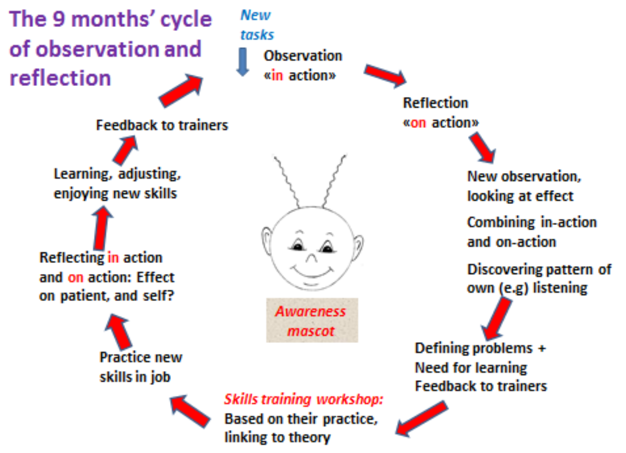
Reflective learning: How does the use of these methods affect providers’ motivation to provide patient centred care, and the skills to do so?

How can the effect be measured, and attributed?

Ane Haaland, Mwanamvua Boga

Background

Reflective learning methods are increasingly used to strengthen providers’ skills. Interactive reflection in groups (Schøn, “Reflection on action”), narratives to reflect on experiences (Bradley, 2002), and action research (Ghaye 2008) are common. Recently, mindfulness training is used to stimulate health providers’ reflective skills.



Methods

A 9 months’ training process implemented at Kilifi Hospital used on-the-job individual observation and reflection tasks to create awareness of how providers’ communication affect patients and colleagues, followed by workshop using experience-based learning and interactive reflection; further observation in “Skills into Action”, using informed reflection. The work builds on a model implemented in 6 countries in Africa and Eastern Europe.

Evaluation is based on self-reports and on evaluation by independent researchers.

Results

In five courses, 141 providers were trained. Providers reported improvement on three dimensions of patient centered care, especially on ability to recognize and step back from automatic reactions to emotional challenges, and to see situations from patients’ perspective. Reflective learning particularly strengthens provider-self relationship by developing awareness of how their own communication affects patients, and taking responsibility for learning. They realize their actions hurt patients. Absence of external shame and judgment motivates them to learn, rather than to defend their actions.

Through interactive reflection on experiences with colleagues in workshops, they share challenges. Informed reflection practiced in tasks after workshop makes them experience how well new skills work, and how positively patients respond. Job satisfaction increases, and so does motivation to continue to practice skills that work, and that feed their own energy and well-being. Process of using individual reflection to discover, followed by interactive reflection in the workshop, and informed reflection in subsequent work seems crucial to enable providers to be motivated and skilled to practice patient centred care.

Question

How do we show the causal relationship between training method and outcome?

Session A9: Victims

Challenges in communication with child sexual abuse survivors in the dental office.

Tiril Willumsen, Professor, Department of behavioral science, Dental faculty, University of Oslo

Background: Child sexual abuse (CSA) survivors may have problems when receiving dental treatment and many report high a level of dental anxiety. In a recent report it was concluded that strong behavioral and communication skills and understanding the health effects of trauma are important factors when treating traumatized dental patients. In an earlier anonymous questionnaire study, the author compared elements of dental fear reactions in women with dental fear with and without CSA history. Women with CSA history reported to be statistically more vulnerable in factors associated with communication with the dentist, trusting the dentist, being given negative information and lack of control in the dental situation. It could be of interest to gain deeper understanding of these elements of communication styles. To the author’s knowledge there is no published qualitative study analyzing these factors.

The aim of the present study is to explore communication styles (open/ closed questions, empathic response, control techniques etc.) that may be useful and communication styles that may be harmful for CSA survivors in dental consultations.

Material and method: Qualitative interview with CSA survivors who have received successful dental anxiety - and dental treatment.

Participants: 10-15 patients, women and men from the TOO program (adapted dental treatment for persons survivors from torture, domestic violence, abuse or odontophobia) who have completed treatment. The interviews are estimated to last 30 to 60 minutes. The interviews will be recorded and transcribed to paper.

Challenges faced by torture victims when seeking and undergoing dental treatment

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Supervisors: Professor Dr odont Tiril Willumsen, Odontologisk fakultet, UiO. Dr med Birgit Lie, RVTS-sør og Sørlandet sykehus. Dr odont Jenny Bernson, Odontologisk fakultet, Universitetet Gøteborg.

Background

Norwegian health authorities have increased focus on establishing a dental health plan for torture victims, victims of abuse, and individuals suffering from severe dental fear (the TOO-project). As part of this, we have spent the last year performing clinical oral examinations and structural interviews in Norwegian reception centers for asylum seekers and refugees. It has become apparent that a significant proportion of those with a history of trauma, experience difficulties when it comes to seeking or receiving dental treatment. Some research has been done in this field among victims of sexual abuse. But concerning torture victims, research is limited to a few case studies.

Dental fear was measured by the Modified Dental Anxiety Scale (Humphris 1995), which has been widely used in surveys in several countries. But we faced some challenges with measuring dental fear among the 30 percent of refugees who had never seen a dentist. Further, some of the refugees were illiterate and many were unfamiliar with questionnaires.

Aim

In attempt to gain a deeper understanding of the challenges faced by torture victims when seeking and receiving dental care, we plan to apply a qualitative approach. Topics of interest include faced challenges and experience from dental treatment, communication challenges, perceived barriers to seeking dental treatment, and which degree of dental treatment is needed to facilitate the total trauma rehabilitation.

Material and method

Qualitative research is known to be a good approach to sensitive topics. Thus, we plan to conduct semi-structured exploratory interviews with approximately 15 adult torture survivors who are receiving dental treatment through the TOO-project. Severe dental anxiety will not be an inclusion criterion, and the interviews will not be recorded.

Session B9: Shared decision-making 2

Sharing decisions during diagnostic consultations; an observational study in paediatric oncology

Sandra van Dulmen

Buskerud and Vestfold University College, Drammen

Objective

Children and parents need to make important decisions in the stressful period of being informed about the diagnosis of childhood cancer. Although parents' and children's involvement in medical decision-making is legally required, it is unclear to what extent oncologists actually involve them. This study investigated which decisions parents and children face during diagnostic consultations, how oncologists assist children and parents in becoming involved in shared decision-making (SDM) and which contextual factors are associated with this process.

Methods

Forty-three families with children (8-16 years), starting treatment for childhood cancer, were recruited from three Dutch academic paediatric oncology clinics. Diagnostic consultations were audio-taped and coded with the OPTION tool. Verbatim transcriptions were used to determine the discussed number and type of decisions. Linear regression analyses were performed to investigate which factors are associated with oncologists' assistance in SDM.

Results

On average, 3.5 decisions were discussed per consultation. Most frequently discussed decisions concerned registration in a patient database and how to deal with hair loss. Oncologists' assistance in SDM focused on giving information and ensuring the parents' and the child's understanding. Only, the hospital in which children were treated was associated with oncologists' assistance in SDM.

Conclusions

Decision-making during diagnostic consultations appears to focus on non-treatment related decisions. Oncologists' assistance mostly concerned sharing information, instead of SDM. Additional research is needed to provide insight in how to increase oncologists' assistance, while taking into account children's and parents' preferences concerning SDM.

Clinical trial or standard treatment? A qualitative study on shared decision making in an oncology unit.

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Background:

Cancer patients often have to decide whether or not they shall participate in a clinical trial. The literature indicate that the decision often is based on little knowledge and many patients who have given their consent to participate not always are aware that they are participating in a trial. This place great demand on the healthcare providers' ability to involve and advise patients in the decisions. Both patient and provider must have a clear understanding of the trial if the participation should be efficient and ethically justifiable. International health services focus on the term "shared decision making" which allows patient and provider to make healthcare decisions together, taking best evidence and the patient's values and preferences into account. SDM can secure that trial participation is based on active and individual decisions.

Purpose:

Investigate the characteristics of the communication when decisions about participation in clinical oncology trial are made. Including:

- The context in which decisions about the treatment are made.
- Patients', relatives' and healthcare providers' experiences and preferences with regard to the decision about participating in trials.

Develop and test a tool for improvement of patient and relatives' experiences of the decision making process about participation in clinical trial.

Method:

Qualitative study combining observation, interview and intervention. Including 20 patients, relatives and healthcare providers. The project consist of two stages:

First: Observation of conferences where patient treatment is discussed and of sessions where healthcare providers inform patient about clinical trials. Interviews with patients, relatives and healthcare providers.

Second: Based on the observations, interviews and a pre-study conducted in cooperation with a designer the method *participatory design* will be used to develop and test the tool.

Discussion points:

- Experiences with SDM tools?
- How to test the effect of the tool?

Session A10: Patient activation

Patients' use of audio recordings in four different outpatient clinics

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Purpose: Previous research on consultation recording has found recordings beneficial especially in cancer settings although a few studies have focused on other patient groups. Despite these positive effects and the fact that recording is widely accepted and valued by patients, it has not yet become part of everyday clinical practice. This may partly be explained by lack of adequate technology with prior use of mainly audio cassettes as recording media. In this study, we investigated a new technology with digital audio recording applied to patients in diverse clinical settings, thereby providing knowledge about patients' use and evaluation of this new method as well as association between use and different patient- and consultations characteristics.

Method: A total 2,784 patients were included in this study, all receiving digital audio recording as part of a larger RCT. Audio recording were carried out by 49 participating health professionals from four different outpatient clinics: paediatrics, orthopaedics, internal medicine and urology. Evaluation was based on data from the digital audio recording platform and patient administered questionnaires.

Results: Replay frequency in the adult outpatient clinics were 33-39% and in the pediatric clinic significantly lower at 16.2%. When replaying, this was primarily done once although 30% of the consultations were replayed twice or more. Usage of the audio recording was associated with patient age and gender, as well as first time visits to the clinic. The majority of patients evaluated the digital recording technology as easy to use.

Conclusion: Results indicate that audio recording is accepted and used by adult patients in a more general setting and not merely should be targeted at cancer patients. Identification of several replay associated patient characteristics may be of practical importance in terms of planning implementation in a broader clinical context. In terms of usability for parents the results are less conclusive and further research is needed in order to clarify whether it would be feasible to offer audio recording to a specific pediatric patient group.

Issues for discussion:
In the light of the above results, I would like to discuss ideas that comes to your mind, in terms of further research in this field – what could be interesting?

How does shared decision making work?
Effects of user participation in Norwegian Learning and Mastery Services

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Shared decision making is gaining popularity in the health care services, but little is known about its impact in education programs for patients with long-term health challenges.

Aim of the study

To explore if and how user participation in education programs for patients with long-term health challenges change their mastery and quality of life. Specifically, we want to examine:

1. What happens when experienced users participate in education programs at Norwegian Learning and Mastery Services?
    a. Does user participation change the way health care personnel teach?
    b. Does user participation change the way patients learn?
2. What are the effects of user participation in such education programs?
    a. Does user participation change the way patients master their health challenges?
    b. Does user participation change the way patients master their daily lives?

Methods

We will use both qualitative and quantitative methods in this study.

To better understand how user participation change the learning process for patients, we will conduct both in-depth interviews and focus group interviews with teachers and patients. Further, we will explore the process through observations of different education programs both in the specialist health services, and in the municipal health and care services.
After analysing the qualitative descriptions, we will measure effects of user participation. We will conduct a survey among patients who have participated in education programs at Norwegian Learning and Mastery Services. Data will be collected directly before and directly after the interventions, and about one year after the interventions.

Background and discussion

Learning and Mastery Services in Norway offers mainly group-based courses. Essential for the education programs is that experienced users, i.e. patients who have extensive experiences with health challenges, are involved together with health care personnel when planning, executing and evaluating the programs.

In our previous study on peer support for cancer patients, we found that peer supporters provided invaluable support for patients and relatives visiting the peer support centres (”Vardesentre”), support that could not be offered by neither health care personnel, nor friends and family. However, for the peer support to have an impact, the patients had to trust the peer supporters. We found the trust relationships were negotiated implicitly, through normal, daily activities, and chatting about normal noninvasive topics. Difficult topics and questions about life with cancer were rarely mentioned until open mandates of trust had been established. We will focus on the role of trust in the learning process in the present study.

We will also build on ongoing studies from Helse Bergen, Holland and NK LMH before deciding what questionnaire to use, and what outcomes to measure (e.g. adherence, anxiety and depression, physical activity, knowledge and skill, mastery).