

## **5<sup>th</sup> ÖCHER workshop on Clinical Communication Research**

**January 13-15, 2015**

*The Oslo Communication in Healthcare Education and Research (ÖCHER) group*

### **Program**

Start: Wednesday 13 January, 10:00  
End: Friday 15 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:**

**Anna Lindström, professor of language and social interaction, Uppsala University Sweden.**

[http://www.lingfil.uu.se/staff/anna\\_lindstrom](http://www.lingfil.uu.se/staff/anna_lindstrom)

**Jennifer Gerwing, PhD, senior researcher, Akershus University Hospital**

<http://www.microanalysis.ca/who-we-are.html>

**Arnstein Finset, PhD, professor, Dept. of Behavioural Sciences in Medicine, Institute of Basic Medical Sciences, University of Oslo**

<http://www.med.uio.no/imb/personer/vit/arnsten/index.html>

**Local faculty: Pål Gulbrandsen and Jan Svennevig, University of Oslo and Hilde Eide, University College of Buskerud and Vestfold**

*Working languages: English, Scandinavian*

<b>Wednesday January 13</b>			
<b>Time</b>	<b>Activity</b>	<b>Plenary room / Room A</b>	<b>Room B</b>
1000	Plenary	Introduction, mutual presentation	
1045	Break		
1100	Plenary keynote 1	<b>Anna Lindström</b>	<i>From the cradle to the grave: Results and insights from my experience of conducting CA research in clinical and care settings</i>
1230	Lunch		
1315	Plenary keynote 2	<b>Pål Gulbrandsen and Marla Clayman</b>	<i>Lines of research emerging in the OCHER community – forming good cross-disciplinary projects</i>
1415	Break		
1430	Groups	<b>Session A1 Subtle signals</b>	<b>Session B1 SDM 1</b>
		Wallander Karlsen	Bergvik
		Gorawara-Bhat	Landmark
1530	Break		
1545	Groups	<b>Session A2 Patient-centered education 1</b>	<b>Session B2 SDM 2</b>
		Ege Møller	Hultberg
		Eide	Kasper
1645	End Groups		
1715	Walk to Pål's house for get-together	The walk is 20 minutes. Shoes should stand snow. Follow path on map!	
2000	Dinner at hotel		
<b>Thursday January 14</b>			
0830	Groups	<b>Session A3 Provider self-efficacy and emotional intelligence</b>	<b>Session B3 SDM 3</b>
		Sundling	Kienlin
		Haaland	Liethmann
0930	Break		
0945	Groups	<b>Session A4 Patient-centered education 2</b>	<b>Session B4 Survivors</b>
		Skirbekk	Lie
		Steinsbekk	van der Laaken
1045	Break		
1100	Plenary keynote 3	<b>Jennifer Gerwing</b>	<i>Talking matters: linking contemporary dialogue theory to research on clinical communication</i>
1200	Lunch		

1245	Groups	<b>Session A5</b> <b>Forming collaborative groups</b>	<b>Session B5</b> <b>Forming collaborative groups</b>
1430	Break		
1500	Groups	<b>Session A6</b> <b>Miscellaneous</b>	<b>Session B6</b> <b>SDM 4</b>
		Brembo	Nordfalk
		Thybo Pihl	Ofstad
1600	Plenary keynote 4	<b>Jette Ammentorp</b>	<i>Experimenting with non-traditional research methods – initial thoughts and experiences</i>
1630	Break		
1645	Groups	<b>Session A7</b> <b>Development of coding</b>	<b>Session B7</b> <b>Trials</b>
		Waidtløw	Gregersen
		Haukeland	van Dulmen
1745	End Groups		
1900	Dinner at hotel		
<b>Friday January 15</b>			
0830	Groups	<b>Session A8</b> <b>Learning essential skills</b>	<b>Session B8</b> <b>New technology</b>
		Skjeggestad	Vatne
		Lønnebakke Norberg	Wolderslund
0930	Break/ Check-out		
1000	Plenary keynote 5	<b>Arnstein Finset</b>	<i>Analysis of trouble talk in medical consultations: Implications for communication skills training</i>
1115	Break		
1130	Groups	<b>Session A9</b> <b>More than just symptoms</b>	<b>Session B9</b> <b>Distress</b>
		Svensson	Hafskjold
		Timmermann	Lundeby
1230	Lunch		
1315	Plenary keynote 6	<b>Jan Svennevig</b>	<i>Preempting problems of understanding</i>
1400	Break		
1415	Groups	<b>Session A10</b> <b>Work in collaborative groups</b>	<b>Session B10</b> <b>Work in collaborative groups</b>
1500	Plenary	Collaboration and way forward	
		Round up and evaluation	
1530	End		

## **Abstracts**

### **Session A1: Subtle signals**

*Conscious and alert critically ill patients on mechanical ventilation and their interaction with healthcare personnel*

**Marte Marie Wallander Karlsen, Lena Heyn**

#### **Aims**

The aim of this study is to obtain more in depth knowledge about interaction between healthcare personnel and patients who are conscious and alert on mechanical ventilation in Intensive Care Units (ICUs). Mechanical ventilation reduces patient's ability to communicate their needs in a natural way. Being non-verbal is frightening and frustrating for many patients, it may even be interpreted as a threat towards life and health. The main objective is to describe the communicative content, ways of establishing communication and factors, which promote or inhibit the communication. A secondary objective is to observe how the healthcare personnel pick up and interpret interactional cues from non-verbal, mechanically ventilated patients, and how this is affected by or affects the patient's vital signs, measures, medication and healthcare personnel activities.

#### **Methods**

This is a qualitative, descriptive and exploratory study. Video recordings will be conducted of segments of interaction in different contexts between health personnel and 8-10 patients lasting between 2-4 hours. Two cameras will be positioned in the patient room; one to capture the entire environment and the other to capture patient and healthcare personnel's expressions and actions more detailed. The cameras will be synchronised with assessment of patients' vital signs and data from the electronic journal. The analytic steps are: 1) Watch sequences 2) Identification of boundaries and key events 3) Organisation in segments 4) Transcription and more detailed interpretation of statements and nonverbal communication and 5) Comparison of segments from earlier stages with the recordings as a "whole".

The study starts 2016, is a collaborative project between Lovisenberg Diaconal College University (phd-student Marte-Marie Wallander Karlsen and main Supervisor Lena Heyn), University of Oslo (Professor Arnstein Finset) and Oslo University Hospital (Clinic of Emergencies and Critical Care).

**Rita Gorawara-Bhat, Hilde Eide, Linda Hafskjold, Pål Gulbrandsen**

Physician-older patient interaction comprises both verbal and nonverbal components. We measured the verbal and nonverbal dimensions in physician-older patient interactions independently, and then overlaid them over each other, to understand total communication.

An international team of researchers comprising two sub-teams is currently studying the verbal and nonverbal dimensions in physician-older patient communication. One sub-team focuses on the verbal aspects, and the second team on the nonverbal. A sample of 26 videotapes was extracted from the larger AHUS dataset of 89, with inclusion criteria asserting that physicians' and patients' nonverbal expressions be visible in the interaction. VR-CoDES (2011) was used to code the verbal, and NDEPT (2007) was used to code the nonverbal dimensions in these interactions. Inter-rater reliability was high in both, the verbal and nonverbal codings (viz. Cohen's Kappa 0.85 and 0.88).

In 15 of 26 videotapes, the verbal and nonverbal codings corroborated each other, i.e., tapes coded as "providing space," by the verbal team, were independently coded as "patient-centered" by the nonverbal team; and the verbal coding of "reducing space," was coded as "prescriptive" by the nonverbal team. We found 9 tapes to be discrepant between the verbal and nonverbal codings. For instance, tapes coded as "providing space," by the verbal team were coded as "prescriptive" in the nonverbal dimension, and those coded as "reducing space" were coded as "patient-centered" by the nonverbal team. So as to better understand the reasons for, and possible explanations of, these discrepant tapes, we are in the process of qualitatively analyzing the specific situations and nuances of these physician-older patient interactions.

Verbal and nonverbal components are both salient for understanding total communication. Beyond coding the verbal and the nonverbal aspects, it may be imperative to qualitatively analyze the total discordant interactions, rather than just the individual--verbal and nonverbal-components.

## **Session B1: Shared decision-making 1**

*Supporting doctor-patient communication. A study of Question Prompt List and audio recording of the consultation as communication aids in oncology consultations*

**Svein Bergvik, Anna Amundsen**

Communication aids in health care aim to provide patients and health professionals with tools to ensure effective communication. They include strategies such as a Question Prompt List (QPL) provided to the patient prior to the consultation and audio recording of the consultation which the patient may bring home and listen to. A question Prompt List (QPL) is a structured list of potential questions for the patient or family member to ask the doctor or health provider. A Cochrane review found that most cancer patients provided with an audio file of the consultation listened to the audiotape and many participants reported better recall of information. While various communication aids have been evaluated separately, the effect of combining QPL and audio file of the consultation has so far not been reported.

In this project, we are studying the combination of these communication aids applied in the first doctor-patient consultation at the oncology outpatient clinic. The main research questions are:

Does providing the patient with the QPL

- 1) increase the number of questions from patient/care-giver, particularly about sensitive topics such as prognosis?
- 2) increase shared decision-making?

Does providing the patient with the combination of QPL and audio recording

- 3) increase the overall satisfaction with the consultation and information retrieved?
- 4) affect quality of life/anxiety/depression?

The Australian QPL: “So you have cancer...” was translated and culturally adjusted to Norwegian patients’ needs. This QPL and the combination of QPL and audio recording of the consultation will be tested in a clinical situation and compared with a historical control group.

### Primary endpoint

Number of questions asked by the patient, mainly concerning the prognosis.

### Secondary endpoint

Shared decision-making measured by OPTION score from transcripts of the audio recording. Mental distress (anxiety and depression) (HADS) and health related quality of life (EORTC QLQ-C30).

Patient satisfaction with the consultation and information retrieved (The Cancer Patient Experiences Questionnaire)

**Anne Marie Dalby Landmark, Eirik Hugaas Ofstad**

What we know about shared decision making (SDM), is that it occurs rarely, and that doctors are not sufficiently trained to implement this advanced task. What we know less about, is how 'best practice' SDM is accomplished (or not) moment-by-moment in medical encounters.

Data and methods: Reviewing a data set consisting of 380 video-recorded hospital encounters, we have inductively included 30 encounters with characteristics of SDM, i.e. more than one option has been brought up, or the patient has been offered a choice. These decision-making sequences may be indicative of 'best practice SDM' and will be analyzed using Conversation analysis (CA).

The objective of this study is to identify specific practices that contribute to SDM and patient involvement, as well as what practices may derail and hamper this process.

Hypotheses and analytic process: Previous research has indicated that doctors and patients regularly enter the consultation room with expectations and treatment preferences, and this may play an important role for how the decision making process unfolds. Based on this, we will divide the 30 cases into four groups: 1. Doctor and patient express coinciding treatment preference (agreement) 2. Doctor and patient express opposing treatment preferences (disagreement) 3. The doctor express clear treatment preference (recommendation), the patient does not. 4. The doctor does not express a clear treatment preference (equipoise), and neither the patient. A possibly fifth group is where the patient expresses a clear preference, while the doctor does not. We will also map decision outcomes, i.e. whether the final decision coincides with the patient's or doctor's preference when they differ, and whether it is the doctor or patient (or others) who makes the final decision when this is discernable. The aim is to investigate the interplay between expressed treatment preferences and SDM, and how management of (various constellations of) treatment preferences may affect SDM. Based on this, our initial research question is: How are treatment preferences dealt with, and how does it affect SDM and patient involvement? Our hypothesis is that doctors (and patients) use different communicative strategies for decision making depending on these preference constellations, revealing different decision trajectories and outcomes.

## **Session A2: Patient-centered education 1**

*Situated learning and collegial structures in communication skills training for hospital doctors*

*-A qualitative study*

**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, lung medicine, and ophthalmology) 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. 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.

**Hilde Eide, Iren Ruud, Dorte Kristensen, Hjørdis Frisnes, Espen Brembo**

To prepare students for practice through theater-based training (simulation training) we developed web-based resources in combination with theater training. To enhance the simulation training older people were trained to be patients as well as counselors for the students in the training situation. To integrate older students clinical experience as well as their education experience we trained older students (3<sup>rd</sup> year bachelor nursing) as facilitators. The aims of the study are to evaluate the students' use of the intervention and the students' experienced learning outcomes.

The aim of the intervention was to enhance the students' competence in capturing the patient's needs and to provide adequate information. The students had no practice experience on beforehand. The intervention consisted of three parts:

- 1) 10 days before the training the students had access to the learning platform "FLOW" where we developed content for use within a technology called "Key Capacity" developed by CONEXUS AS in Drammen. The students first evaluated their capacity in 6 areas: a) getting to know the patient, b) mindful presence; c) validating skills d) leading skills, e) nonverbal communication and f) information skills. Then they got access to learning content in the 6 different areas consisting of video-example(s) of characteristic situations they could encounter in home health care, and reflective questions related to theory, which they should answer in writing on the platform.
- 2) When they had finished the task at hand; they logged into an app on their mobile phone called "mYouTime". There they had access to several short postings of videos of a patient expressing needs. In reply they should make own mYouTime video-recordings of their answers to the patient's expressions. These brief answers should then be posted and shared with their study group with 10 participants so that they could learn from each other.
- 3) Then they attended a three hour theater based workshop where they practiced communication in small groups of 4 to 5 peers lead by a senior student. The older "patients" had scripts in the context of 4 nursing care visits in the patients home during one day; including helping with daily hygiene, meal serving (lunch & dinner) and the evening preparation before bedtime. Each student trained twice and received feedback from the patient; peer students and the facilitator.

We will present examples of the platforms; and details of the preliminary data from the students' evaluations of the program and the technology, as well as the data collected by the learning platforms. We also want to discuss how to enhance the intervention for the next iteration that will take place autumn 2016.

## Session B2: Shared decision-making 2

*Formats for requests from patients not to take medication*

### **Josabeth Hultberg**

Decision making about treatments is in focus in discussions about patient adherence to long-term medications, practitioner adherence to guidelines and patient participation in health care decisions. Greenhalgh et al propose the practice of evidence based medicine to be "*the sharing of decisions through meaningful conversations*". ([BMJ 2014;348:g3725](#)) In order to improve the practice and education of evidence based medicine, and patient centred medicine, empirical exploration of these conversations is essential.

Cardiovascular preventive drugs are commonly and increasingly prescribed in primary care. This requires an element of risk communication.

Aims: To explore the deciding-who-decides-process about cardiovascular preventive drug prescribing in clinical encounters in primary care.

The material is selected from a corpus of 80 audio-recordings of booked appointments in primary care in the southeast of Sweden. Cardiovascular preventive drugs were discussed in 36 of the encounters. Those were scrutinized for treatment proposals, to find decision-making sequences. The phenomenon of patients' requests to stop medication was identified. They appeared in different formats.

We went back to the whole 36 encounters to check for additional instances and formats of requests to stop medication.

Requests from patients to avoid medication can be an initiator of negotiations although most come after a treatment proposal from the doctor.

- Explicit requests
- Statements of general (and/or specific) skepticism towards drugs
- Questioning the diagnosis or the indication
- Asking for test results or asking to have tests done
- Disclosures of non-adherence
- Side effects (narratives about)
- Narratives - about previous own experiences, about other medication experiences, about other people's experiences.

**Aims of presentation:** Input and discussion about analytical angle and preliminary results. Suggestions for references to previously described phenomena to consider?

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

**Jürgen Kasper, Simone Kienlin, Madeleine Latvala, Maria Kristiansen, Eirik Ofstad**

“No decision about me without me”. This statement of the Norwegian health minister (2015) represents the current political will to implement Shared Decision Making (SDM) in the Norwegian health system. This implies, however, a cultural change; successful models are hardly to find all over the world. SDM implementation requires combination of structural and communicative interventions. Sustainable change must build up on attitudes rather than just skills and can be achieved using research driven developments.

Any attempt made to improve patient involvement in clinical care should base on knowledge about the status quo. The study aims at determining the current level of communication performance of specialist doctors making medical decisions with their patients.

The study employs a secondary analysis of a representative sample of 380 clinical consultations recorded in a project evaluating the four habits doctor communication training. Using a rigorous algorithm, consultations within which SDM is indicated were identified amongst the total sample. Records in the subsample were analyzed using two validated observation based measures of patient involvement (OPTION<sup>3</sup> and MAPPIN'SDM). Inter-rater-reliabilities were calculated using a modified Cohens kappa coefficient between two independently rating observers. Using judgements of an SDM expert, ratings were validated in terms of sensitivity and specificity. Result scores were built based on consensus between the two raters and are reported as total scores and on item level.

Both measures turned out having high reliabilities and validity. Amongst consultation sequences which following the criteria are relevant for a shared decision making process, only few attempts made by few doctors were observed in this respect. Barriers to patient involvement comprise in particular skills to support patients being aware of a choice and those to present information in terms of the criteria of evidence based patient information. Results will be presented in detail and are related to results from qualitative analyses of the same material presented in the same session.

The results are supposed to be discussed in context of the current efforts made by policy makers, stakeholders as well as researchers in Norway to strengthen the patients' part in the health communication. Evidence based health professional training in SDM is needed as a part of a broader and coordinated strategy.

### **Session A3: Provider self-efficacy and emotional intelligence**

*Can communication self-efficacy adjusted for gender and emotional intelligence predict person-centred home healthcare?*

**Vibeke Sundling, Linda Hafskjold, Sandra van Dulmen and Hilde Eide**

Health care providers communication self-efficacy do not necessarily reflect clinical performance. However, emotional intelligence is closely related to interpersonal- and communication skills, empathic communication encourages patient trust and mutual understanding, and health care providers scoring high on mindfulness show more person-centred communication. We propose that communication self-efficacy relates to emotional intelligence, empathy and mindfulness, and that communication self-efficacy, when adjusted for gender and these personal attributes may predict person-centred home healthcare. The aim of this study is to explore the relationship between emotional intelligence, empathy, mindfulness and healthcare providers' communication self-efficacy and actual clinical communication in home healthcare.

The study has a cross-sectional quantitative design. The sample includes 37 home healthcare providers and 240 encounters with older people ( $\geq 65$  years) in home healthcare in Norway. The health care providers reported communication self-efficacy, emotional intelligence, empathy and mindfulness by questionnaires and audiotaped home visits. We will analyse the communication using the Verona Coding definitions of Emotional Sequences (VR-Codes) and then defined the home visit as person-centred or non-person-centred based on combined analysis of patient cues and concerns and health care provider response to the cues and concerns.

This abstract provide the results from preliminary analysis of the relationship between nurse and nurse assistant's communication self-efficacy and emotional intelligence, empathy and mindfulness. Further analysis will explore the relationship between communication self-efficacy and person-centred communication as defined by VR-Codes. The material included 37 health care providers, 31 female and 19 nurses. The mean communication self-efficacy score (scale 1-10) was 7.6 (95% CI 7.2 to 8.1), ranging from 3.5 to 9.6. The global trait emotional intelligence (TEIQue-SF) score (scale 1-7) ranged from 4.0-6.1, mean score of 5.1 (95% CI 4.9 to 5.3). The mean Jefferson Scale of Empathy score (range 20-140) was 112 (95% CI 106 to 117), spreading from 80 to 134. The mean Mindful Attention Awareness Scale score (range 15-75) varied from 44 to 71, with mean score of 58 (95% CI 55 to 61). There was no statistically significant difference in scores between nurses and nurse assistants. When adjusted for gender, both empathy ( $p=0.48$ ) and mindfulness ( $p=0.22$ ) were independent predictors of emotional intelligence. However, emotional intelligence was not a significant predictor of communication self-efficacy ( $p=0.085$ ).

#### **Focus for the OCHER seminar:**

We want to present and discuss prediction of person-centered home healthcare based on personal attributes and communication self-efficacy, and considerations for training of communication skills in home healthcare.

**Ane Haaland, Mwanamvua Boga, Debbie Cohen**

Resilience is essential for health care personnel (HCP) to cope well with daily emotional challenges like stress, crises, difficult decisions, and death and dying. Positive emotions are “fuel” for resilience; common definitions of resilience include focus on “why does it go right” (not “what went wrong”). Lack of resilience frequently leads to stress, burnout, neglect and work dissatisfaction.

A 9-month training programme to strengthen communication skills and emotional awareness among 240 HCP was implemented across 7 countries (Eastern Europe, Africa), using self-directed learning through guided observation/reflection tasks plus experiential learning. Training aimed to strengthen the foundation for resilience by using supportive learner-centered methods, including critical reflective interaction, exploring reasons for mistakes rather than judging, and trainers using positive reinforcement and appreciation. Independent evaluation supplemented self-reported process evaluation.

The self-observation and reflective learning practices stimulated participants to take responsibility for improving communication rather than “blame” others. Perspective gained through learning to step back from automatic reaction patterns allowed participants to grow more helpful and positive towards others, become involved in fewer conflicts, experience higher job satisfaction and lower burnout, fuelling a cycle of improved emotional balance and motivation to continue using the skills. Overall HCPs strengthened: emotional intelligence; ability to show kindness and use appreciation, humor and positive emotions consciously; handling their own and others’ insecurity respectfully; coping with stress and crises; communicating with patients/colleagues, and managing time and teamwork. Improved family communication was frequently reported.

The crucial shift was to take responsibility for communication. Resilience can be strengthened through a conscious process of raising self-awareness of how one communicates in relationships and how communication affects others. Improved emotional intelligence strengthens resilience. Training will be implemented at School of Medicine, Cardiff to improve resilience in trainee doctors. Another version will be implemented with GPs in Oslo.

### **Session B3: Shared decision-making 3**

*Comparison of two measures of patient involvement – may it be a little less?*

**Simone Kienlin, Katrin Liethmann, Friedemann Geiger, Jürgen Kasper**

There has been a growing interest for shared decision-making (SDM) the last decade, and a clear move towards greater patient involvement. Since recently, Norway joins this international movement. However, means allowing for sound evaluation of interventions to support patient involvement require adjustment and validation in the Norwegian context. Beyond pure translation and application of validation standard procedures, these activities provide opportunity to new reflections on underpinning assumptions of SDM.

Our study aims at comparing two observation based instruments (MAPPIN'SDM & OPTION5) with regard to their ability to capture essential dimensions of SDM.

The study employs a secondary analysis of a representative sample of 380 clinical consultations recorded in a project evaluating the four habits doctor communication training. Using a rigorous algorithm, consultations within which SDM is indicated were identified amongst the total sample. Records in the subsample are analyzed using both OPTION<sup>5</sup> and MAPPIN'SDM. All ratings refer to identical sequences and to the same information about the medical background. Representing a newly published shortened version of OPTION<sup>12</sup>, OPTION<sup>5</sup> goals at enhancing efficiency of measurement by focusing on the very core elements of SDM. Observation using MAPPIN'SDM comprises an identical set of 11 items for each of three perspectives (doctor, patient & dyad). The two approaches will be compared with regard to inter-rater-reliability, sensitivity and specificity. Quantitative results will be related to results from qualitative content analysis of the item sets.

We expect both measures to work highly reliable. Moreover, we expect oversimplification in the OPTION scale to cause significant lack of validity.

Implications of using more superficial compared to more elaborated measurement approaches will be discussed.

*Analyses of the feedback intervention within the doktormitSDM training – component of a complex intervention*

**Katrin Liethmann, Benthe Untiedt, Friedemann Geiger, Jürgen Kasper**

The doktormitSDM training program aims at enhancing SDM skills of doctors. It was piloted, pretested and recently evaluated within a multicenter randomized controlled trial (IT'SDM trial, N = 38). 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-feedback sessions based on analysis of an own consultation. The RCT showed a training effect (t-test,  $p \leq .05$ ) on the endpoint variable  $SDM_{MASS}$ : 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,  $p = .06$ ).

At OCHER 2015, we discussed how to analyze and identify the active components of the doktormitSDM training program. Meantime, we realized some of these ideas and want to continue with the discussion.

We conducted content analysis of all available feedback sessions (N = 64). We wanted to know, which SDM skills were addressed and how corresponding suggestions were provided by the trainer. The sheet used for analysis was structured according to the skills listed in the MAPPIN'SDM inventory. Each time a skill was addressed during a feedback session five dimensions were rated using predefined ordinal categories (interaction, proposal for action, consensus between trainer and trainee, reasons for a proposal, humor). In addition, we examined whether discussion of any of the SDM skills was crucial with regard to overall improvement of the trainee's SDM performance and whether characteristics of participants were related with training success.

Clinicians with low SDM-competence were more likely to benefit compared to those already performing better at baseline. The most frequently the feedback addressed the skills "defining the problem", "key message", "listing the options" and "pros and cons of the options". Many suspected correlations could not be shown e.g. between interaction and success of the training concerning SDM skills. Hence, results on strategies of suggestions and possible crucial SDM skills will be in more detail discussed at the meeting. In addition, we want to discuss further proceedings.

## **Session A4: Patient-centered education 2**

### *Shared decision making and trust - Effects of user participation in medical education*

#### **Helge Skirbekk, André Vågan**

We will present in English, but since we write for a Norwegian journal, the abstract is in Norwegian:

Vi lever lengre og må dermed forvente en økning i forekomst av stadig mer komplekse og langvarige helseutfordringer. Samtidig har økt brukermedvirkning blitt et stadig større krav i moderne helsevesen. I pasient- og brukerrettighetsloven heter det at pasienten har rett til å medvirke ved valg mellom undersøkelses- og behandlingsmetoder. Legeutdanninger flest er i midlertid i all hovedsak innrettet mot behandling av akutt sykdom, og mange påpeker at leger mangler kunnskaper om kroniske lidelser og mestringsstøtte for denne pasientgruppen. En metaanalyse av Aarhun & al. (2014) fant at helsepersonell kan synes det er vanskelig å gi fra seg makt blant annet fordi de står ansvarlige for behandling og budsjetter, og at evidensbasert praksis iblant ikke er forenelig med pasienter og pårørendes ønsker.

Vi har studert litteratur om effekter av brukermedvirkning. Brukermedvirkning bidrar til at pasienter og pårørende forstår og fortolker helseinformasjon på en bedre måte (Nilsen & al. 2006), og at informasjonen blir mer relevant og forståelig (Chumbley & al. 2002). Språket blir enklere og informasjonen mer nøyaktig og mindre forvirrende (Aabakken & al. 1997). I tillegg er det flere studier som tyder på at brukermedvirkning i forskjellige former hjelper pasientens egenmestring og styrker behandlingsmotivasjon (Fagermoen & al. 2014, Neale & al. 2006). Den viktigste grunnen til å innføre brukermedvirkning i helsevesenet er kanskje likevel det moralske: "It's the right thing to do", som professor Victor Montori uttrykte det i Oslo i 2015.

Samtidig er det avgjørende at helsepersonell bidrar i rådgivning, spesielt behandlingsansvarlige leger. En metaanalyse har vist at råd fra helsepersonell medfører langt større atferdsendringer hos pasienter enn råd fra legfolk, og at leger og sykepleiere har høyere tillit som informasjonskilder (Durantini & al. 2006). Det er altså av stor betydning at leger blir klar over og anerkjenner betydningen av brukermedvirkning i helsevesenet.

Pasienter har vært sentrale bidragsytere i norsk medisinerutdanning lenge, og er grundig beskrevet i litteraturen om sosialisering til profesjonen (Vågan 2009). Men pasienter har i hovedsak vært brukt som illustrasjoner på interessante diagnoser, eller som en del av studenters kliniske ferdighetstrening og kommunikasjonstrening. På begynnelsen av 1990-tallet begynte det imidlertid å komme eksempler på studieprogram hvor pasienter fikk andre roller og økt innflytelse. De fleste medisinerutdanninger i Vesten legger i dag en pasientsentrert tankegang til grunn, hvor lege-pasient møtet forstås som et møte mellom eksperter; leger med biomedisinsk ekspertise og pasienter som er eksperter på deres egen personlige og kulturelle bakgrunn og deres egen sykdomshistorie.

Det er i midlertid stor variasjon i hvor stor grad og på hvilken måte pasienter deltar i medisinerutdanningen. En metaanalyse viste at pasientinvolvering omfattet alt fra at pasienter beskrives i skriftlige eller web-baserte kasuistikker, deltar som standardiserte eller frivillige pasienter for å illustrere kliniske fenomen (for eksempel i form av en sykehistorie), til at de utgjør såkalte "pasientlærere", det vil si at de har en undervisnings- og evalueringsfunksjon (Towle m.fl 2010).

## **Aslak Steinsbekk**

We have under development a research project focusing on how the medical health record should be organised to support patient centred intake consultations in hospitals across specialities.

The starting point is that the physician (or health care worker) have to document what they do for various reasons. There can be discrepancy between what the physician needs to document for medical reasons and what the patients wants to feel that s/he gets good care. With the move from doctor centred consultations to patient centred consultations, the intention is that the focus in the consultation should include more of the topics that are important in the patients lives. There are different barriers to this happening, and one of these are the tradition of how the health record (also (previously) called the medical record) is organised.

Traditionally the structure of the health record have been based on what is needed in the diagnostic work. Typical topics in the health record are Chief complaint that has brought the patient to the doctor, History of the present illness with detailed exploration of the symptoms, Physical examination with recording of observations of the patient that might directly be responsible for the symptoms and Assessment and plan which are written summation of likely causes, diagnosis and treatment. Furthermore, different medical specialities have different traditions for how their structure their health record, which stereotypically can be described as:

- Surgeons: Short to the point notes, little history and context
- Psychiatrists: Long elaborate notes, many details
- Internists: In between the surgeons and psychiatrists, medium long notes
- General practitioners: Notes includes more of the patients history and social context and are regarded to be somewhat more patient centred

It is a general observation that even if medical students learn to conduct patient centred consultations and record relevant information according to this, after some time in a clinical environment, the start to adopt a more medical oriented documentation style. This indicates that there are strong medical rationales for keeping the health records the way they are. Since this can be a barrier to patient centred consultations, the question is if it is possible to develop templates for the health record that take into account both the medical needs of the physician while at the same time supports a patient centred consultation.

To investigate this, as mixed methods study will be developed. The initial thoughts are to do qualitative studies to elicit clinicians ideas on how the structure of the health record should be to support patient centred intake consultations, conduct a user driven design process to develop a prototype of such a health record and finally to test this in e feasibility study.

At the OCHER workshop more details will be presented and input sought on how to investigate this topic

## Session B4: Survivors

*Information and health care needs amongst long-term survivors of Childhood, Adolescent and Young adult (CAYA) cancers: a national representative survey*

**Lie HC, Loge JH, Ruud E, Finset A, Fosså SD, Mellblom AV & Kiserud CE**

CAYA cancer survivors face persistent higher rates of morbidity and of early mortality compared to the general population due to treatment-related health problems (late effects). The survivors need information about their risks of late effects to make informed lifestyle choices, to seek timely medical advice and to communicate their health risks to health care personnel without knowledge of late effects. Yet the majority of survivors lack such knowledge.

Here the aim is to investigate knowledge of, need and preferences for information about late effects in a national representative cohort of CAYA survivors and factors associated with these. Effects of item-order on response-rates will be tested for using two versions of the questionnaire: one starting with cancer-specific questions and one with sociodemographic questions. It is hypothesised that the cancer-first version will have the largest response rate.

*Sample:* Six diagnostic groups of relatively young cancer survivors with good prognosis, long life-expectancy and relatively high risk for late effects have been identified through the Norwegian Cancer Registry and have been mailed the questionnaire (n=5800; diagnosed before age 40, current age: 18-65 years; diagnosed: 1985-2009; diagnosis: Childhood- ; Breast- and Colorectal-cancer; melanoma; Leukemia and Lymphomas)

<p><i>Explanatory variables:</i></p> <ul style="list-style-type: none"><li>• Disease-related variables</li><li>• Socio-demographics</li><li>• Health Literacy</li><li>• Lifestyle</li><li>• Quality of life (Sf-12)</li><li>• Fatigue (Chalder's FQ)</li><li>• Post-traumatic stress symptoms (IES-6)</li><li>• Neuroticism (Eysenck)</li><li>• Depression (PHQ9)</li><li>• Anxiety (HADS)</li><li>• Comorbidity index</li><li>• Current symptoms (MDASI)</li><li>• Patients' experiences, preferences and needs for information.</li></ul>	<p><i>Outcome variables:</i></p> <ul style="list-style-type: none"><li>• Knowledge of late effects</li><li>• What information about late effects they have received, from whom</li><li>• Need for information about late effects</li><li>• Preferences for receiving information about late effects</li></ul>
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**Status of Study.** Data on effects of item-order on response-rates will be presented.

I would also like to discuss opportunities for data analyses and research questions of interest, experiences using large datasets and other ideas regarding this dataset.

**Manon van der Laaken, Elin Derks**

Recent studies report that physician-patient communication in cancer consultations can be quite upbeat. As Beach et al. (2014) put it, “few other medical settings are more ‘benign’ than interactions designed to manage ‘malignancies’ during oncology encounters” (459). Patients recurrently emphasize how well they are doing and how they are engaging in healthy lifestyles, that is, they ‘justify’ their ‘wellness’; (Beach, 2013) physicians use their medical expertise and test results to reassure patients that they are still ‘safe’ (Beach et al., 2014; Sandén et al., 2001) and will offer ‘encouraging assessments’ when patients report positive developments in their recovery from cancer and how they deal with it (Jones, 1997). When presenting bad news, physicians will often pair it with good news, so as to end on a hopeful note, (Leydon, 2008) and they regularly refer to patients’ lingering physical complaints as ‘normal’, using a folk term to relay to patients they are still well (Gutzmer & Beach, 2015). In short, the cancer consultation seems oriented towards wellness.

The findings above come from different types of cancer consultations. To rule out the influence of different types of consultations on the interaction, we will focus on one specific type of consultation, which has so far been underexplored: the follow-up cancer consultation. For years after treatment, cancer patients return to the outpatient cancer clinic for follow-up. These consultations deal with “a distinct phase on the cancer control continuum”, “the period of health and wellbeing experienced by survivors after active cancer treatment (and before diagnosis of recurrence or a new malignancy)” (Rowland, Hewitt & Ganz, 2006: 5101). This project explores the very layered notion of ‘wellness’; investigates what makes the follow-up cancer consultation a likely *locus* for an orientation towards wellness, and analyses whether and how the participants in the follow-up consultation display such an orientation.

**Session A5+B5:**

*Forming collaborative groups*

## **Session A6: Miscellaneous**

*Do preoperative levels of self-efficacy and social support explain variations in patient outcomes 3 months and 1 year following hip replacement?*

**Espen Andreas Brembo, Heidi Kapstad, Sandra Van Dulmen, Hilde Eide**

Total hip replacement (THR) is one of the best surgical interventions available for patients with hip osteoarthritis (OA). It is cost effective and leads to improved physical function and decreased pain levels for most eligible patients. THR is one of the most frequently used elective surgical procedures. According to The Norwegian Arthroplasty Register, 8099 primary hip replacements were performed in 2014 - approximately 80 % (6369) of these were done for people with primary hip OA. Although studies demonstrate good clinical outcomes, some patients experience postoperative complications and/or fail to recover optimally. In this study we investigate if measures on self-efficacy and social support explains the observed differences in patient outcomes. A general sense of self-efficacy, refers to a global confidence in one's coping ability across a wide range of demanding or novel situations and reflects a person's problem-solving ability. General self-efficacy aims at a broad and stable sense of personal competence to deal effectively with a variety of stressful situations over time. Social support can be defined as the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network. The research questions are as follows:

1. Do individual differences in self-efficacy and social support explain observed variations in patient outcomes following THR?
2. What patient specific determinants of patient outcomes can be identified?

### **Methods**

This is a retrospective cohort study with a longitudinal design. Data were collected at six hospitals in three different counties in Norway during the period 2003-2004. 203 patients with hip OA who were placed on the waiting list for THR completed the following questionnaires at baseline, 3 months and 1 year after THR:

- Pain, stiffness and physical function: Western Ontario and McMaster Universities Arthritis Index (WOMAC)
- Quality of life: EQ-5D-3L (EuroQoL)
- Social support: Social provisions scale
- Self-efficacy: General Self-efficacy scale

*How did the mothers experience the information given before deciding to have their new-born child immunized with BCG? A mixed method design.*

## **Gitte Thybo Pihl**

Childhood vaccination programmes have proven to be very successful public health tools for preventing infectious diseases and death causing parents to perceive the risks from vaccine-preventable diseases as low. In contrast to this, their concern about risk of vaccinations has increased. In a public health perspective it is important that most children receive vaccines, but in the perspective of the parents it is important that the vaccine is beneficial for their child and not causing any harm. Thus, it is of great interest to explore parents' informational needs about vaccines and side effects.

To evaluate parents' informational needs when participating in a trial about BCG-vaccination of their new-born child with the purpose of achieving non-specific effects on the immune system. Furthermore, to evaluate their experiences of having adequate knowledge about side effects 3 months after birth.

Data from a telephone survey and focus groups are used in a mixed method design.

95 % of the parents assess they are well informed three months after giving birth. A scheme about where the parents sought additional information is presented.

There are significant more low-educated parents in the group of not well informed parents. Furthermore, significant less low-educated parents are seeking additional information about side effects.

Focus group discussions point at health literacy as a central factor.

Several aspects of health literacy are discussed.

Examples of how lack of fundamental literacy influence parents' informational needs are given.

Aspects of scientific literacy and the ability to critically interpret mass media messages are discussed with how to meet parents' informational needs.

Discussion and conclusion are preliminary.

## **Session B6: Shared decision-making 4**

*Enabling shared decision making about treatment with multiple sclerosis patients: A preclinical intervention study*

### **Jenny Maria Nordfalk**

The goal is to research how to improve patients' involvement in decision making by teaching doctors small, and highly specific changes in communication style, in a specific and complex situation involving making a choice of MS treatment.

Many doctors find it difficult to include the patient in decision making in a manner that does not confuse her, or make her feel left with too much responsibility. We do know, however, that treatment compliance is better when the patient is part of the decision.

We have chosen a consultation with a MS patient, in which treatment decisions needs to be made.

Multiple sclerosis (MS) is a serious and unpredictable disease, and the choices needed to be made concerning treatment are difficult; with a certain insecurity both when it comes to treatment effect and side effects. The patients differ in personality, educational level, emotional distress level and how much they want to be part of making a decision.

So far, there has not been conducted adequate research to decide what sufficient information is, nor how to optimally support the patient in the course of choosing a treatment. We're planning a descriptive study based on video recordings of IRL (in real life) MS consultations, followed by patient interviews. We will develop a consensus based fact sheet, involving ethicist, neurologists, MS patients and MS organization representatives, in deciding what kind of information a neurologist *must* give, *should* give, and *could* give to these patients. Step 2 is to make an intervention, by giving the neurologists training based on this fact sheet, before videotaping new consultations, where the neurologists meet real MS-patients who simulate a given case.

*SDM derailed? A qualitative study of 30 hospital encounters "along the tracks" of shared decision-making*

**Eirik Hugaas Ofstad, Anne Marie Landmark, Jürgen Kasper**

Shared decision making (SDM) is a public and ethical imperative that has gained momentum over the past decades. Still, several studies indicate that SDM is far from having been integrated into everyday clinical practice. Assessments of SDM in medical encounters are commonly reported with quantitative measures like questionnaires and observer instruments – normative measures that presuppose that SDM is best practice. How attempts of SDM unfold in everyday clinical practice, has rarely been reported with qualitative methods - interpretive analyses that describe the dialog related to clinical decisions, without taking a normative stance.

To describe attempts of SDM in patient-physician encounters and how attempts of SDM align with normative SDM-models as a linear, chronological process.

During the process of identifying and classifying clinically relevant decisions in 372 videotaped patient-physician encounters from a large university hospital, we identified attempts of 30 encounters where attempts of SDM were displayed. 28 of these videos were from the outpatient clinic while two were from inpatient ward round encounters. 77% of physicians were male, 23% female. 60% of the physicians had not finished their specialization, 40% were consultants within their specialty. Transcriptions surrounding the relevant decisions where SDM was attempted, have been analysed to see how they align with normative SDM-models as a linear, chronological process.

Preliminary analyses of the 30 encounters show that most attempts of SDM is abandoned at some point in the process. In only a handful of encounters do the process follow the path of normative SDM-models and even when they meet SDM-criteria in a chronological fashion, it is relevant to discuss how well they align with SDM and other normative models of decision-making in medical encounters. .

In a large material of hospital encounters, attempts of SDM are rare and when SDM as a strategy is attempted, it commonly is abandoned at an early stage in the process. For discussion it would be relevant to point at specific factors that might explain why SDM as a strategy is abandoned and how uncertainty, insecurity and insufficient awareness in both physician and patient might be a factor in the presented examples.

## **Session A7: Development of coding**

*Coding of patients' complaints as a basis for developing a new categorizing system in a Danish hospital*

### **Karin Yde Waidtløw**

Four years ago the communication program "Clear Cut Communication with Patients" was launched at Lillebaelt Hospital in order to improve the health professionals' communications skills. One of the success criteria for the intervention was an expected decrease in the number of communication-related patients' complaints. The system used for categorizing patients' complaints is equivalent to the system used for unintended events. An average of 10% of the complaints in Lillebaelt Hospital are being categorized as communication-related while a spot check of 10 random complaints revealed that 8 out of these actually originated from communication issues. Furthermore the *National Agency of Patients' Rights and Complaints* has estimated that approximately 40-50% of complaints within the Danish healthcare system either originates from or are related to communication. It is therefore evident that the current system has proven insufficient for identifying the core of the complaints.

#### **Purposes of the study:**

1. To explore how communication-related patient complaints will be categorized using a new classification tool developed on the basis of a scientific categorization of data from existing complaints.
2. To examine the possible difference in the number of communications-related patients' complaints using the current classification system and a new classification tool.

As a starting point all of the patients' complaints from 2012 (a total of 175) will be subject to a content analysis in order to identify the signifying units through which a coding system and thereby a new classification tool will be developed. Afterwards all of the complaints from 2013, 2014 and 2015 will be coded using the new tool and the result will be compared to the previous outcome in order to determine if there is a difference in the number of communications-related patients' complaints.

An exchange/discussion of the experience with coding of communication-related issues in either patients' complaints or other interactions (e.g. consultations within the healthcare system).

**Yngvild Bjartveit Haukeland, Torun M. Vatne**

Siblings of children with chronic disorders constitute an underserved population both in clinical practice and in research. An ongoing intervention study of manualized support groups for siblings of children with chronic disorders and their parents is being tested out at Frambu competence center for rare disorders and at some additional sites arranged by other centers and user organizations. The main of the intervention is to strengthen or improve communication between parents and healthy siblings about the disorder and emotional challenges that siblings face. It is hypothesized that parents' exploration and validation of the child's internal states, are crucial components of supportive parent-child communication. The group intervention comprises both separate and joint sessions (five in total) for siblings and one parent, and in the two joint sessions the sibling and their parent sit down together to discuss (a) questions the sibling have about their brother's/sister's disorder, and (b) emotional challenges they experience. Although a constructed setting, these sessions provide important insight into how communication between parents and siblings on emotionally loaded topics occur, and give insight into features of family communication that interventions like the one in this research project seek to influence. In the present study we, (1) explore the topics of emotionally loaded conversations between siblings and parents, (2) develop observational measures of exploration and validation, and (3) examine how these dimensions relate to subjective evaluations of parent-child communication.

To conduct communication analysis on parent-siblings dyads to discuss what characterizes instrumental versus relational oriented family communication, and parent-centered versus child-centered conversation.

The sample is a convenience sample of 30 siblings aged 11-16 of children with a rare disorder, who participate in the intervention study together with one of their parents. The dyad is instructed to talk about a challenge chosen by the sibling. Prior to the session parents have received training in child-centered communication. Audiotapes of the sessions (b) about emotional challenges are transcribed for analyses. Consensus coding and thematic analysis are applied to explore conversation topic. The dimensions exploration and validation is analyzed qualitatively in an inductive manner. Observational measures are compared to a self-report measure of parent-child communication.

The following preliminary categories were identified: disorder prognosis, sibling relationship, challenging behavior, differential treatment, family environment, and negative reactions from others. In-depth analysis of exploration and validation will identify different manifestations of these communicative behaviors and how they relate to self-reported PCC. The study will provide information about characteristics of child-centered family communication about difficult emotional topics. Important elements that should be targeted through sibling interventions will be identified. The mixed-method design can contribute to the validation of a self-report parent-child communication measurement.

## Session B7: Trials

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

**Trine A. Gregersen, Regner Birkelund, Jette Ammentorp**

Cancer patients often have to decide whether or not they shall participate in a clinical trial. The literature indicates that the decision is often based on little knowledge and that many patients who have given their consent to participate are not always 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" (SDM) which allows patient and provider to make healthcare decisions together, taking best evidence and the patient's values and preferences into account. SDM can contribute to trial participation that is based on active and individual decisions.

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.

It is a qualitative study including 20 patients, relatives and healthcare providers. Data will be collected from: 1) Observation of conferences where patient treatment is discussed and of sessions where healthcare providers inform the patient about clinical trials. 2) Interviews with patients, relatives and healthcare providers. First interview with patient will be two days after information and second interview three month after treatment start or before the patient change treatment again.

- Field notes: Audio notes or written notes during participant observation?
- How to write useful field notes?
- How to analyze field notes systematically?
- How many interviews with the patient?

**Sandra van Dulmen**

Prevailing paradigms in health care policy and practice demand increased patient participation. This is reflected in more self-management, shared decision-making and empowered interactions. The patient voice counts and so do his preferences, needs and values, i.e. the building blocks to person-centered or personalized health care. Interestingly, such a democratic approach does not yet count for study designs; a RCT is still considered the gold standard for testing treatment effectiveness. In a traditional RCT there is no place for treatment preferences. RCTs make an assumption of clinical equipoise and provide research evidence of group efficacy. This could explain disappointing recruitment rates, high dropout and less clinically valid results. A specific preference for (or against) treatments under study may moderate treatment efficacy, especially in case of highly preference-sensitive interventions where motivation may impact outcome. If preference is an effect modifier then a treatment may be maximally effective for those who prefer it (being more motivated) and minimally for those who do not. Hence, accounting for patients' preferences in studying treatment effectiveness can boost the widely pursued personalized healthcare paradigm. To account for patients' treatment preferences, patient preference trials (PPTs) have been proposed. PPT-based studies suggest that allowing patients their preferred treatment promotes recruitment and outcomes. Yet, it is questionable if every patient is capable to express a preference. Moreover, various PPT designs exist that differ in randomization and moment of choice. It is unclear which subtype is most person-centered; the opportunity to choose may already enhance one's sense of control and thereby increase self-efficacy and active participation resulting in enhanced outcomes. During the OCHER meeting I want to discuss the idea of contrasting outcomes of traditional RCTs with those of PPTs to examine the added value of accounting for patient preferences.

## **Session A8: Learning essential skills**

*Language and professional identity – A qualitative study of communication barriers in collaboration between international doctors and colleagues*

### **Erik Skjeggstad**

A number of studies worldwide have described language barriers as an issue for new international medical graduates (IMGs) and concluded that IMGs need both language training and language tests. Sufficient language skills is important for patient safety and for the well-being of both IMGs and their colleagues. In this Norwegian study, we investigated how recent IMGs and their Norwegian colleagues emotionally handled experiences of language barriers in everyday work practice.

We interviewed 16 IMGs who had recently begun working in Norway, and 12 doctors, nurses, and healthcare leaders who have extensive experience working with IMGs. Participants were encouraged to share experiences of collaboration in everyday work practice. The research team applied principles of systematic text condensation to the interview transcripts.

The IMGs described a loss of professional communication skills, a loss of identity that made them uncertain in communication, and an awareness that their language challenges made them a burden for coworkers. Most described an experience of becoming introverted in their practice because of an inability to handle communication as they desired.

Colleagues recounted that even a small language deficiency spread uncertainty about the IMG's knowledge and skills. This uncertainty made these colleagues act differently when collaborating with IMGs than with other colleagues.

Both sets of interviews demonstrated that situations that were considered as language barriers were indeed also about cultural differences, unclear authority conditions, awareness of xenophobia, and a general lack of understanding about systems and procedures.

Even small language barriers provoked emotions of uncertainty for both IMGs and their colleagues. Acculturation is a process of adaptation for both the immigrant and the native citizens that they interact with. Both IMGs and their colleagues need support in handling the uncertainty that is inherent in their collaborations.

Handling language barriers seems to be close related to professional identity.

*Impacts of improved communication skills after an intervention of a 5-day Calgary-Cambridge communication skills course*

**Børre Lønnebakke-Norberg**

The aim of this proposed study is to determine whether introduction of a 5-day-communication skills course tailored after the Calgary-Cambridge model, for all relevant doctors at St. Olav's Hospital in Trondheim, will have system impacts.

The study will follow 300 patients admitted with dyspnoe (breathing difficulties). The initial interview will be videotaped and questionnaires completed by the physician and the patient. Tentative diagnosis will be recorded as well as vital parameters. Using the electronic patient record we will collect data on type of department(s) they are admitted to, length of stay, procedures they have undergone, and time to definite diagnosis. Patients admitted to the Department of Pulmonology (assumed to be the majority) will have their discharge interviews videotaped. Later, the study will include a patient questionnaire 6 months after discharge and an interview after one year, to determine adherence to treatment, healthcare contacts, and quality of life. Hospital records will be screened to determine re-hospitalization, morbidity and mortality.

My initial plan is to do a before-after study, that is, half the patients will be recruited before the training of physicians, half after.

I need all the advice I can get at this very preliminary stage of planning. Should we run the Cambridge-Calgary course with or without a specific motivational interviewing approach? Should we emphasize the information giving and shared decision making modules more than others? How about the design of the study, parameters to collect?

I hope to document: impact on healthcare costs, reduced diagnostic delay, patient and physician satisfaction, time spent on admission and discharge interviews, patient recall and understanding, patient participation in decision-making process, adherence, medical and patient-reported outcomes.

## **Session B8: New technology**

### *Counseling through use of videoconference in the field of rare disorders: implications for patient communication*

#### **Torun M. Vatne**

In Norway, 9 state-financed resource centers for rare disorders serve clients with a total of several hundred different diagnoses. The centers provide local counseling and support to clients, their families, and local healthcare and service providers. Traditionally the counseling services have been provided by one or two resource centre professionals, who would visit the client's place of residence to meet the client and/or next of kin, together with professionals from the municipality.

As a well-developed modality of electronic interaction in meetings and counseling services, videoconferencing has been widely used in Norway in healthcare and other fields. Around 2007 the first video conference counseling meetings were conducted by one of the resource centers. At the current date the resource centers all have a common aim of increasing the amount of videoconference counseling conducted the next years.

A study of videoconferences conducted has shown that that local participants consider videoconferences to be a good alternative to 'traditional' face-to-face meetings. However the activity level of clients, parents and local professionals was significantly lower during videoconferences compared to face-to-face meetings (Wynn et al. 2012). In addition the attitude of many professionals includes skepticism and hesitance towards this new technology; they fear technical errors, impairments in the communication with clients, and greater difficulties in fulfilling the clients' expectations.

Previous research and experiences from practice both made the need for a structured evaluation of the communicational pros and cons of fuse of videoconferences evident. As a result, four resource centers; Frambu, TRS, SSD and NK-SE, are planning to develop and conduct a multi centre study with the academic support of the department of Linguistics and Scandinavian studies and the Department of Behavioural Sciences in Medicine, University of Oslo.

In 2016 a pilot study aiming to provide a proper basis to develop an effect evaluation study will be conducted. At the OCHER workshop the planned pilot study will be presented with the aims of discussing the design of the planned effect evaluation.

**Maiken Wolderslund, Jette Ammentorp**

Providing digital audio recording of consultations to outpatients has proven beneficial and feasible in routine practice, in a recent PhD study conducted at Lillebaelt Hospital. Results showed that one in three consultations was replayed, mostly because the patients experienced difficulties with recall or understanding of the given information. The study revealed some disadvantages with the recording technology, namely unsatisfactory audio quality and lack of overview when recording multiple consultations. Consequently, the aim of this project is to develop, test and implement a new audio recording tool in collaboration with patients and health professionals.

The idea is to develop an audio recording extension to the newly developed app “Mit Forløb i Region Syddanmark”. This app provides patients with information and outline of their clinical pathway. The extension will enable patient and health professionals to audio record consultations throughout the clinical pathway also when transition between hospitals occur. Patients, relatives and health professionals will be involved in developing the recording feature to ensure high usability when implemented.

- I. The developmental phase:** Development of a recording feature using innovative participatory design to ensure: feasibility, improved audio quality and adequate record/replay possibilities for both patients and health professionals.
- II. The optimization phase:** Pilot test with user evaluation focusing on feasibility in clinical practice along with patients’ and relatives’ perception of the recording feature in the app.
- III. The implementation and effect evaluation phase:** Implementation of the app at Lillebaelt Hospital, and evaluation of use and effect concerning the recording feature.

***Focus for the group discussion***

At the moment we are considering the following effect measurements: patient participation and/or shared decision-making, patients’ health literacy, health outcome as definite endpoints.

*How should we evaluate the effect of this intervention?*

*What would be interesting from an international perspective?*

*What about the perspective of policy makers?*

## **Session A9: More than just symptoms**

*Communication on existential matters - a randomized controlled trial of a training program for doctors and nurses*

**Connie Timmermann, Niels Christian Hvidt, and Jette Ammentorp.**

Conversations concerning existential matters such as hope, death or faith have often shown to be a challenge for the health professionals, thus requiring special skills and competences. Also, the existential concerns of the patients may lead to the health professionals feeling powerless which again may lead to more prescriptions, further tests or meaningless treatments. Therefore, it is essential for the health professionals to feel able to accommodate and respond to existential concerns of the patients.

The purpose of our project is to develop and measure the effect of a training program for doctors and nurses, aimed at enhancing the communication on existential matters with patients in clinical practice in hospitals.

A total of 34 doctors and nurses will be randomized to either a 1-day training program on existential matters or a control group. One of the hypotheses is that after the intervention the communication in the intervention group is significantly more patient-centered and concerned with existential matters compared with the control group. This will among other be tested by analyzing 10 sound records of ambulatory conversations from each participants using an extended version of the Four Habits Coding Scheme.

In relation to the use of the Four Habits Coding Scheme we need to develop and validate a guide to score the sound recorded conversations in relation to the specific focus on existential matters. Therefore, we hope to be able present our ideas for a score-guide at the OCHER-workshop and engage the participants in a fruitful discussion and further development of our guide.

**Staffan Svensson**

A fairly large share of all consultations in primary health care concern symptoms that have no medical explanation. Some patients seek care repeatedly and go through a lot of investigation without finding a cause of their problems. Usually, after much frustration, attempts to find organic causes of the symptoms are abandoned and attention is instead focused on ways of containing them. This re-orientation may, however, prove difficult for both patients and physicians; probably more so if the search for explanations was extensive. It would thus be useful if cases at risk of lengthy and fruitless symptom investigation could be identified at an earlier stage. I want to explore the hypothesis that the participants' way of presenting and reasoning about symptoms, may serve this purpose.

We audio-recorded eight patient-physician appointments in a study of patients with medically unexplained symptoms in primary care. In the present project, parts of the consultations dealing with symptom evaluation and the need for investigation will be explored, using discourse analysis.

Talk about symptoms often concern whether they indicate a dangerous, treatable medical condition or not. Typically, the patient is in favour of this view, while the physician is against it.

- What topics are brought up for discussion, and how is this negotiated?
- What are the arguments for and against symptoms being "alarming" and "in need of investigation"? How are they presented and underpinned?
- What arguments seem to work?
- What continuity is there between propositions and conclusions?

Problems

- There is no pool of "normal" consultations to compare with in this material.
- A lot of decision-making seems to be invisible and many utterances refer to contexts outside the recorded consultations.
- What are the ethical implications of attempts at early identification? What if some patients present their symptoms in a similar fashion regardless of their underlying cause: would they not be at risk of not being properly investigated?

## **Session B9: Distress**

*Older peoples' expressed distress during home healthcare visits: A qualitative analysis of cues and concerns as identified by the Verona Coding definitions of Emotional Sequences*

**Linda Hafskjold, Vibeke Sundling, Sandra van Dulmen, Hilde Eide**

It has been emphasised that care providers need to be aware of how older people expresses deterioration of health and well-being to prevent dependency and tailor appropriate home healthcare services. The aim of this study is to explore older peoples' expressions of distress presented verbally and paraverbally in home healthcare.

The material presented in this study is part of an international research project on communication in home healthcare. The study uses an exploratory qualitative design including content analysis of transcripts of older people's ( $\geq 65$  years) verbally expressed distress.

The audio-recorded home healthcare visits ( $n=37$ ) were purposefully selected to provide maximum variation of contexts, care assignments, care providers and patients, including 23 patients and 13 nurse assistants. The visits were coded with the Verona Coding Definitions of Emotional Sequences (VR-CoDES) – cues and concern, to capture the older people's expressed distress, resulting in a total of 204 statements. Both inductive and deductive content analysis of these statements were used to explore the content and meaning of the expressed cues and concerns.

The cues and concerns are descriptions of the patient's expressed distress and worries. The patient usually hints (cues) to an emotion and uses words low on arousal like bad, irritated and foolish or expressions like "I cannot take this anymore". The themes identified cover social relationships, identity and existential issues, bodily aspects regarding pain, reduced physical abilities, and treatment or care issues, including subcategories within each theme. The statements can be understood as aspects of threats or challenges to the patient's well-being.

The results in this study will form the basis of a thematic coding system. For the OCHER seminar, we want to present this system and get feedback on operationalisations and structure.

**Tonje Lundeby, Kjersti Grotmol, Jon H. Loge, Arnstein Finset, Nina Aass**

Oncologists and palliative care physicians feel less confident about discussing prognoses and cessation of anti-cancer treatment compared to other communication tasks. Without appropriate discussion and goals setting, the oncologist may inadvertently delay referral to palliative care. Around a quarter of oncologists from western countries report that they occasionally administer a treatment that is not likely to work to avoid the discussion of bleak prospects. Less than half of American oncologists discuss life expectancy with their patients, and only 10% discuss end-of-life treatment preferences with their physician. Further, there is significant misunderstanding of disease prognosis and goal of care, even when the oncologist's skill was rated as good by their patients. Patients with advanced cancer overestimate life-expectancy, and they are overly optimistic about chemotherapy benefits. The stress experienced by health professionals involved in the care of the seriously ill and dying has been increasingly recognized. Approximately one-third of oncologists report high levels of emotional exhaustion.

PALLION is a national cluster-randomized trial of hospital departments with cancer patients with short life expectancy. The overarching goal of PALLION is to integrate palliative care and oncology. The project is constituted by three modules; systematic assessments of symptoms, implementation of standardized care pathways, and an educational program for palliative care physicians and oncologists.

We carry out focus groups because we want the physicians to voice the issues or concerns that are important to them. This is expected to ensure that the content of the educational program is experienced as relevant by the participants. An interview guide is currently being prepared, asking about challenging situations, communication and cooperation in the work of palliative care physicians and oncologists working with cancer patients with short life expectancy.