

- 1) To provide a fruitful arena for discussion of research projects at all stages of development, with particular attention to challenges in methodology
- 2) To build a Scandinavian network (with international collaboration partners) of multidisciplinary researchers with interest in communication in health care

7th OCHER workshop on Clinical Communication Research

January 10-12, 2018

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

Program

Start: Wednesday 10 January, 10:00

End: Friday 12 January, 16:00

Venue: **Thon Hotel Triaden**, Lørenskog, Norway

<https://www.thonhotels.no/hoteller/norge/lorenskog/thon-hotel-triaden/>

Address: Gamleveien 88

1476 Rasta

Telephone: +47 66 10 97 00

Lecturers and group discussants:

Professor Douglas Maynard, University of Wisconsin, Madison, Wisconsin, USA

https://www.ssc.wisc.edu/soc/faculty/pages/DWM_page/DWM_index3.htm

Keynote titles:

- Avoiding versus addressing end-of-life issues in cancer care
- Doing diagnosis: The use of narrative in clinical talk (with a focus on autism spectrum disorders)

Professor Kathryn Pollak, Duke University School of Medicine, Durham, NC, USA

<https://medschool.duke.edu/about-us/our-faculty/kathryn-iionka-pollak>

Keynote titles:

- Computer-based communication skills training: Plans for scalability
- Teaching communication via 1:1 coaching: Building resilience

Professor Anne Stiggelbout, Leiden University Medical Center, Leiden, The Netherlands

<https://www.lumc.nl/over-het-lumc/hoo/stiggelbout?setlanguage=English&setcountry=en>

Keynote titles:

- Implicit persuasion as a barrier to SDM
- A conceptual model of SDM: can we measure it in a valid way?

Local faculty: Pål Gulbrandsen, Arnstein Finset, and Jan Svennevig, University of Oslo, Hilde Eide, University College of Southeast Norway, Jennifer Gerwing, Akershus University Hospital

Working languages: English, Scandinavian

Wednesday January 10			
Time	Activity	Plenary room / Room A	Room B
1000	Plenary	Introduction, mutual presentation	
1045	Break	Talk to someone you don't know (much)	
1100	Plenary keynote 1	Douglas Maynard	<i>Avoiding versus addressing end-of-life issues in cancer care</i>
1200	Lunch		
1300	Plenary keynote 2	Anne Stiggelbout	<i>Implicit persuasion as a barrier to SDM</i>
1400	Break		
1415	Groups	Session 1A Handling and defining decisions	Session 1B Existential issues and challenges
		Gerwing et al.	Firing et al
		Netsey-Afedo et al	Hafskjold et al
		Sundling et al	Schaufel
1545	Break		
1555	Groups	Session 2A Preparing for/managing elderly care	Session 2B Existential issues and challenges
		Sundler et al	Sand et al
		Svennevig et al	Gregersen et al
1655	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		
Thursday January 11			
0830	Groups	Session 3A SDM: Readiness and barriers	Session 3B Visible aspects of communication
		Siouta et al	Svennevig & Marstrand
		Kienlin et al	Wallander Karlsen et al
		Kasper et al	Belisle Hansen
1000	Break		
1015	Groups	Session 4A Poor communication/barriers	Session 4B Option sensitivity/equipoise
		Ege Møller & Brøgger	Ofstad
		Iversen	Brembo
1115	Break		
1130	Plenary keynote 3	Kathryn Pollak	<i>Computer-based communication skills training: Plans for scalability</i>
1230	Lunch		

1330	Groups	Session 5A Supervision/mentorship	Session 5B Patient recall
		Haaland	Holt & Finset
		Brøgger & Ege Møller	Nordfalk & Gerwing
		Steinsbekk	Hultberg
1500	Break		
1530	Plenary keynote 4	Doug Maynard	<i>Doing diagnosis: The use of narrative in clinical talk (with a focus on autism spectrum disorders)</i>
1630	Break		
1645	Groups	Session 6 Planning research collaboration	
1800	End Groups		
1900	Dinner at hotel	Feel free to entertain, make a short speech, or just enjoy food, drink, and company	
Friday January 12			
0830	Plenary keynote 5	Kathryn Pollak	<i>Teaching communication via 1:1 coaching: Building resilience</i>
0930	Break/ Check-out		
1000	Groups	Session 7A Emotions	Session 7B Lindström & Lindström
		Sørensen et al	Lindström
		Heyn et al	Berbyuk Lindström et al
1100	Break		
1115	Groups	Session 8A Emotions	Session 8B Teaching program
		Van der Laaken	Grauslund et al
		Bergvik	Hyldmo & Finset
1215	Lunch		
1315	Plenary keynote 6	Anne Stiggelbout	<i>A conceptual model of SDM: can we measure it in a valid way?</i>
1415	Break		
1430	Groups	Session 10 Planning research collaboration	
1515	Plenary	Evaluation and round-up	
1600	End		

Session 1A – Handling and defining decisions

What is a medical decision (and how are they accomplished in medical encounters)?

A narrative review of the literature on decisions and related phenomena

Jennifer Gerwing¹, Eirik Hugaas Ofstad², Anne Maria Dalby Landmark³,
Pål Gulbrandsen^{1,4}

¹Akershus University Hospital, Health Services Research Unit. ²Nordlandssykehuset, Department of Internal Medicine. ³University of Oslo, Centre for Multilingualism in Society across the Lifespan. ⁴University of Oslo, Institute of Clinical Medicine.

The public and ethical imperative for patient participation in decision-making requires a research foundation in which actual decision-making processes are described and evaluated. Such research depends on a clear definition explicating how to recognize verbal statements of medical decisions in clinical dialogues. Comprehensive, logically-coherent definitions can lead to new insights, revealing previously unacknowledged phenomena. Subtle differences in how decisions are formulated can influence how the decision-making process unfolds, underlining the need to include all relevant phenomena. Thus concerning ourselves with how decisions are operationalized is more than an academic pursuit; it is essential for applying a normative approach to clinical communication training and evaluation.

Gathering research on how physicians and patients accomplish medical decisions is challenged by immense heterogeneity in the field. Even a cursory review of the literature reveals a variety of terminology (e.g., treatment recommendations, treatment options, proposed tasks). Furthermore, limiting decisions to statements oriented to future actions has excluded relevant phenomena (e.g., physicians' evaluations of test results). Finally, differences in academic disciplines and methodological approaches have made the literature highly fragmented and disconnected.

Our aim is to review and synthesize literature identifying and analyzing statements concerning decisions in clinical consultations. We begin with Ofstad et al.'s (2016) comprehensive definition of medical decisions: "verbal statements committing to a particular course or clinically relevant action and/or statement concerning the patient's health that carries meaning and weight because it is said by a medical expert" (p. 3). We will gather literature describing phenomena that fit within this definition, including only research in which the primary source material was videotaped, authentic clinical interactions between patients and health care personnel. Rather than an exhaustive review, we will take a narrative approach, showing commonalities and connections. We hope to highlight the need for inclusivity and acceptance of unfamiliar approaches to familiar questions.

Ofstad EH, Frich JC, Schei E, Frankel RM, Gulbrandsen P. What is a medical decision? A taxonomy based on physician statements in hospital encounters: a qualitative study. *BMJ open*. 2016 Feb 1;6(2):e010098.

Who decides in the treatment of advanced prostate cancer?

*Mette Løwe Netsey-Afedo^{1,2}, Palle Jörn Sloth Osther², Jette Ammentorp¹,
Regner Birkelund¹*

¹Department for Health Services Research, Institute of Regional Health Research, Centre Hospital Lillebaelt, University of Southern Denmark. ²Urological Research Center, Institute of Regional Health Research, Centre Hospital Lillebaelt, University of Southern Denmark.

Introduction:

As a method to promote patient involvement, shared decision-making (SDM) is acknowledged. However, it is argued that the approach is complex, easily influenced by organizational factors, time-consuming, and requires specific communication skills training of the health professionals. Moreover, there is a difference to which degree patients wish to be part of decision-making. In the treatment of advanced prostate cancer, it is often narrowed down to a choice between different types of hormone deprivation therapies, all associated with unpleasant physical and psychological adverse events, or no treatment at all. For some patients, it is furthermore a choice between early chemo-therapy or not. When making such treatment-related decisions, it is essential to involve the patients' preferences, needs, and desires. Research related to decision-making and the influence of organizational factors on patient involvement in relation to this patient group is limited.

The aim:

To examine:

- communicative processes between patients with advanced prostate cancer and health professionals related to decision-making.
- health professionals' and patients' approach to patient involvement.
- organizational possibilities and constraints related to involvement.

Methods: Data will be collected using participant observations followed by qualitative interviews of 15 patients with advanced prostate cancer and health professionals. Data interpretation will be based on Ricoeur's theory of interpretation.

Preliminary findings: SDM only takes place to a lesser degree. Communication is mainly characterized by one-way communication primarily focusing on informing patients about their illness and the overall treatment method. Usually, the patient is offered a specific treatment and asked for acceptance. Patient's preferences and demands are rarely asked about. Overall, the patients are satisfied and consider doctors capable of making the right decision.

To be discussed: Which studies, theories, alternative concepts to SDM etc. can be included in the discussions of these findings in my articles?

Person-centred communication, clinical decisions, and shared decision making in optometric practice

Vibeke Sundling^{1,2}, Grete Helen Andersen¹ and Hilde Eide²

¹ National Centre for Optics, Vision and Eye Care, Department of optometry and visual science, Faculty of Health and Social Sciences, University College of Southeast Norway, Kongsberg, Norway. ² Science Center Health and Technology, University College of Southeast, Drammen, Norway.

Background

Person-centred communication is central to understand patients' visual needs and to provide patient education allowing for patient involvement and shared decision making on vision correction and management of vision and ocular health in optometric practice. The aim of this study is to assess person-centred communication in optometric practice and how person-centred communication it is related to clinical decisions and degree of decision sharing.

Method

We will grade the degree of person-centred communication using VR-COPE, and explore the association between person-centred communication and type of clinical decisions and degree of shared decisions made in optometric practice. The grading and analysis will be applied to a sample of patient-optometrist encounters already coded using the DICTUM framework for clinical decision and the degree of decisions sharing. The sample includes 40 video-recorded patient-optometrist encounters, including 11 optometrists (6 female) and 40 patients (20 female). The mean age of the patients is 66 years (range 46-91 years).

Results

We will present results of the rating of person-centred communication, as well as how person-centred communication is related to clinical decisions and shared decision-making.

Points for discussion

1. How does degree of person-centred communication rated by VR-COPE predict types of clinical decisions and decision sharing?
2. How could we train optometrists' communication skills to improve person-centred communication and shared decision making?
3. How should we further research patient-optometrist communication to develop targeted communication skills training for optometrist?

Session 1B – Existential issues/challenges (1)

Understanding the needs and perspectives of patients with advanced cancer and their next of kin over the disease trajectory: A proposal for a PhD project.

Nina C. Firing, Tonje Lundeby, Arnstein Finset og Hanne C. Lie,

Background

Advanced cancer disease is associated with a high burden of physical and psychosocial symptoms and reduced quality of life. The patients' and their next-of-kin's care and support needs likely change over time, but are poorly researched. Moreover, few have examined the patients' values, beliefs and preferences, how they change, and how they enable or hinder participation in decision making.

The PhD project aims to generate an in-depth understanding of the perspectives of patients and their next-of-kin in the context of advanced cancer care; including changes in care and information needs as the disease progress.

The specific aims are:

1. Explore the patients' and next-of-kin's perspectives on the medical care provided in the context of advanced cancer at a public hospital in Norway, including their needs for information, experiences receiving information; and opportunities for, and experiences of, shared decision making.
2. What individual abilities do the patients and next-of-kin perceive as necessary/helpful to enable shared decision making? How do their perspectives and needs change across the disease trajectory?
3. What are the relatives' perspectives and needs, and how do they differ from those of the patients?

Methods

This will be a mixed-method study, using existing questionnaire data (study 1) and serial, multi-perspective interviews with patients with advanced cancer and their next-of-kin (study 2 and 3). Participants will be interviewed 3-4 times over a 12-month period.

In this session we would like to discuss the proposed project and:

1. Time of interviews: Should they reflect changes in health status, treatment changes or be at regular intervals?
2. Possible theoretical framework(s) to guide the interviews and the qualitative analyses: Activation level, theory of existential health or something else?
3. Sampling: patient characteristics to take into consideration, including advantages/disadvantages of including patients with, or without, a history of a preceding cancer disease.

Cancer patients and clinical trial decision-making – A systematic review of qualitative interviews exploring patients' experiences.

Trine A Gregersen RN, Cand.cur (PhD student)^{1, 2, 3}, Regner Birkelund RN, PhD (Professor)^{2, 3}, Maiken Wolderslund RN, PhD (Postdoc)^{2, 3}, Karina Dahl Steffensen MD (Associate professor)^{1, 2, 3}, Jette Ammentorp RN, PhD (Professor)^{2, 3}

¹ Department of Oncology, Lillebaelt Hospital, Vejle Denmark. ² Health Services Research Unit, Lillebaelt Hospital, Vejle Denmark. ³ IRS University of Southern Denmark, Odense Denmark.

Introduction

Most cancer patients are involved in difficult treatment decisions and many patients must decide whether or not they want to participate in a clinical trial. Therapy for advanced cancer is only life-prolonging which places patients with advanced cancer in a special situation where existential concerns such as dealing with end of life, hope and meaning becomes a vital part of life.

Method

A qualitative systematic literature review, based on Thomas and Hardens methods for thematic synthesis, was conducted to summarize existing knowledge and give direction for future research concerning patients and their relatives' experiences when they are given the opportunity to participate in a trial.

Results

11 full text articles were included. 6 descriptive themes appeared and were grouped under two analytical themes: 1) *Individualized decisions* 2) *Hope and Existential matters*. Both of the themes related to one main theme *what matters in treatment-related decisions close to end of life*.

Conclusion

This review has shown that hope and existential matters are important in the decision-making and dealing with this might be of great importance in the medical decision-making, whether it concerns the patient, their relatives or the health care professionals' existential matters. From the perspective of this review the theory of whole person care – combining healing and cure - can be essential when discussing decision-making in the future. The theory states that death anxiety contains challenges and opportunities and influences patients, their relatives and health care professionals' medical decision-making and that health care professionals may strive to manage their own unconscious death fears.

Future research should include the health care professionals' experiences when going in depth with decision-making with focus on the existential matters and the health care professionals' uncertainties.

What we would like to discuss:

- Investigating the health care professionals' existential matters and uncertainties.

Information exchange and decision-making in doctor-patient-dialogues about palliative lung cancer treatment

Margrethe Aase Schaufel

Background:

Further research is needed exploring how doctors and patients with advanced lung cancer discuss diagnosis, prognosis, treatment decisions and palliative care needs. An especially underexplored matter is existential challenges and how these affect decision-making.

Objectives and sub studies:

The main aim of this postdoctoral project is to develop new knowledge about doctor-patient-dialogues contributing to improved decision-making, treatment and care for patients with advanced lung cancer and their relatives. The proposed project is organized in five sub studies:

1. How do patients with advanced lung cancer, their relatives and doctors exchange information when making decisions about chemotherapy, radiotherapy, molecular targeted therapies or immunotherapy?
2. How do existential conditions and challenges affect the doctor-patient/relative-dialogue when discussing palliative lung cancer treatment?
3. How do patients and their relatives experience information, shared decision-making and needs in these dialogues?
4. Which challenges and barriers do doctors experience in these dialogues, and how is further coordination of care affected by those challenges?
5. How does existential suffering in a Norwegian lung cancer population correlate with quality of life and depression?

Design and methods:

Qualitative observational data from doctor-patient/relative-dialogues will be collected from university hospitals in all health regions in Norway treating lung cancer. The participants will be asked to participate in sub studies 1-3 (patients/relatives) or 1,2 and 4 (doctors), where the treatment dialogue after a diagnosis of advanced lung cancer has been established will be audio taped and transcribed verbatim. Qualitative analysis will be performed interpreting speech acts in the medical discourse of the clinical interaction and information exchange, following the procedure of systematic text condensation. Semi-structured interviews will be conducted in sub study 3-4. In sub study 5 we will use standardized questionnaires detecting existential suffering (the Demoralization Scale, DS-II), depression (the Patient Health Questionnaire, PHQ-9) and quality of life (EORTC QLQ-L13).

Session 2A – Preparing for/managing elderly care

ACTION – Attentive and person-centered communication. A clinical intervention study aimed to improve communication competences of nursing staff in home care services

Annelie Sundler, Tanja Gustafsson, Elisabeth Lindberg, Hanna Maurin Söderholm & Inger K Holmström

Background:

The communication between professionals and recipients of home care services is important in order to assure the quality of home care services and to promote older persons independence and influence over their lives. Previous research indicates several challenges related to communication and care of older persons, and challenges related to how to deliver efficient educational efforts in the home care context. To date few educational interventions to enhance the communication competence for nursing staff have been tested.

Aim:

The aim of this study is to develop and test a web-based educational intervention on communication with older persons in home care settings.

Method:

In this pilot study, a web-based educational intervention is developed. This intervention consists of several modules on different aspects of communication and person-centred care. A flexible learning platform is used for web-based lectures, movies of role-play, quiz-questions and reflecting exercises to complete for the nursing staff.

The educational intervention will be evaluated with pre- and post-assessments and a process evaluation. The assessments will include questionnaires on self-efficacy communication skills and job satisfaction, in addition to audio recordings of communication during home care visits. Process evaluations will be performed based on interviews with participating staff before, during and after the intervention.

This presentation will discuss methodological challenges in performing clinical interventions on communication training with nursing staff outside hospitals. This pilot study started during the autumn 2017 and will run until spring 2018. The study is the first phase in a research project. After the pilot study we have planned for a multicentre study where the educational intervention will be further developed with interactive, virtual, training facilities. Based on the findings in this study the final educational intervention will be adjusted before implemented and tested in a multicentre study.

Managing the sensitivity of forgetfulness in dementia interaction

Jan Svennevi, Maria Njølstad Vonen, Anne Marie Dalby Landmark.

A substantial amount of research on interaction involving persons with dementia (pwd) has focused on how the cognitive impairment impacts the progression of the talk and the establishment of mutual understanding. Less research has been devoted to the social consequences of forgetfulness. Not remembering things that one would normally be expected to know (i.e. firsthand experience, and knowledge within the pwd's epistemic domain) can be treated as accountable, and thus a socially sensitive issue. Both pwd's and their interlocutors orient to this threat to face by engaging in what we propose to call *social compensation strategies*, that is, communicative practices aimed at dispersing, reducing, or accounting for the potential threat to face created by a memory problem. In this study, we describe three such practices used by pwd's in contexts where they display problems of answering a question. The first is a strategy of dispersion, whereby the pwd produces a 'transformative answer' (Stivers and Hayashi 2010), substituting the specific information asked for by a more general type of information, more easily accessible. The face threat is thereby potentially dispersed by the fact that an answer is produced and presented as fulfilling the conditional relevance of the question. The second strategy is the expression of frustration at not being able to answer, such as sighing, laughing or producing a metacommunicative comment (cf. Wilkinson 2007). By displaying 'troubles resistance' (Jefferson 1988), the pwd distances him- or herself from the memory problem by treating it as exceptional and thereby implicitly claiming better cognitive capacities than what is currently being displayed. The third is to produce an account, rationalizing and normalizing the inability to provide the projected answer. Rather than invoking the dementia condition as an explanation, the pwd may refer to general problems that are common to all people, such as the fact that the event asked about occurred a long time ago.

The data come from a collection of video-recorded conversations with pwd's in both institutional and private settings.

Keywords: dementia, accounts, answers, face, sensitivity

Session 2B – Existential issues/challenges (2)

The physician perspective regarding providing information about late-effects to cancer patients and survivors: The dilemma of when and what

Kari Sand, Hanne Cathrine Lie, Cecilie Kiserud, Jon Håvard Loge and Jo Åsmund Lund

Background: Many long-term cancer survivors are at risk for developing late-effects, yet the majority of them lack knowledge of such health problems that might appear years after termination of treatment. Information about late-effect is necessary to enable self-management and promote a healthy life-style. We explored the experiences of oncologists, oncologists-in-training (OiT) and general practitioners (GPs) regarding their current practices for providing information about late-effects to patients and survivors.

Methods: We conducted 16 focus-group interviews with 70 physicians (24 oncologists, 16 OiTs, 30 GPs), representing the four university hospitals and urban, semi-rural and rural primary care settings across Norway. The interviews were audio-recorded, transcribed and are analyzed using principles of thematic content analysis.

Results: Preliminary analyses identified “Lack of routines for providing information about late-effects” as major theme. This theme was discussed in most groups, but without reaching consensus regarding what is “best practice”. Discussions of late-effects were seen as especially important at two time-points. Prior to treatment, health care personnel are obliged to inform about acute and long-term side effects. However, patients were seen as unable to take on-board such information due to the severity of the situation and the amount and complexity of all information to be provided at that time-point. The time of transition from specialist to primary care setting was also seen as an important time-point for providing such information, but then a major concern was to avoid “pathologizing” the patients and not hindering them to “move on” again.

Throughout, the physicians appeared to be torn between providing information about late-effects and “shielding” their patients from unnecessary anxiety and/or disrupting their transition from “the patient role” to “feeling healthy” again. Our results suggest a gap in practice between an obligation to inform and how and when to provide the patient with necessary information about future health.

Exploring communication about existential issues as it unfolds between older persons and nursing staff in home care visits

PhD candidate Linda Hafskjold¹, Associate Professor Lena Heyn¹, Professor Tom Eide², Professor Hilde Eide²

¹ Faculty of Health and Social Sciences, University College of Southeast Norway. ² Science Centre Health and Technology, Faculty of Health and Social Sciences, University College of Southeast Norway.

Background

Previous studies show that communication challenges occur in home care visits when the older persons express worries and share emotional distress caused by existential issues. The thematic content of the existential worries shared during home care visits includes worries about aging and bodily impairment (including fear of physical pain), pondering about death and lack of hope for the future. Little research describe how these topics are actually talked about during home care visits.

Aim

The main aim is to explore communication concerning existential issues.

The tentative research questions are:

Which existential issues emerge (directly and indirectly) in dialogues between older persons and nursing staff, how are these issues met and dealt with by the nursing staff, and what comes to light in the dialogue concerning the patient as a person and the development of the relationship.

Method

The study builds on the work done in an international research project on person-centered communication with older persons (≥ 65 years) receiving home care (COMHOME).

Sample: Between December 2013 and May 2014, 196 audio-recorded home care visits (48 older persons, 16 registered nurses and 17 nurse assistants) were collected and subsequently analyzed with Verona Coding Definitions of Emotional Sequences (VR-CoDES). In total 144 visits included expressions of negative emotion according to VR-CoDES ($n=638$). All cues and concerns have been transcribed. 290 expressions have been coded as having the thematic content described as “*coping with existential challenges*”. These 290 expressions will serve as examples of a “critical moment”. A purposeful selection aiming at maximum variation will be used to select among visits where one or more of these expressions are found. Transcriptions of these critical moments will be explored in-depth through phenomenological-hermeneutical close reading of the transcribed texts.

Points for discussion

- Feedback on research question
- Selecting cases and analytical approach

Session 3A – SDM readiness and barriers

Patient Involvement and Participation Authority in Medical Consultations about Atrial Fibrillation Treatment - A qualitative content analysis of the cardiologist's perspective

Ulla Hellström Muhli¹, Jan Trost¹, Eleni Siouta^{1,2}

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Abstract

Patient involvement and participation authority in treatment decisions is of high priority in the value structure of the Swedish health care system. However, when it comes to atrial fibrillation (AF) treatment, knowledge about the professional practice in medical consultations with individual patients is lacking. The aim was to analyze and describe how cardiologists describe patient involvement and participation authority in consultations about atrial fibrillation (AF) treatment. The research questions are: (i) how cardiologists practically handle patient involvement and participation authority in medical consultations, and (ii) how cardiologists orientate to shared decision-making regarding AF treatment as part of the value structure of patient involvement.

This article is a qualitative interview study from a project that interviewed ten (n=10) cardiologists at four Swedish hospitals. The interviews were transcribed verbatim and examined with content analysis method. The analysis shows cardiologists' accounts of (i) persuasive practice, (ii) protective practice, (iii) professional role, and (iv) medical craftsmanship when it comes to patient involvement and participation authority. The patients' possibility for involvement and participation authority in consultations regarding AF treatment is dependent on how the cardiologists define their own situation in the consultation environment. However, the way in which cardiologists contribute to patient involvement and participation authority is by the talk-interaction, assessing the patients' abilities to be receptive to information. According to the ideology of shared decision-making there are two sets of decisions to be made, namely the patient's and the cardiologist's. However, these two sets are often labeled as only one set of decisions and might be called a "shared decision". Cardiologists should problematize patient involvement and participation authority in decision-making regarding AF treatment decisions in consultations when trying to meet patients' expectations to provide a quality experience. This problematizing requires more interest in the patients' perspective and opinions.

KEYWORDS: Patient Involvement, Participation, Authority, Medical Consultations, Atrial Fibrillation Treatment, Cardiologists, Decision-making.

An intervention to improve shared decision making

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Background

In response to an obvious lack of shared decision making (SDM) professional training in Norway, a draft of the “Ready for SDM” program was developed based on a proven effective German module (doktormitSDM). Two applications (norw. “Klar for samvalg”) (M1 / M2) have recently been evaluated by a pilot study, indicating a need for better adaption to various health professions and inter-professional learning.

This study aims at testing the efficacy of the revised M2 regarding SDM-competency, and at further explaining variance of competency by inter-individually varying perception of barriers towards practicing SDM.

Methods

A cluster-randomized waiting control group design is used including a nested regression design. Within two hours the module provides three components: A) lecture introducing SDM with regard to background, idea, indication and proven effects. B) lecture, teaching the “six steps to SDM”, C) video-based interactive training. Revision refers to “C)”, where domain specific video examples are provided and inter-professional contribution to SDM is focused.

Clusters are multi-professional clinical teams. The size of the total sample will be calculated based on a similar study.

Participants evaluate a video recorded clinical decision consultation using the MAPPIN’SDM scales either before (waiting-) or after (intervention-group) the training.

In addition, participants are asked to report perceived barriers to practicing SDM in a questionnaire which is developed based on the theory of planned behaviour. Moreover, sociodemographic and profession related variables are assessed.

SDM-competency is operationalized as the observations’ reliability with regard to a given expert judgement. Group affiliation, barriers and person-related data are used as potential predictors in a multiple regression analysis, to predict communication competence and intention to practice SDM.

Expected results

Ready for SDM is expected to improve communication competency. Knowledge on relevance of reported barriers will inform implementation strategies and further refinement of the “Ready for SDM” curriculum.

Session 3B – Visual aspects of communication

Touch during instructions in elderly care

Jan Svennevig and Ann Katrine Marstrand

In residential care, professional caregivers routinely employ touch in giving instructions and guiding the residents in carrying out everyday tasks. We use Conversation Analysis to study how a caregiver uses touch as a key resource when instructing and helping a person with Parkinson's disease to take a seat in the common room. The participants jointly accomplish the task by cycling through a variety of semiotic resources (Goodwin, 2013), e.g. talk, gaze, gesture, bodily positioning, and touch. The analysis shows how a caregiver uses touch to facilitate the initiation, continuation, or termination of an instructed action. Touch is shown to have both supporting and controlling functions in the collaborative accomplishment of the joint project (Cekaite, 2016). In this caregiving context, touch is oriented to as less problematic than what has been described for many other care contexts (e.g. Denman & Wilkinson, 2011). Yet, there is a clear orientation to touch as a sensitive action, invading the patient's intimacy and right to self-determination. First, the semiotic resources are shown to occur in a *successive order*, where talk and gesture generally precede touch. Second, less invasive kinds of touch, such as patting, precede more invasive kinds, such as holding and shoving. The study thus contributes to theory on multimodality by showing how different modalities vary with regards to social sensitivity, which may then motivate the choice of a specific modality on a given occasion.

Cekaite, A. (2016). Touch as social control: Haptic organization of attention in adult-child interactions. *Journal of Pragmatics*, 92, 30-42.
Denman, A., & Wilkinson, R. (2011). Applying conversation analysis to traumatic brain injury: investigating touching another person in everyday social interaction. *Disability and Rehabilitation*, 33(3), 243-252.
Goodwin, C. (2013). The co-operative, Transformative organization of human action and knowledge. *Journal of Pragmatics*, 46(1), 8-23.

Communication and interaction with patients during mechanical ventilation in intensive care units- *analytic choices in a qualitative video recorded study*

Marte-Marie Wallander Karlsen (MNSc, Lovisenberg Diaconal University College), Lena Guntenberg Heyn (PhD, Lovisenberg Diaconal University College), Arnstein Finset (Professor, University of Oslo)

Aims

The aim of this study was to obtain more in depth knowledge about interactions between healthcare personnel and patients who are conscious and alert on mechanical ventilation in Intensive Care Units (ICUs).

Methods

In this qualitative study with a hermeneutic-phenomenological approach, 10 patients on mechanical ventilation and healthcare personnel were video recorded in natural occurring interactions. The videos are 3-4 hours long, in total 30 hours of video has been collected. The videos have been transcribed for non-verbal and verbal actions, then analyzed by using content analytic techniques (Graneheim & Lundeman), focusing both on the manifest and latent content. "*Attention seeking actions*" became an important theme, as the patients' initiation of communication was rare. Mostly the healthcare personnel were the principal initiators.

Topic for the presentation at OCHER

The main topic will be the methodological approach for analyzing videotaped natural occurring interaction. Further discussions are desirable, as we want feedback on the analysis. Preliminary content analysis yielded many themes, and the data was very rich. For a novel researcher, it has been a complex decision making process. "*Attention seeking actions*" is a main theme that will be presented more in depth. The patients made various number of attempts to seek attention, ranging from none to 17 for each patient. By comparing all the attention seeking actions, we found that expressions of attention seeking actions also related to several subcategories of content. The way they were responded to depended upon both patient and healthcare personnel's interaction. The subthemes of attention seeking actions "*immediately responded to by healthcare personnel*", "*giving up*", "*delayed response by healthcare personnel*" and "*intensified*" will be presented with narratives to exemplify and contextualize.

Interpreting in the virtual meeting room - ideas and practice

Jessica P B Hansen, PhD candidate, University of Oslo

My PhD project *Interpreting in the virtual meeting room* combines ethnographic methods (e.g. interviews, fieldwork) and Conversation Analysis to explore video mediated interpreting as ideas held by public authorities and practitioners in the field and as practice carried out in meetings with patients in Norwegian hospitals. In this presentation I will discuss the divergence between video mediated interpreting as ideas and as practice based upon preliminary findings from the two methodological approaches.

Interpreting is considered an intervention to ensure equity in public services, e.g. in health care, for an increasingly diverse population. Video technology is suggested to increase access to qualified interpreters and to cut travelling time and expenses. The parties have mutual visual access to each-other, and video interpreting is therefore commonly described as a better option than telephone interpreting. However, preliminary findings from interviews indicate that the interpreters find video interpreting to be different than on-site interpreting and emphasize the similarities to telephone interpreting despite mutual visual access.

Preliminary findings from conversation analyses of hospital meetings suggest that interpreting is a communicative activity that the participants orient to during the interaction. The activity of interpreting is something achieved by the participants in collaboration. Although the participants have visual access to each-other, what the participants assume to be efficient ways of managing interaction through video technology (e.g. gestures, facial expressions), are not always so.

The project is still within its first year, and data collection is just beginning. However, preliminary findings indicate that the combination of Conversation Analysis and ethnographic methods shed light on the divergence between video mediated interpreting as ideas or notions and video mediated interpreting as interactional practice. This presentation will raise further discussion regarding the methodological combination and the tension between ideas and practice.

Session 4A – Poor communication/barriers

Discourse patterns in ophthalmology doctor-patient communication

Jane Ege Møller & Matilde Nisbeth Brøgger

Aarhus University, Denmark

There is substantial evidence that adequate patient-centered communication is essential for high-quality clinical practice and that it leads to better health outcomes. In addition, there is a widespread conception that communicative patterns such as doctors' interruptions and the use of medical jargon are signs of bio-medical dominance, and barriers for achieving such patient-centered communication.

We present the preliminary findings from a qualitative study of exactly these patterns in doctor-patient communication between doctors, patients and their relatives in an ophthalmology department.

Our empirical material is video recordings of 42 consultations between 8 doctors and their patients.

Drawing on, among others, the work of Li et al. (2004), we raise the questions: How do interruptions influence the doctor-patient conversation? Is interruption always an instantiation of power dominance and thus intrusive or can cooperative interruptions be found?

In addition, our analytical focus will be to identify the characteristics of the 'voice of the doctor'.

Central analytical concepts in this study thus are 'Interruption', 'Voice' and 'Polysemy' and we will discuss the analytical strengths and weaknesses by providing examples from the preliminary findings.

Li, H.Z., Krysko, M., Desroches, N.D., & Deagle G. (2004) *Reconceptualizing interruptions in physician-patient interviews: Cooperative and Intrusive Communication & Medicine* 1(2), pp. 145–157

Identification of poor communication skills

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Introduction:

The Four Habits Coding Scheme (FHCS), an instrument to assess clinicians' communication behavior, is calibrated to the presence of good communication. However, researchers who have experiences with the FHCS have noted, that some clinicians can receive a high score, although the researchers have a feeling, that this high score does not reflect the clinicians' overall communication skills. Therefore a suggesting of incorporation a score for inappropriate or poor communication has been made. The aim of this study is to identify inappropriate or poor communication skills in the patient-physician encounters for inclusion into the FHCS.

Methods:

A qualitative study at the Department of Oncology, Odense University Hospital, Denmark including 5 - 10 encounters. The encounters will be video recorded and for each encounters two semi-structured interviews will be conducted; one with the physician (same day) and one with the patient (one week after). Both interviews aim to explore the experiences of the communication.

Discussion:

By having this data (video records and interviews) there will be three points of views: the researchers', the physicians' and the patients'.

But how to analyze these data?

How do we manage if their points of views differ from each other?

How to make a study looking for poor communication skills without insulting the clinicians?

Session 4B – Option sensitivity/equipoise

Building Utopia together: aiming to implement shared decision-making (SDM) through user participation in a joint behavioral and cultural change – a project outline

Eirik Ofstad, eirikofstad@gmail.com, Nordland Hospital, Bodø, Norway

Shared decision making (SDM) has been promoted as a silver bullet for two decades, but is still far from integrated into everyday medicine. Most studies measuring observed SDM in clinical encounters have reported low levels of patient involvement in decision-making and real life decision-making rarely plays out as SDM is described in the literature. Why is this? And what will it take to integrate SDM as a natural part of everyday medicine?

Firstly, I will present some reflections from studying the phenomenon of decisions in medical encounters and attempts of patient involvement in the pool of 380 patient-physician encounters recorded at Akershus University Hospital ten years ago.

Secondly, I will present relevant barriers and facilitators to SDM, not just those described in previous literature, but also elements inherent in all medical decisions that may affect whether or not SDM is desired from a traditional medical perspective.

I will describe how I think these barriers and facilitators can be made explicit and how this awareness in turn may be a first step towards a change in behavior and culture.

The study planned will include 20 physicians from three different specialties (orthopedic surgery, oncology and obstetrics and gynecology). Each physician will be video-recorded twice in encounters with different patients where a decision with a certain “level of equipoise” will be discussed (e.g. hip/knee replacement, cesarean section or second line chemotherapy for advanced cancer). After each encounter, the patient and physician will be interviewed separately (in some cases while seeing the video together with the interviewer). Focus group interviews/group sessions with patients and physicians will be conducted, firstly to establish common ground regarding current attitudes and behaviors towards SDM and secondly to include the user perspective in the development of potential efforts to increase patient involvement in dialog concerning medical decisions. The user perspectives will be integrated into the development of an intervention aimed at physicians and patients, in their specific contexts.

After the intervention, all 20 physicians will be video-recorded twice in encounters with different patients where equipoise decisions are up for discussion. After each encounter, the patient and physician will be interviewed separately again. Focus group interviews might be relevant to conduct once more.

All videos will be analyzed from the observer perspective, using both quantitative (MAPPIN-SDM and OPTION-5) and qualitative approaches (microanalysis of face-to-face dialog). Findings from the qualitative patient and physician interviews will be integrated into the analyses.

I would like to discuss with the fine group of OCHER-participants whether or not this project is meaningful to go ahead with and if so, what I need to have thought thoroughly through before I go ahead.

The hip journey: An exploration of patient needs, treatment decision-making and psychosocial predictors of surgical outcomes in patients with hip osteoarthritis

Brembo, Espen Andreas (UiO, HSN)

Supervisors: Prof. Hilde Eide (HSN), Dean Heidi Kapstad (HSN), Prof. Sandra van Dulmen (HSN, NIVEL) and Prof. Em. Arnstein Finset (UiO).

Background:

Osteoarthritis (OA) of the hip is a prevalent and painful musculoskeletal condition, which for many severely affected patients result in reduced physical functioning and quality of life. Patients may struggle over several years while trying to establish helpful behaviors to relieve pain and to maintain acceptable functioning in daily living. If conservative treatment strategies such as physical activity, physiotherapy, weight loss, and pain medication are ineffective, patients are usually referred to an orthopedic surgeon to consider having the hip joint replaced by a prosthesis (called total hip replacement). Given that all patients are unique with their own needs, experiences and expectations, there are no fixed criteria for treatment decision-making. Each option is sensitive to individual preferences; hence, every patient must be actively involved in all stages of the decision-making process. This PhD project aims to explore the needs of patients living with hip OA, psychosocial predictors of surgical outcomes, and the possibilities and barriers for shared decision-making in orthopedic outpatient consultations.

Papers and research questions:

- 1 Patient information and emotional needs across the hip osteoarthritis continuum
 - How do patients with hip OA describe living with OA and their consequent healthcare needs?
 - How does decision-making about total hip replacement take place?
- 2 Role of self-efficacy and social support in short-term recovery after total hip replacement
 - Does low self-efficacy and low social support predict poorer short-term recovery after total hip replacement?
 - How does age, gender and number of comorbidity affect short-term recovery, general self-efficacy and perceived social support?
- 3 Possibilities and barriers for shared decision-making in orthopedic outpatient consultations
 - To what extent are patients involved in decision-making?
 - What factors can be identified that influence patient involvement?

Methods:

The research questions are explored using a combination of qualitative and quantitative research methods. In paper 1, we individually interviewed patients recruited from both specialist and primary care settings. The data was analyzed using inductive thematic analysis. In paper 2, we analyzed longitudinal questionnaire data deriving from a previous PhD-project using a set of statistical methods. In paper 3, we observed and audiotaped orthopedic outpatient consultations to identify if and how the patient was involved in decision-making. The data was analyzed thematically using template analysis.

Focus at the OCHER workshop: To present the main results of my PhD-project and receive constructive feedback relevant for my upcoming disputation.

Session 5A – Supervision/mentorship

From Re-action to Pro-action, using emotional intelligence: Changing perception of vulnerability through reflective and interactive learning

Ane Haaland, Thomas Kitchen, Isra Hassan

Introduction:

Vulnerability is often perceived as a sign of weakness or embarrassment by medical professions. A trainee doctor said: “*There was an innate belief within that feels that vulnerability needs to be stamped out and hidden*”. Many fear vulnerability, and have not learnt how to recognize, understand and handle it with care. Automatic emotional reactions to situations where their vulnerability is triggered is common, and can compromise teamwork, patient safety and professional well-being. Doctors and medical students in the UK have higher levels of mental ill health than the general population.

Method:

A programme to strengthen emotional intelligence (EI) as foundation for resilience was implemented in 2016 and 2017 (11+21 trainee doctors) in Wales Deanery, building on a model implemented with >300 care providers in eight countries. Self-directed learning through guided observation/reflection tasks is the core method to discover their own reactions and identify learning needs, and 4-6 three hour workshops using experiential learning methods to interactively reflect by linking to theories and work situations. Evaluation pre and post training included quantitative (EI questionnaire) and qualitative measures: questionnaire, semi-structured interviews, reflective narratives and FGD.

Preliminary results:

Trainees learnt to recognize, understand and appreciate positive aspects of vulnerability rather than fear or deny it, using EI to step back from automatic emotional reactions and speak openly with colleagues. By recognising their own vulnerability when working with patients and colleagues who are also in a vulnerable state, they can reach out and make connections that enable them to meet as human beings. Many describe being kinder to themselves and enjoying work more. Participants have changed from being Re-active when faced with these emotions, to becoming Pro-active, handling emotions with EI.

Discussion:

Reflective learning has enabled participants to recognize, acknowledge and care for vulnerability with awareness, and with focus on the relationship.

Young doctors' main communication challenges

Matilde Nisbeth Brøgger & Jane Ege Møller

Aarhus University, Denmark

The transition from medical student to young doctor can be challenging for a number of reasons. One is the role change from that of student to that of practicing doctor. Previous studies have demonstrated that the transition can be perceived as stressful because of increased responsibility, uncertainty, lack of support and lack of medical knowledge and credibility (Brennan et al. 2010, Lempp et al. 2004, Pitkala & Mantyranta 2003). However, to our knowledge, only one study mentions communication problems at the workplace as a stressor or challenge in this transition phase, and here focus is mainly on difficulties in communicating with seniors and peers, not patients (Luthy et al. 2004). While many of the above-mentioned challenges might influence and be influenced by patient communication challenges, there is a lack of studies that investigate the transition from a patient communication perspective.

Our empirical material stems from Danish communication courses which are obligatory for all young doctors in their first year after graduating from medical school. As part of the preparation for these courses, all course participants are asked to prepare two cases based on concrete communication situations in which they are felt challenged. Course participants are then asked to share these two cases orally in a so-called 'case round' during the beginning of the course. In 2017, we will video-record all case rounds; so far cases from around 85 young doctors have been recorded and transcribed. Our analyses are only just commencing, but preliminary results show that young doctors are communicatively challenged when patients disturb the structure for example by either talking too much or too little. For the structure to be clear, patients thus need to talk a sufficient amount. Many also mention the gap between doctors' and patients' knowledge and understanding as a communicative challenge.

Supervision in longitudinal integrated clerkship

Aslak Steinsbekk

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A new model for medical education will be introduced at NTNU from august 2018. Sixteen medical students will after their second year continue their education off campus at Levanger hospital. The study model is longitudinal integrated clerkship (LIC model), where the main teaching activities will be having patients at outpatient clinics under supervision of clinicians. A central aspect of the LIC model is the contact between each students and a few clinicians who will follow them over time. Thus, the student and clinicians has to form a long-term learning relationship. Skill in supervision is a much needed competency for both the supervisor and the supervisee.

As a result, a program to support the clinicians and students is planned and will commence in November 2017. The activities will start with a seminar where the clinicians together with experts in supervision will plan the program. The seminar will be built upon the principles of supervision, starting with all participants stating what they want from the seminar and jointly agreeing on what to do. The experts in supervision has up fronts stated that the topic they think of as important is the principles for supervision in the LIC model and the level third year medical students have. In addition they have made a number of micro presentations to be used if they are requested.

The presentation will focus on the thinking behind supervision in the LIC model, the role of communication and how the start up seminar turned out.

Session 5B – Patient recall

Use of Question Prompt Lists in arranged consultations with Type 2 Diabetes patients: Potential effects on satisfaction, recall and psychophysiological stress responses **“ Forberedelse til legetimen” - “Preparation for the consultation”**

Erik Holt and Arnstein Finset, Dept. of Behavioural Sciences in Medicine, UiO

Background:

The question whether it matters if the patient to be prepared for the consultation or not has been studied by using a Question Prompt Lists (QPL) before consultations with doctors, in particular in cancer care. So far no studies are found investigating the effect if QPLs on using psychophysiological variables.

Purpose:

To investigate the effect of presenting patients with Type 2 Diabetes (T2D) with a QPL before arranged consultations on patient satisfaction, recall anxiety and psychophysiological activation.

Method:

Two groups of patients with T2D will be given an arranged consultation with a physician in laboratory. Each group will consist of people of age 60 – 80, of both sexes. The intervention group will be given a Question Prompt List (QPL) before an arranged consultation. The Control group will receive the consultation only.

An Australian QPL for cancer patients (no QPL found for GP use) translated to Norwegian by A. Amundsen et al., UiT will be revised after focus group interviews with patients recruited through the Diabetes Association in Norway.

A presentation of the the study will be given, and we will open for discussion of the design, methods and feasibility of the proposed study.

Treatment discussions between MS patients and neurologists: How does perceived relevance affect patient recall?

Jenny Maria Nordfalk and Jennifer Gerwing

HØKH: Health Services Research Unit, Akershus University Hospital

Introduction

In consultations with their doctor, patients receive information about treatment options. Each option the doctor describes may seem more or less relevant to the patient. This study aimed (1) to explore whether patients' judgements about relevance are observable during the consultations and (2) to measure whether patients' recall of information is poorer for options they had deemed less relevant.

Method

Participants were 17 neurologists and 34 MS patients currently on first-line treatment. Each neurologist had a simulated consultation with two different patients about starting second-line treatment, a scenario that the patients in reality had not yet faced. Directly after each consultation, JMN interviewed each patient to determine how much information he or she remembered. Data were 34 videotapes of the neurologist-patient consultations and the following post-consultation interviews.

Analysis

From transcriptions of the post-consultation interviews, JMN noted when patients spontaneously declared that they had found one of the three options irrelevant. To meet the study's two aims, two analyses were required. (1) JG conducted a microanalysis of the consultations to determine whether there were observable signs that the patient had deemed an option less relevant while the neurologist was describing it. (2) An analysis of units of information that the patient recalled in the post-consultation interview showed whether each patient remembered fewer units of the less relevant option.

Implications for training and research

Analysis may identify factors in these dialogues that ensure or inhibit patient recall. If a patient signals that an option is not of interest, should physicians refrain from offering more information about that option? Or should physicians address relevance directly, in order to probe whether the patient has sufficient understanding to dismiss the option entirely?

Cardiovascular preventive drugs - prescribing situations, decisions, and re-evaluations from the patient perspective

Josabeth Hultberg

Aim:

To explore the patient perspective of decision making and prescribing of cardiovascular preventive drugs.

Methods:

Individual interviews with 20 persons with experience of care for acute ischemic heart disease. Two analytical approaches are tried: Systematic text condensation (1) and narrative analysis (2).

Drug treatment of risk conditions to prevent cardiovascular disease is common and increasing. Patient centredness, patient participation and shared decision making in health care are increasingly advocated ideals, although shown often not to occur in clinical practice. We wanted to capture the patient perspective and the subjective experience of decisions about preventive medication. The interviews were carried out in the participants' homes and set off by asking them to recall and reflect upon one or more situations when they have received or discussed a new medication. All participants had the experience of drug prescribing from a recent discharge from hospital after an incident of ischemic heart disease and most of them had previous experiences, some from many years of preventive medication.

The presentation will include preliminary results and reflections on the choice of analytical approach.

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Session 6 – Planning research collaboration

Session 7A – Emotions (1)

Pain and fear in association with repeated needle-injections in children (5-12 y) suffering from Juvenile Idiopathic Arthritis

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Abstract

Despite decades of research into pain management, children continue to suffer from pain related to medical procedures and treatment. Children with chronic diseases like Juvenile Idiopathic Arthritis (JIA) are offered more targeted treatment that requires repeated subcutaneous injections for months and years. So far, there has been little research into fear and pain associated with their needle-injections and how this affects quality of life.

Painful needle-injections during childhood may contribute to long-lasting changes in the physiological and behavioural responses, which may alter the pain perception and increase the risk of developing chronic pain. Inadequate pain control is associated with high levels of distress and anxiety prior to medical procedures seems to heighten pain and anxiety reactions even to non-painful procedures. As well parent`s anxiety influence on children`s distress and coping during procedures.

Nurses give the first injection and teach children and parent how to do this at home. Pharmacological and non-pharmacological pain management strategies are available, but still a challenge to implement into clinical practice. Improving pain management encompasses education, decision-making strategies and organisational practice.

The purpose of this project is to gain new knowledge into the experiences of pain and fear among children and parents, and to develop and test a protocol aimed to minimize children`s pain related to repeated needle injections.

The studies:

	Aims	Design and activity
Study 1	Explore the child-adult interaction before and during needle-injection	Video based observational study of children, parents and nurses the first time of injection
Study 2	Explore children and parents' experiences of repeated needle-injections during a period of 6 months.	Interview with children and parents six months after the child's first injection
Study 3	Develop and pilot-test a tailored educational intervention	

Positive emotion in health care communication

*Lena Günterberg Heyn, Associate Professor¹, Lee Ellington, Associate Professor²,
Hilde Eide, Professor¹*

¹ University College of Southeast Norway, ² University of Utah

Background

We know that positive emotions increase well-being in the moment by triggering upward spirals of cognitions and actions improving the capacity to cope with adversities experienced in the course of daily living. Thus, being able to mobilize positive emotions is an important part of resilience potentially leading to a more positive experiences during stress. Yet, less attention is given to the role of positive emotions in health care communication. Also, the relative balance of focusing on the experience of troubling emotions (negative emotions) and focusing on positive emotion is unknown. The aims of this project are a) Explore how focusing on positive emotions can contribute to older peoples' health and well-being in general and b) How focusing on older people communication of positive emotions when in need of palliative care in late phases of life influence well-being.

Method

The literature about positive emotions in health care communication is scarce and is useful to map existing literature in terms of its nature, features and volume. We will perform a realist review. A realist review has methods for dealing with the complexity of research, such as influence of context and heterogeneity. Also, it provides explanatory answers which allow for causal inferences to be made. Realist reviews are iterative with an explanatory rather than predictive focus. In a realist review, the first step is to formulate the review question, then to articulate key candidate theories to be explored. Then, to synthesise data retrieved to achieve refinement of programme theory – that is, to determine what works for whom, how and under what circumstances.

We are currently in the early stage of this project, and we are developing the project proposal that need to be registered in Prospero. We will present the proposal as far as we have come at the time of OCHER.

Session 7B – A case for cross-disciplinary research

ANTIBIOTIC PRESCRIPTION IN SWEDISH PRIMARY CARE CONSULTATIONS

Anna Lindström

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Antimicrobial resistance poses a serious threat to global public health. Sweden has comparatively low rates of antibiotic use. This gives an incentive to explore factors that contribute to low usage including communication between medical professionals and patients. Another reason to examine medical consultations is to identify ways to further reduce antibiotic prescription within the Swedish health care sector. This multidisciplinary PhD project will investigate the social and linguistic patterns of antibiotic prescription in Swedish primary care. We will make video-recordings of Swedish primary care visits where the patient is seeking medical care for routine upper respiratory infection symptoms. Previous research has established that this is a context where inappropriate antibiotic prescription is a concern. Our corpus will include consultations with nurses as well as doctors and it will be the first of its kind. We will use conversation analytic methods to document how expectations for particular remedies (including antibiotics) are raised, how triage, problem presentation, physical examination, paraclinical testing and diagnoses are carried out and how treatment recommendations are negotiated. Our findings will be developed into teaching resources targetted towards pre- and post-qualification medical training and nursing programs. These resources will document real life situations where antibiotics are prescribed as well as the communicative strategies used by experienced doctors and nurses to avoid inappropriate antibiotic prescription. Our study will fill a gap in international research on how antibiotic treatment discussions are carried out *in situ* within the details of primary care consultations and the educational materials that we will develop will provide tools for engaging in responsible antimicrobial stewardship.

This study was one of 14 projects funded by the Uppsala Antibiotic Centre in March 2017. A PhD student (Klara Bertils) was recruited to the project in September 2017 and we are now in the midst of negotiating access to primary care centers and preparing an ethics application.

Discussion questions:

- Tips on how optimize collaboration among senior and junior researchers, scholars in medicine and linguistics, participants in the UAC graduate school and professionals at primary care centers.
- How can we make this research relevant to the broader field of clinical communication rather than just antibiotic prescription?
- What would be meaningful ways of expanding this project in upcoming grant applications?

LINK: <http://www.uac.uu.se/phd-projects/>

Intercultural Communication Training and Employability: Mobile Support for Health Care Professionals

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During 2015-2016, about 200000 people have sought asylum in Sweden (Swedish Migration Agency, 2017). Supporting their integration is an urgent issue. Early language training and labour market entry are essential (Degler and Liebig, 2017). Smartphones can be a bridging tool between the migrants and host society (Bradley et. al., 2017). Though many mobile apps are available (Berbyuk Lindström et. al., 2017), none provide a targeted communication training for health care professionals (HCPs).

The study investigates the needs in terms of employability in general, and medical communication in particular of HCPs with a degree outside the EU and how these can be met in a mobile app.

The study is based on a combination of focus group interviews (6) and interactive workshops (3). Audio-and video-recordings, field notes and photos were used for documentation. Thematic Content analysis was used for analysis.

The results show that getting a picture of what steps to take in order to get Swedish medical license, learning about Swedish health care and the medical test are emphasized. Need for information about communication with patients and colleagues and developing intercultural competence are acknowledged. HCPs wish to establish contacts with fellow HCPs from Sweden. Further, HCPs express the need for a *personalised* interactive roadmap to license depending on user characteristics, such as professional specialty. Providing videos of medical encounters and work meetings with transcripts and translations is mentioned. Medical language quizzes, sample medical tests with a forum for discussions are suggested as well.

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Session 8A – Emotions (2)

The construction of psychosocial distress in cancer consultations

Manon van der Laaken

University of Amsterdam

This study investigates whether, and if so how, the use of a specific discussion tool affects how doctor and patient co-construct psychosocial distress in follow-up cancer consultations.

Many studies indicate that physicians tend to limit themselves to biomedical concerns in their consultations, and to avoid psychosocial topics (see e.g., Beach et al., 2004; Rogers & Todd, 2010), even though it is widely agreed that psychosocial distress is an essential topic, especially in cancer care (Arora, 2003). To stimulate the discussion of psychosocial problems during the consultation, screening instruments such as the *Distress thermometer* (DT), designed to measure the psychosocial distress of cancer patients, are increasingly being used as discussion tools. However, quantitative psychological studies show that it is unclear whether this is effective (see e.g., Boyes et al., 2006; Greenhalgh et al., 2005).

The current study of how doctors and patients co-construct psychosocial distress attempts to help answer whether and how the use of discussion tools like the DT can effectively contribute to the discussion of psychosocial problems in doctor-patient interaction. This study aims to surface a) whether there is a difference in how doctors and patients discursively construct psychosocial distress in the consultations with and without the DT and b) if so, what that difference is. When comparing the two contextual environments, it becomes clear that in the control group without the DT psychosocial distress is exclusively nominated as a topic by the patients. In the consultations that involve the use of the DT, doctors, too, nominate the topic of psychosocial distress, exclusively on the basis of what they see in the DT. Whether that topic is accepted by the co-participants as relevant and how it is discussed varies. This paper will investigate how all this is interactively co-constructed by doctor, patient and companion.

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Addressing emotional topics in cancer care – A conversation analytic approach to doctor-patient consultations in an oncology outpatient clinic

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Abstract

A cancer diagnosis may initiate a range of worries and concerns for the patient. However, both patients and doctors often hesitate to introduce emotional topics, and doctors may vary in their response to such issues. We applied Conversational Analysis to study how emotional topics were introduced and responded to in doctor-patient consultations in oncology. Data included transcripts of audio recordings from 31 primary consultations between oncologists and patients at an oncology outpatient clinic. Sequences including emotional topics were selected from 7 of the 31 consultations. We identified some characteristic pattern in how emotional topics were addressed and responded to in these clinical consultations. Emotional topics were rare, and addressed mainly when it was explicitly introduced by the doctor. Emotions were picked up and responded to by the doctor when explicitly expressed by the patient, and less so when the patient gave implicit hints or suggestions. Emotional topics were absent when not introduced by the doctors, or when doctors failed to respond to patients' initiative on such issues. Doctors also tended to provide more active responses to emotional expressions by female than by male patients. Selected sequences were included from one of the consultations where emotional topics were absent, as they illustrate how the conversation may include potential emotional topics without the participants addressing any emotional content. The findings emphasizes the importance of doctors' initiative and awareness of emotional topics in cancer care.

Session 8B – Teaching programs

Offering communication skills training and supporting initiatives to a wider range of The Danish Healthcare System

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Based on our many years of research focusing on interventions that improve the communication between patients and clinicians at Lillebaelt Hospital in Denmark, we now seek to develop an extended and conceptual solution that can be implemented in- and transferred to other clinical settings within The Danish Healthcare System. A concept that, besides improving the communication between patients, relatives and healthcare professionals is aimed at contributing to an improved treatment, a feeling of greater confidence with the chosen treatment regimen, an enhanced coherence between different parts of the patient's treatment course and so forth. This involves different phases of concept development to make sure that it fits other settings than Lillebaelt Hospital, Denmark.

Thus, the aim of the first phase is to develop, evaluate and implement preexisting yet further developed communication skills initiatives into a conceptual solution, and pilot test its relevance and content in a clinical setting at 2-3 hospitals in Denmark. The concept will include continued communication skills training aimed at the healthcare professionals, and an app developed for the patients allowing them to audio record, rate and store their consultations plus find question prompt lists to use as they prepare for their communication with the healthcare professionals. These initiatives will be combined in an interactive feedback system enabling the healthcare professionals to continuously learn from their own practice. A new classification system for categorizing patient complaints is currently being developed at our research unit and will be used to monitor the effects of this conceptual approach to communication skills training.

We would like

- Your thoughts on the core idea
- Ideas for further development of the conceptual solution
- Discuss the feedback system – how do we make it attractive for healthcare management as well as clinicians?
- To discuss the new classification system for categorizing patient complaints

Implementation and Evaluation of the Four Habits Concept in a General Hospital - The Diakonhjemmet Model

Arnstein Finset & Ingrid Hyldmo

In Diakonhjemmet Hospital, a general hospital within the Norwegian public health system, the Diakonhjemmet Model for communication skills training, largely based on the "Four Habits" concept, have been developed and implemented. The aim of the program is part of the quality improvement program of the hospital to improve clinical communication skills and to enhance the quality of clinical services.

One core element of the program is Four Habits courses over two days for physicians, since 2014, also for other health professionals at the hospital. Other elements, such as shorter courses on specific topics, have been added.

The participants have included physicians from different clinical departments (medicine, rheumatology, surgery, psychiatry) and local GPs, as well as other health personnel in the interdisciplinary courses.

A main feature of the Diakonhjemmet Model is to apply in-house facilitators from all relevant specialties. In courses for physicians, each training group has two facilitators, one from a medical specialty and one from psychology/psychiatry. For the interdisciplinary courses, nurses, social workers and physical therapists also serve as facilitators. Two other hospitals, Bærum Hospital (VVHF) and Tønsberg Hospital (SiV) have implemented the Diakonhjemmet Model with in-house teachers, after training provided by the Diakonhjemmet team.

To evaluate the courses, a Self Efficacy Questionnaire, open ended questions and online QuestBack have been applied.

We will briefly describe what we have learned from six years of development of the Diakonhjemmet model. Preliminary findings from the Self-Efficacy Questionnaire will be presented. Moreover, we will discuss approaches to evaluation of the program, possibly including a multi-center study aimed to evaluate communication skills training programs in different hospitals.

Session 9 – Planning research collaboration