9th OCHER workshop on Clinical Communication Research

January 15-17, 2020

Program

Start: Wednesday 15 January, 10:00
End: Friday 17 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:

Senior lecturer Merran Toerien, Dept. of Sociology, The University of York, UK
https://www.york.ac.uk/sociology/our-staff/academic/merran-toerien/

Keynote titles:
- Challenges of enacting patient choice in practice: a mixed method, conversation analytic study of neurology outpatient consultations
- Challenges of researching patient choice in practice: methodological lessons from a study of neurology outpatient consultations

Associate professor Arwen Pieterse, Leiden University Medical Center, Leiden, The Netherlands
https://www.researchgate.net/profile/AH_Pieterse
https://www.lumc.nl/org/bds/medewerkers/904090251135212?setlanguage=English&setcountry=en

Keynote titles:
- Shared decision making: concept, measurement, and determinants
- Challenges, successes and failures in our research on shared decision making

Local faculty: Pål Gulbrandsen, Hanne C. Lie, and Jan Svennevig, University of Oslo, Hilde Eide, University College of Southeast Norway, Jennifer Gerwing, Akershus University Hospital

Working languages: English, Scandinavian

Time	Activity	Plenary room / Room A	Room B
		Wednesday January 15	
1000	Plenary	Introduction, mutual presentation	
1045	Break	Talk to someone you don't know (much)	
1100	Plenary keynote 1	**Merran Toerien**	Challenges of enacting patient choice in practice: a mixed method, conversation analytic study of neurology outpatient consultations
1200	Lunch		
1300	Plenary keynote 2	**Arwen Pieterse**	Shared decision making: concept, measurement, and determinants
1400	Break		
1415	Groups	**Session 1A Shared decision making**	**Session 1B Language challenges**
		Keij	Berbyuk Lindström
		Noordman	Siddiqui
		Sundling	Landmark
1545	Break		
1555	Groups	**Session 2A Teaching communication**	**Session 2B Chronically ill children**
		Dalsgaard Iversen	Sørensen
		Steinsbekk	Ålykkja
1655	End Groups		
1715	Walk to Pål's	The walk is 20 minutes. Shoes should stand snow. Follow path on map!	
2000	Dinner at hotel		
		Thursday January 16	
0830	Plenary keynote 3	**Arwen Pieterse**	Challenges, successes and failures in our research on shared decision making
0930	Plenary abstracts 1	**Lillebælt group**	A blended learning communication skills training program in Denmark
1030	Break		
1045	Groups	**Session 3A Uncertainty and alignment**	**Session 3B Home care**
		Stortenbeker	Brembo
		Menichetti	Heyn

		Gerwing	Van Dulmen
1215	Lunch		
1315	Groups	**Session 4A Information issues**	**Section 4B Challenging situations**
		Lie	Kebede
		Vegni	Wallander Karlsen
		Ososami	Hamilton Larsen
1445	Break		
1500	Plenary abstracts 2	**OCHER group**	Independent multidisciplinary examination and synthesis of shared decision making in two hospital encounters
1600	Break		
1615	Groups	**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 17	
0830	Plenary keynote 4	**Merran Toerien**	Challenges of researching patient choice in practice: methodological lessons from a study of neurology outpatient consultations
0930	Break/ Check-out	**Please note that it would be good if many of you remember to check-out before keynote 4. This break is somewhat short for the hotel to manage checking out all of you.**	
1000	Groups	**Session 5A Existential issues**	**Session 5B Methodology in development**
		Skirbekk	Plug
		Hofset Larsen	Hrubos-Strøm
		Hjorth (Schaufel)	Øvregaard
1130	Lunch		
1230	Groups	**Section 6A Greetings and metaphors**	**Section 6B Adherence to treatment**
		Rossi	Øverby
		Van der Laaken	Thorshov
1330	Break		
1345	Plenary abstracts 1	**Section 7 Brain-behavioral mechanisms in communication**	
		Ellingsen	

1415	Plenary abstracts 2	**Section 8 Teaching shared decision-making**
		Skjelbakken
		Kienlin
1515	Evaluation, round-up	
1600	End	**Safe travel!**

Patient readiness for shared decision-making about treatment: What is it and how can we measure it?

Sascha M. Keij, Anne M. Stiggelbout, Arwen H. Pieterse

Medical decision making, Department of Biomedical Data Sciences, Leiden University Medical Center, Leiden, The Netherlands

Introduction. We aim to identify what patients need to feel ready to participate in SDM about treatment, and to develop a questionnaire to measure readiness.

Methods. We are conducting three studies to conceptualize patient readiness. In Study 1 we conducted semi-structured interviews with patients and professionals (physicians, nurses, general practitioners, and researchers). Interviews have been analyzed through open, axial, and selective coding. Study 2 is a scoping review in which we aim to identify what has been reported in the literature on what patient elements are related to SDM. We identified 52 qualitative and 67 quantitative studies from which the data are in the process of being extracted. In Study 3 we are conducting longitudinal interviews with patients who have just been diagnosed with cancer and whom we will meet from before to two or three months after the treatment decision was made.

Results. For study 1 we have interviewed 15 patients and 16 professionals. We identified five elements of patient readiness: 1) health literacy, 2) communication skills, 3) consideration skills, 4) self-awareness, and 5) understanding of and attitude towards the decision making process; and seven characteristics that may influence the elements of readiness: 1) age, 2) educational background, 3) cultural background, 4) emotional distress and acceptance of the diagnosis, 5) psychiatric disorders, 6) close relationships, 7) decision type, and 8) clinician-patient relationship. Study 2 and 3 are still ongoing. Preliminary results have shown a wider variety in elements that may contribute to readiness.

Discussion. In Study 1 we have identified a wide range of elements that may contribute to patient readiness for SDM. Preliminary results from Study 2 and 3 show an overlap with the identified elements, as well as other elements. We aim to combine the results of the three studies to get a final list of elements. We then wish to develop a questionnaire to measure patient readiness for SDM. However, to limit patient burden, we want to identify the key elements of readiness to measure in this questionnaire. During OCHER, we would like to discuss the final list of elements of readiness and most appropriate and pragmatic ways to identify what the most important elements are. Furthermore, we would like to get input on the development of the questionnaire.

Shared decision-making with patients with limited health literacy in palliative care

Janneke Noordman[1], Ruud Roodbeen[1], Gudule Boland[2], Maria van den Muijsenbergh[2,3], Sandra van Dulmen[2,3,4]

[1]Nivel, Netherlands institute for health services research, Utrecht, The Netherlands.
[2] Pharos, Dutch Centre of Expertise on Health Disparities, Utrecht, The Netherlands.
[3]Radboud university medical center, Radboud Institute for Health Sciences, Department of Primary and Community Care, Nijmegen, The Netherlands.
[4]Faculty of Health and Social Sciences, University of South-Eastern Norway, Drammen, Norway.

Background
Person-centred palliative care poses high demands on professionals and patients with regard to appropriate and effective communication and shared decision-making (SDM). Even more so for patients with limited health literacy, because they lack the necessary skills to find, understand and apply information about their health and health care. Care professionals find it difficult to adapt their level of communication to the needs of these patients. This study explores how healthcare professionals involve their patients in decision-making in real-life hospital-based practice, and explores how patients and providers look back at their communication and decision making.

Method
A total of 40 encounters between healthcare providers (doctors and nurses) and patients with limited health literacy in palliative care were video-recorded in four Dutch hospitals, at the departments of oncology and pulmonology. Inclusion criteria for patients were: diagnosed with cancer or COPD in the palliative phase; limited health literate; encounter planned with a healthcare provider in a participating hospital. The decision-making process was assessed by coding the videos with the OPTION[5]. In addition, individual stimulated recall session with patients and providers were held within a month after the video-recording took place. Patients and providers were asked to look back at 'critical incidents' of their recording together with a researcher. Reflections of patients and providers with respect to decision-making during these sessions were transcribed and will be analysed.
To ensure inter-rater reliability, 10 encounters (25%) were coded by two observers individually.

Expected results
All observations were coded with the OPTION[5] instrument. Inter-rater reliability was good with a Kappa of 0.83. We expect the majority of the scores to be 'a minimal attempt' towards SDM behaviour, but final analyses still need to be conducted. We also expect to see a difference in decision- making process between patients with cancer and patients with COPD.
Interpretation of decision-making behaviour by patients and providers (through the stimulated recall sessions) can be associated with the observation scores.

Discussion
We would like to discuss our method, specifically how to analyse and compare observations of recorded consultations and the data of the stimulated recall sessions. In addition we would like to discuss the interpretation of our (expected) results.

Positive and negative emotions expressed during decision making in optometry: A mixed-methods approach

Authors: Vibeke Sundling, Lena Heyn, Espen Andreas Brembo, Hilde Eide & Linda Hafskjold
Affiliation: National center for optic, vision and eye care and Science Center Health and Technology, University of South-Eastern Norway (USN)

Background:

Person-centred communication is essential for eliciting patients' needs in the process of making decisions, as well as in providing information about choice and options. The aim of the proposed study is to explore if positive and negative emotions occur in the decision making process, and if present, how positive and negative emotions affect decisions.

Methods: The study will have an exploratory mixed methods design. The data material consists of 40 video-recorded eye examinations, including 34 patients and 11 optometrists. Clinically relevant decisions has been identified by observation using the Decision Identification and Classification Taxonomy for Use in Medicine (DICTUM). In all, 891 decisions were identified, of these 70% were related to assessment and plan. We propose to code positive and negative emotions for slices of communication including decision related to treatment (DICTUM #4 and #5), advice and precaution (DICTUM #8) and follow up (DICTUM #7) to explore the decision making process in optometry. Positive emotions will be coded using Positive Emotion Communication (PEC) coding and negative emotions using the Verona Coding Definitions of Emotional Sequences (VR-CoDES). The context and content of positive and negative emotions during the decision making process is further proposed to be analyzed inductively.

Our focus on OCHER: We would like to discuss the feasibility of the proposed study design to understand decision making in optometry.

Use of Information and Communication Technology in Transcultural Child Care Encounters in Sweden: Perspectives of Doulas and Nurses

Nataliya Berbyuk Lindström, Rocio Rodrigues Pozo

Department of Applied Information Technology, University of Gothenburg, Gothenburg. Sweden

Abstract

Aim: Multicultural population in Sweden is increasing. As in many non-Western societies mothers are primary caregivers, their contact with child care is important for both them, their children and families. This study explores the role of information and communication technology (ICT) in managing communicative challenges related to language and cultural differences experienced in communication between migrant mothers, Swedish nurses and doulas.

Methods: Deep semi-structured interviews with five pediatric nurses and four doulas from a migrant-dense urban area in Western Sweden were audio-recorded, transcribed and analyzed using Thematic Content Analysis.

Results: The results show that stationary phones and mothers' smartphones are used for interpreting, when on-site interpreters are unavailable. *Google Translate* and the Internet are also used searching for images and films to illustrate or to complement a verbal message, especially in case of sensitive issues.

Conclusion: ICT can be a bridging tool between healthcare and migrants, contributing to managing language problems and cultural differences, which has a positive impact on migrant integration. Both advantages and pitfalls of translation tools should be discussed to ensure quality of communication and access to information.

Discharge conversation among geriatric patients and specialists-physicians

Tahreem Ghazal Siddiqui[1,2], Socheat Cheng[1,2], Christofer Lundqvist[1,2], Ramune Grambaite[1,3], Pål Gulbrandsen[1,2], Jennifer Gerwing[1].

[1]Health Services Research Unit, Akershus University Hospital, [2] Institute of Clinical Medicine, Campus Ahus, University of Oslo,[3] Department of Psychology, Norwegian University of Science and Technology, Trondheim, Norway

Introduction: For patients leaving the hospital, a treatment plan is the intended set of activities that should happen to help the patient to become healthier or stay as healthy as possible. While the treatment plan is directed towards and tailored to the particular patient, the activities involved in the plan could be carried out by the patient, the patient's general practitioner, the specialist- physician or other health care professionals. Treatment plans are particularly important to patients because they pertain both to how patients can manage their health when they are on their own (without the immediate support of the hospital) and to the available support system.

The purpose of this study is to examine the discharge conversation between older in-patients and specialist-physicians. Specifically, we are analysing these discussions for information about the treatment plan (e.g., about medication, plans for future contact). These plans are important for the patient to avoid readmission and adverse events (e.g., related to medication use). Geriatric patients might find the discharge conversation and information about the treatment plan challenging due to reduced cognitive function. Thus, we will also analyse the conversation for cues of reduced cognitive function, with the intention that doctors can learn to recognize these cues and adapt accordingly.

Method: The study is a part of a larger study that recruits inpatient from the Geriatric department in Akershus University Hospital between 65 and 90 years old. So far, we have collected 11 videos of the discharge consultation, communication satisfaction questionnaire, medication information, cognitive tests and demographics.

Analyses and themes of interest : Working from an inductive, thematic approach, we are using microanalysis of face-to-face dialogue [1], for gaining a detailed understanding of particular sequences of interest. Utterances about the *treatment plan* are identified because they contain information about the patient's health, an action (by the patient, general practitioner, home nurse or specialist) and are oriented towards the future (i.e., using future tense verbs or other contextual cues). That is, health, action and future-orientation have to be present in the sequence to be qualified as referring to the treatment plan. *Cognitive cues* can be explicit (the patient directly telling the doctor about the cognitive impairment) or implicit, recognized indirectly in the ongoing conversation by specialist-physician (by the patient's disorganized speech, low participation and/or attention difficulties) or by utterances that, by implication, suggest the impact of reduced cognitive function on the patient's current medical situation and/ or daily life.

Feedback: Discussion on definitions of treatment plan and cognitive cues based on presented examples.

Word finding difficulties in testing and conversation: An interdisciplinary approach to the study of multilingual speakers with dementia

Anne Marie Dalby Landmark; Pernille Hansen; Hanne Gram Simonsen; Jan Svennevig

MultiLing, Center for Multilingualism in Society across the Lifespan, University of Oslo, Norway

In neurological illnesses like dementia, problems with word retrieval may lead to communicative challenges. When speaking, we need to select from our mental lexicon the words that fit what we are trying to say in that particular context. Multilingual speakers also need to take into account which language(s) that are appropriate in that specific context. In this study, we combine a usage based and a conversation analytic approach to language and communication in order to explore word finding difficulties in multilingual speakers with dementia, as well as how the persons with dementia and their interlocutors deal with these difficulties.

Participants in the study are seven persons with dementia, that all have different first languages (English, Japanese, Tamil, West-African Creole, Swedish, Urdu). All have Norwegian as a second language in common. The data consists of video recordings of cognitive testing, a picture based naming test, interviews, and naturally occurring conversations with family, friends and health care personnel. Assessments and interviews have been conducted in several languages, but for this presentation we will focus on the Norwegian results. The video recordings have been used to score test results quantitatively and for conversation analysis.

When comparing the results, we found that word finding difficulties did not necessarily predict the participants' ability to take part in conversation, due to communicative strategies deployed by the persons with dementia and their interlocutors. Participants' strategies during testing also affected the test results, in that words from other languages were used for finding appropriate words in Norwegian, or through the use of filled pauses for keeping the floor and thereby bying more time to find the word searched for.

Can Medical Students Learn Communication Skills from Team-based Learning?

Else Dalsgaard Iversen[123], Julie Killerup Kaae[23], Katrine Rahbek Schønnemann[23]

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

Introduction:

Communication skills training has been a fundamental part of the medical training program at the University of Southern Denmark since 2004. Today's training is based on the Calgary-Cambridge Guide. The students are taught in small groups of 8-10 students per teacher with a mixt of dialogue, training with simulated patients, a clinical residency, and feed-back on real-life audio recorded consultation. After the candidate program, students are examined in the communication skills with the OSCE (Objective Structured Clinical Examination).

In 2019, students expressed a need for more communication skills training, and the University of Southern Denmark suggested Team-based Learning (TBL). It was not possible to offer more training with simulated patients.

TBL is a learner-centered, instructor-directed strategy for small-group active learning in a larger group. It is a student-activating teaching method, and one instructor can teach over 100 students in smaller groups at the same time. The TBL is characterized by individual student preparation, individual and team tests, and the majority of in-class time devoted to decision-based assignments done in teams.

In the tests, the students are reflecting and discussing essential parts of patient-centered communication, including agenda making, eliciting the patients perspective and breaking bad news. In November 2019, we will teach the first class by the TBL-method, and we would like to share our experiences at OCHER 2020.

For discussion:

At OCHER, we would like to discuss if it is possible to teach medical students communication skills using TBL. Are there other ways to teach communications skills when traditional training in small groups with one teacher per group is not possible? And would it be possible to assess outcome from the TBL?

[1] D. Parmelee, L.K. Michaelsen, S. Cook, P.D. Hudes, Team-based learning: a practical guide: AMEE guide no. 65, Medical teacher 34(5) (2012) e275-87.

Using virtual reality (VR) to practice team communication

Aslak Steinsbekk

Department of public health and nursing, NTNU, Trondheim, Norway.

Virtual reality (VR) offers new opportunities for learning. VR can give students more time on task and prepare them for direct patient contact of various types. One basic skill needed for all health professionals, is competency in is competency in systematic clinical observation and team communication.

The aim of this study was to investigate if there was a difference between first year medical and nursing students who have practiced systematic clinical observation with the ABCDE approach in VR either alone or in groups.

This was a non-inferior randomised controlled trial. We have made a VR application for practicing systematic clinical observation using the ABCDE approach in teams. After watching a video on how to do the ABCDE examination, the students practiced individually or in groups of 3 students for 20 minutes in the VR app using Oculus goggles and hand controls. Then they answered a knowledge test. The hypothesis was that there was no difference between the groups.

The study was conducted in September 2019, and the results will be presented.

Children's management of home-administration of needle injections

Kari Sørensen[1,2,3,], Helge Skirbekk[2,3], Gunnvald Kvarstein[1,4], Hilde Wøien[1,2]*

[1]Oslo University Hospital, [2]University of Oslo, [3]Lovisenberg Diaconal University College [4]The Arctic University of Norway, Tromsø

Background

This study is a follow-up from a study where we used video observations to explore how children expressed fear and pain during training sessions for home administration of subcutaneous injections in a rheumatic hospital ward. **The aim** of this follow-up study was to explore how children and parents manage repeated injections at home, both technically and emotionally.

Methods

Both qualitative, individual, in-depth interviews and focus group interviews (FGIs) were conducted. The individual interviews took place 4-6 months after the video-observation with children and parents, and represent the same participants as for the first study. The participants in the FGIs were children and parents with experiences from administration of home injections. They were recruited through The Norwegian organization for young people with Rheumatic diseases (BURG). The FGIs were divided into four groups; children aged 11- 13 years, adolescents aged 14 -17 years and two groups with parents. A user participant was present in the FGIs that included the children and the adolescents. The analysis will follow thematic analysis. We are still in an early phase of the analysis and the preliminary results are based on the first impression of the material.

Preliminary results

The data material consists of interviews with a total of 16 children and 16 parents. The first impression suggests that both children and parents want the needle injection to become a natural part of their daily lives. Still, it seems like the needle injection is a "big happening", involving several family members trying to help the children cope. All families report having regular routines for time and performance of the injections (specific day, time, who performs it and how). Some children like to be distracted and some like to have control during the needle injection. Many children like to get a reward. The parents have learned technical skills a bit randomly, partly from healthcare providers (HP), social media, neighbours, family and learning by doing. A few adults admit that they have restrained their child during the injection sometimes, especially when the child was very young. However, all the parents express the importance of dealing with their own distress and helping their children cope with the needle injections. They would have preferred some kind of follow-up from healthcare providers.

What we like to discuss: We would like to know your opinion about mixing data from both individual interviews and focus groups. We think that gives a broader perspective and richer data material. What do you think? We also consider using a middle-range theory to illuminate our findings. Would health literacy be an appropriate perspective?

Designing follow-up care to meet the needs of the pediatric brain tumor survivor, based on the views from the users and the health care providers

Anette Ålykkja [a,b], Ellen Ruud MD, PhD [a,e], Marie Hamilton Larsen PhD [c,f],
Torun Marie Vatne PhD [d] and Hanne Cathrine Lie PhD [a,b].

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[b]Department of Behavioural Sciences in Medicine, Institute of Basic Medical Science,
Faculty of Medicine, University of Oslo, Oslo, Norway, [c]Medical Faculty, Department of
Health Sciences, Institute of Health and Society, University of Oslo, Oslo, Norway, [d]Frambu
resource center for rare disorders, Siggerud, Norway. [e]Institute of Clinical Medicine,
Faculty of Medicine, University of Oslo, Oslo, Norway, [f]Lovisenberg Diaconal University College, Oslo,
Norway.

Background. In Norway, around 150 children below 15 years of age develop cancer each year and of these, approximately 1/3 is diagnosed with a brain tumor. The overall aim of this PhD project is to design and feasibility test an intervention to improve current follow-up care practices in accordance with the survivors' perceived needs. To acquire this, the intervention will build on knowledge gathered from multidisciplinary health care providers (HCP), survivors and their families. The project consists of three substudies described below.

Substudies, aims and methods
1) Substudy 1: What are the special care multidisciplinary HCPs experiences on todays follow-up care after pediatric brain tumor? Focus groups and individual interviews with 33 multidisciplinary HCPs have been performed.
2) Substudy 2: What are the experiences of pediatric brain tumor survivors and their parents on current follow-up care? Individual interviews and focus groups.
3) Substudy 3: Co-create and feasibility test an intervention study on the results from study 1) and 2) to improve the current follow-up care after pediatric brain tumor.

Preliminary results. The identified suggestions for improvement of current follow-up care concerning routines and structures regarding communication, cooperation and coordination. Some concrete suggestions were to strengthen the nursing role and establish more tailored care pathways, including survivorship care passports (treatment summary, information about late effects and follow-up recommendations).

Points for discussion. We would like to discuss ideas for how to develop and co-create the content and structure of the intervention. How can we use a co creation process (activating local wisdom from important stakeholders) and the results from study 1 and 2, to make the available services more accessible and develop new strategies to improve follow-up? A major aim will be to find ways to improve communication and interaction between the survivor with family and the involved HCPs as well as between the HCPs. Areas of particular interest include:
- How can we pilot/feasibility test such a tailored intervention consisting of for example:
    o routines for communication between the survivors and involved HCP/providers
    o routines for communication between involved HCP within each hospital, the local hospital and the community
    o a more formalized nursing role with specific responsibility for the follow-up care

Plenary workshop 1 – The Lillebælt group

Communication skills training in a new format:
A digital learning platform based on blended learning methods

Maiken Wolderslund[ab], Connie Timmermann[ab], Trine A. Gregersen[ab] Jette Ammentorp[ab]

[a]Center for Patient Communication/Health Services Research Unit, Lillebaelt University Hospital, Vejle, Denmark
[b]Department of Regional Health Research, University of Southern Denmark, Odense, Denmark

Background

There is solid evidence that communication skills training is an effective tool for enhancing person-centredness. The most effective training programs are characterized by a learner-centred approach focusing on skills training over a longer period of time, using methods such as role-play, feedback, group discussions as well as reflexive methods that foster the health care professional's self-awareness and situational awareness related to emotions, attitudes, and underlying beliefs. However, effective programs are often very time-consuming and it can be difficult to maintain awareness of skills training over time. This points to a need for rethinking how we teach communication skills in clinical practice. Consequently, we are developing a new and more flexible communication program based on blended learning. It is incorporated in a digital learning platform combining interactive learning with practical training. The fundamental element of the platform will be FIPeC Basic which covers the different elements of the Calgary Cambridge Guide. In addition, other more topic-specific elements will be developed as for instance FIPeC Mindful which will be based on the qualitative evaluation of the existing face-to-face course in existential communication. A course that was developed and pilot-tested in collaboration with The Research Unit of General Practice (University of Southern Denmark) who has tested a similar course for general practitioners. In FIPeC Mindful different reflection exercises, reflection videos and exercises for one's clinical practice will be the core elements in the blended-learning version.

Objective

The overall aim is to develop a communication concept (FIPeC Basic and FIPeC Mindful) based on blended learning methods that are feasible for implementation in clinical practice and ensures continuous training of communication skills.

Method

The feasibility and effectiveness of both FIPeC Basic and Mindful will be investigated when the concept is tested in different departments and hospitals in the Region of Southern Denmark. The evaluation will focus on both the participants' actual use of the different content in the blended learning program (acceptability and adoption) and the impact of different aspects of the clinical learning environment (time consumption and sustainability). Effectiveness will be assessed using multiple assessment points, including evaluation done by both patients and health professionals in a longitudinal design.

Discussion points

At OCHER 2020 you will be invited to test selected modules in FIPeC Basic or part of modules (in Danish) and discuss the content, structure, and methods used.
The transformation process of the course in existential communication to FIPeC Mindfull will be presented and participants will be invited to discuss the different methods as well as the proposed content.

Quantifying key linguistic elements of patients that differentiate medically unexplained from explained symptoms: A systematic analysis

Inge Stortenbeker [a], Tim olde Hartman [b, c], Wyke Stommel [a], Sandra van Dulmen [b, d, e], Enny Das [a]

[a] Radboud University Nijmegen (NL); [b] Radboudumc Nijmegen (NL); [c] Donders Institute Nijmegen (NL); [d] NIVEL Utrecht (NL); [e] University of South-Eastern Norway, Drammen (NO).

Background

Patients with medically unexplained symptoms (MUS) often feel misunderstood, while they are in pursuit of recognition for their symptom experiences. They are frequently stigmatized as difficult patients, and their doctors find it challenging to provide the appropriate care. We previously demonstrated that general practitioners (GPs) use different language when communicating to patients with MUS versus medically explained symptoms (MES). For instance, they use less positive words and more implicit uncertainty expressions during MUS vs. MES interactions, which relates to patient outcomes (Stortenbeker et al., 2018; 2019). While language use has the potential to reflect the communicative challenges underlying these interactions, it is yet unknown what language patients use to express their complaints.

Aim and research question

With this study, we aim to quantify relevant linguistic expressions of patients presenting medically unexplained versus medically explained symptoms. The research question is as follows: How does complaint type (MUS or MES) systematically affect language used by patients?

Methods

We will quantitatively analyze naturalistic language use of patients in general practice consultations. Data for this study were collected in 20 Dutch GP practices in 2015 in the context of the "CATMUS" project (see Houwen et al., 2017). We will develop a codebook describing key linguistic elements (e.g. modality, specificity, language intensity, use of metaphors), and we will compare language use of 41 patients presenting MUS with 41 patients presenting MES.

Points for discussion

We plan to develop the codebook in the following months. At OCHER, we would like to discuss a) the relevancy of our selected linguistic variables, b) their operationalizations, and c) whether other linguistic elements should be taken into account.

A first theoretical conceptualization of misalignments in medical interactions: The case of triadic ART consultations

Julia Menichetti[1], Maria Grazia Rossi[2], Jennifer Gerwing[3]

[1]*Institute of Clinical Medicine, University of Oslo.* [2]*ArgLab-Institute of Philosophy of Language, Universidade Nova de Lisboa.* [3]*Akershus University Hospital, Health Services Research Unit*

Misalignments in medical interactions can cause several problems, e.g. compromise the quality of communication, decisions and care, and the effective management of the disease. More frequent misalignments can be expected as medical interactions become more complex and doctors and patients must deal with a high degree of uncertainty. Medical consultations in the field of Assisted Reproductive Technology (ART) represent an exemplification of such a clinical scenario, in which such uncertainty about outcomes is met by couples who are especially motivated and often highly literate and well-informed. Our understanding of how misalignments take shape in the complexity of such interactions is limited: misalignments are mostly investigated in dyadic-only consultations, let alone triadic ones. To fill this gap, we have started analysing a purposively selected subsample of 20 videotaped triadic interactions from a dataset of 85 ART visits to detect misalignments and to offer a first theoretical conceptualization of their different types.

We have distinguished three levels of misalignments potentially affecting mutual understanding in these scenarios: (1) dialogical/relational level, (2) conceptual level, and (3) value level. Each of these levels has its own type of misalignments, which we are differentiating on a provisional base as (1) misunderstandings, (2) misconceptions and (3) disagreements. We define *misunderstandings* as mismatches at a dialogical or relational level, as interlocutors, in the moment, make sense of what each other has said. Misalignment at this level can be observed when interlocutors display alternative interpretations of what each other has said, or they demonstrate a lack of understanding. We define *misconceptions* as mismatches at a conceptual level. Rather than a mismatch based on different interpretations of what each other has said, misconceptions involve different interpretations of the same evidence. Finally, we define *disagreements* as mismatches identifiable at a value level and involving cases of misalignments caused when interlocutors adopt opposing hierarchies of values.

We will provide exemplifications on each level, offering arguments in support of our provisional theoretical conceptualization of misalignments.

Communication alignment between emergency medical telephone operators and citizen callers: An evaluation for assessing improvements after a course

Jennifer Gerwing[1], Trond Mjaaland[2], Bård Fossli Jensen[2], Jon Erik Steen-Hansen[3],
Olav Eielsen[4], Pål Gulbrandsen[5]

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When people need medical assistance urgently, they can telephone the medical emergency line and seek help. In these calls, time is precious and consequences of misunderstandings can be severe and possibly life-threatening. Operators and callers must manage a dramatic lack of common ground: For callers, the situation is unfamiliar and alarming, and they likely lack necessary knowledge and skills. For operators, dealing with emergencies constitutes their everyday work, they are not emotionally involved, and they have knowledge and skills to deal with it. Furthermore, operators must triage calls without being able to verify whether the information callers present is accurate. If action is needed while an ambulance is on the way, operators cannot administer first aid and monitor the patient themselves, they can only direct the caller's actions and observations verbally. In other words, the person who called becomes the operator's eyes and hands. Cooperation and mutual understanding between caller and operator are critical.

This pilot study is a test of an intervention designed in order for the operator to strengthen the impact the communication has on the caller's actions. Thus the course focuses on teaching operators how to become more *aligned* with the caller along several dimensions, thereby creating grounds for smooth and calm cooperation. Eight operators were selected and trained over the course of many weeks of calendar time. The training consisted of group practice of new communication skills out of the workplace context as well as individual on-the-job practice.

Operators were trained to detect and respond to empathic opportunities, as well as opportunities for acknowledgement, thankfulness and agreeing with callers. By acknowledging that the caller did the right thing by calling and cooperating, operators can align at the level of ethics and the caller's sense of moral responsibility. By expressing genuine empathy with the caller's negative and positive emotional expressions, they align at the affective level. By taking opportunities to agree with how the caller sees the situation, they align with the caller's ability to observe and evaluate the situation. Operators must also take into account callers' perspectives regarding what could constitute bad news and were thus trained to express that news with sensitivity. Finally, operators were trained to formulate open questions judiciously instead of unknowingly using closed ones.

Analysis will focus on operationalizing and identifying these behaviors from a random selection of calls, comparing ones recorded before the course was announced to ones recorded within 14 days after operators completed the course successfully. We are particularly interested in feedback regarding (1) how to operationalize respectively: empathic-, thankfulness-, acknowledgement- and agreement-opportunities, and (2) how to aggregate scores in a way that minimizes within group differences (e.g., call duration, medical situation, caller characteristics) in order to reduce variability that could mask significant differences before and after training.

Positive emotions expressed by patients and nurses in home care settings: a qualitative study

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Background: An extensive body of research demonstrates the potential functions and outcomes of patient-physician communication across clinical settings. We know less about how nurses' communication affect older patients' well-being and health. As part of the international cross-sectional study on person-centered communication with older people receiving home care, the COMHOME-study, Hafskjold et al. studied current practice in home healthcare in two Norwegian municipalities. Using the Verona coding definitions of emotional sequences (VR-CoDES) and qualitative analysis, the researchers provided descriptions of and empirical findings about how older patients (aged > 65) expressed emotional distress (mediated through cues and concerns) and how the care providers (nurses and/or nurse assistants) responded to patients' worries. We have also started to explore how positive emotions are being expressed in these visits. In the current study, we aim to explore how patterns of both positive and negative emotions occur and affect communication within and across different home care visits.

Methods: The study has an explorative qualitative design. The chosen sample consists of nurse-patient encounters, previously coded with VR-CoDES. A first step will be to code positive emotions expressed by patients and nurses using the Positive Emotion Communication (PEC) coding system. PEC consists of seven emotional communication category codes:
1) **Connection**: fostering relationships and connecting with another person
2) **Savoring or experiencing joy**: taking delight or joy in a moment
3) **Appreciation or gratitude**: appreciation of life circumstances or gratitude towards others
4) **Positive focus**: being optimistic or having a positive outlook
5) **Praise or support**: complimenting, providing support for, or affirming another person
6) **Humor**: Using humor with intention to be amusing or comical, to ease tension/emotion or normalize a situation
7) **Perfunctory**: automatic or statements reflecting habitual responses

A second step will involve extraction and subsequent inductive qualitative analysis of empirical communication sequences coded as positive emotions or worries (cues or concerns).

Our focus on OCHER: We would like to present preliminary findings, and to discuss interpretation strategies and implications for current and future research.

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Cues and concerns expressed by older people in home care

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Background: Responding to emotions and enabling self-management are two main functions of communication in home healthcare. Hafskjold et al described four categories of emotional worries expressed by older people receiving home health care in Norway. These worries are about relationship with others, about health care-related issues, about aging and bodily impairment and life narratives and value issues.

Aim: To describe the type of cues and concerns expressed by the older persons in different types of home health-care visits and how the nurses respond to the cues and concerns.

Method: The study is a part of a large international research project, COMHOME (Hafskjold et al 2016) where communication between older people receiving home health care in private homes in four districts in Norway and registered nurses (RN) or nurse assistants (NA) were audio-recorded and analyzed. The audiotapes were coded using the VR-CoDES.

Findings: In total, 65 home care visits were analyzed, with an average length of 27 minutes (range 5-70 minutes). The visits were categorized in three categories based on the intention of the visit; medicine administration (n=7), instrumental visits (n=21), and total care (n=37). We found 253 cues and concerns from the older people in the visits, with no difference in the three groups. We are currently analyzing the responses from nurses and nurse assistants. The meaning of these results will be up for discussion at the workshop.

Predictors and protectors of loneliness: communicative opportunities in home care

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Introduction

The population above the age of 65 is increasing more rapidly than in the past. The aging population poses society for major challenges and increases healthcare expenditure. Establishing age-friendly environments with high quality care is one of the main challenges to overcome. Prevalent obstacles elderly encounter are social isolation and loneliness; 50% of elderly above the age of 60 experience feelings of isolation and one third experience feelings of loneliness, particularly when age increases. Frequently occurring discomforts of elderly with medical complications are loneliness and a decrease in self-care and mobility. Loneliness and social isolation result in a decline of subjective wellbeing and therefore a decline in quality of life of elderly. Home care is often offered as a solution for the decrease in self-care and could additionally decrease loneliness through nurse-patient communication. Home care for elderly in the Netherlands is based on the Long-term Care Act and the Social Support Act. The latter consists of non-medical care and support of elderly at home (e.g. assistance with shopping and housekeeping). This Act also enables elderly to age-in-place, i.e. to continue to live independently at home for as long as they are able.

Home care consists of visits by care providers or nurses. Nurse-elderly communication is crucial for the assessment of the needs of the patient and for an efficient task performance by the nurses. However, communication is a challenge if barriers are in place; e.g. hearing deficits of patients, different communication intentions (social engagement or task efficiency) and age differences (differing values and expectations). Nurse-elderly visits mean regular social contacts for elderly and are therefore indispensable when studying loneliness in elderly. For some elderly, nurse visitations are the main occasion to engage socially. Recognition of the patient's feelings or expressions is crucial in the nurse-patient communication and essential for patient's outcome.

To the best of our knowledge, no studies have been performed that looked at how (often) loneliness and loneliness-associated topics are discussed during real-life home care visits. Such observations would help to design interventions by which nurses (or elderly themselves) can be taught to effectively talk about these sensitive issues during time-constraint home visits. This study therefore aims to explore the more or less explicit discussion of loneliness and social isolation with elderly by observing the nurse-elderly communication in Dutch home care visits.

Methods

As no loneliness observation protocol was available we first performed a scoping review to detect the elements (predictors and protectors) associated with loneliness. In a second step we developed the protocol using these elements and applied this to a random selection of 40 audio-recordings of Dutch home care visits made in 2015.

Preliminary results

23 papers were included for the development of the observation protocol. These papers revealed a large variety of predicting and protecting factors for loneliness which could be categorized in four main categories. During the OCHER 2020 meeting, the results of the observations will be presented and discussed for their relevance for designing an intervention to enhance the communication about loneliness with elderly in home care.

Spoken communication strategies for effective information provision in the medical consultation: A systematic review

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Background

The issue of medical information provision has been extensively explored in the literature, tackled in teaching, and stressed by policies. Yet, it is one of the goals of healthcare that frequently is not achieved: patients' knowledge gaps are consistently reported. Medical training and evidence-based guidelines for physicians typically focus on *what* information to provide, but the literature on evidence-based strategies for *how* to best provide it is scant.

Aim

We are in the process of systematically reviewing the existing scientific knowledge on effective ways for doctors for delivering information whilst they talk with patients. In particular, we aim to: (i) determine the quantity and quality of evidence available on the issue; (ii) summarize the effective ways of framing medical information in talks; (iii) study the context, content, and outcomes of these framing strategies.

Methods and preliminary results

We have performed a systematic literature review. The search strategy includes a combination of terms on "doctor-patient communication" and "information provision". This resulted in more than 8300 unique articles. Then, all articles were screened by at least two researchers according to predefined inclusion/exclusion criteria: E.g.:(a) testing ways to frame the information in speech (verbally and non-verbally), (b) testing a message provided by a doctor to improve an outcome of a patient, (c) with an experimental or quasi-experimental design, (d) published in peer-reviewed journals. We plan to exclude information provided in a written format or with numeric contents, and information conveying highly emotional contents (e.g. bad news). After screening title and abstract, a total of 195 articles remained and are in the process of being screened in full-text. For each selected study, the quality will be assessed and relevant aspects on participants, study, intervention and outcomes will be extracted. We plan to synthetize and, if possible, compare the data concerning the tested ways of framing information.

We would like to discuss the research questions and methods, including inclusion and exclusion criteria, possible outcomes of interest from a clinical and theoretical perspectives.

Providing information in Assisted Reproductive Technology filed: a two-steps project to identify and train physicians on crucial aspects

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Background. From the study of den Breejen and colleagues emerged that both patients and professionals put highest value on information and communication in fertility care. However, little is known about key information-provision aspects affecting the quality of doctor-patient communication in ART consultations.

Previous studies. Our team already conducted a research project on doctor-patients communication during actual ART visits. These were videotaped, coded and analyzed using the Roter Interaction Analysis System (RIAS). We discovered that the communication contents from physicians mainly focused on providing biomedical information, while the ones from couples had a 2-fold focus on providing biomedical information and on positive talk (laughs, joke, approves, agree). Contrary to what expected, the style of physician-patient communication was not found to be associated with patient satisfaction and retention in care. However, patients were highly satisfied and engaged. We are now further analyzing the same set of data from a qualitative point of view, trying to clarify the role of positive talk and the aspect of misunderstanding during ART interactions.

Aim. We are now planning a new research project on communication in ART visits, to better explore what are the more effective ways in which clinicians provide information for patients' recall and understanding and if they are associated with patient engagement. We are imaging a two-steps project: the first step with the aim of identifying what are the crucial aspects of information provision from both physicians' and patients' perspectives in order to operationalize them into variables. The second subsequent step will adopt an experimental approach in order to test if an intervention where physicians are trained on the information provision aspects identified in step one will be effective in improving patients' recall and understanding of information, and if they are associated with patient engagement.

Points for discussion. We would like your suggestions and insights on which will be the best methodological approach for both the two steps along with the best procedures for analyzing data.

The evolution of patients' information-seeking behaviour within a consultation and its interplay with doctors' responses

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Background

Unmet information needs are a highly prevalent problem in healthcare which acts as a major barrier to patient autonomy. Some studies focus on the observed interaction between patients and their doctors to explore how these needs can be addressed, focusing largely on patient question-asking behaviour. However, these studies mostly treat patient questions as isolated events within the consultation, independent from each other and the sequential process of information-seeking.

The goal of this study is to investigate how doctors' verbal behaviours influence the evolution of patients' information-seeking about their diagnosis throughout a consultation.

Proposed methods

Data from a United Kingdom postgraduate clinical examination will be used for this study with 154 video-recorded simulated consultations from 78 doctors. Using Speech Act Theory, we will be coding instances of patient information-seeking about their diagnosis, tracking the interaction with doctors' responses and examining how information-seeking evolves throughout the consultation.

Potential implications

By investigating the impact that doctors have on the iterative process of patient-information seeking, we will have a better understanding of the process by which patients search for information during the consultation. This will be a crucial step in working towards enabling patient autonomy.

Exploring communicative challenges in Ethiopian cancer care: A qualitative study

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Background: Cancer is a growing concern in Ethiopia. Though communication is essential for the treatment process, few studies have looked at communication in Ethiopian oncology care. A challenging working environment, due to the large number of patients, and a scarcity of resources make it vital to understand how to better manage consultations in order to effectively help as many patients as possible given the limitations mentioned. Thus, research is needed to analyze and understand the communicative challenges experienced by oncologists, patients, and family, who are often caregivers for patients, in order to successfully handle patient care in practice.

Objective: This study explores communication in Ethiopian cancer care and presents the main challenges faced by oncologists, patients, and family caregivers.

Methods: This is an explorative qualitative study, conducted in the Oncology Department of the Tikur Anbessa (Black Lion) Specialized Teaching Hospital (TASH) in Addis Ababa, Ethiopia. A triangulation of data collection methods was used. This included 91 audio-recorded, semi-structured interviews and 21 video recordings of authentic interactions during hospital rounds. The aim was to obtain as complete a picture as possible of communication from the perspectives of oncologists, patients and family caregivers. The interviews were analyzed using thematic content analysis and the themes were supported by excerpts from the transcribed recordings.

Results: Eight themes emerged from the interview data. Intense time pressure, in combination with little space for privacy, limit possibilities for oncologists to deliver detailed information and provide emotional support. Furthermore, patient literacy levels, in combination with no or little cancer awareness, financial problems, reliance on traditional and religious treatments, the stigma of cancer, and a fatalistic attitude, result in delays in patients seeking care and participating in positive health behaviors, and, subsequently, often result in an unwillingness to openly discuss problems with oncologists and adhere to treatment. The study illustrates the paramount role of family in the treatment process and its influence on communication. All of these themes have important implications for the role of ethically acceptable communication in patient-centered care.

Conclusions: This study indicates a number of serious challenges for successful and ethically acceptable health communication in Ethiopian cancer care. Based on the results, suggestions for managing consultations and for training health care staff are provided.

Communication in intensive care: A multi-dimensional intervention study

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Background

Patients on mechanical ventilation in intensive care units (ICUs) have communication barriers which make them struggle to express their needs, concerns, emotions and thoughts. There is a growing understanding of the consequences of these barriers for both patients and healthcare personnel. After conducting a phd-study using video recordings and interviews with a qualitative approach, it became clear that there was room for improvement in the communication between patients on mechanical ventilation and health care providers. The plan is to develop a multi-dimensional intervention study. Few studies have done this previously within the intensive care context, even fewer have implemented more than one communication aid at a time or included several health care providers. However, patients in ICUs has a variety of communication challenges, and differs in skills both motorically and cognitively. It has also been hypothesized by researchers that good communication may prevent the development of delirium in intensive care patients.

Aim

The aim of this presentation is to present a plan for an intervention study in intensive care, to receive feedback from peers.

Method

A quasi-experimental study, measuring the impact of communication aids on success in communication encounters and decision-making processes bedside. The plan is to review patient documentation, register use of communication aids and to observe levels of decision-making according to a pre-established coding system before the intervention. An educational intervention will after this be developed and implemented. Main outcome will be use of communication aids and success in communication encounters, secondary outcomes are documentation of communication episodes in nursing and medical records, observations of levels of decision-making and prevalence of delirium/agitation.

Topic for the presentation at OCHER

The main topic will be the preliminary methodological approach we used to create the intervention and outcome measures.

"END OF TREATMENT: WHAT NOW?" - How to ensure good transition from active treatment to follow-up in adolescence with cancer?

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Background:

In Norway, approximately 150 children get diagnosed with cancer every year, of which four of five is expected to survive and go on to become long-term survivors. Once the cancer treatment is completed, the children typically attend out-patient follow-up care on regular intervals to check for cancer recurrence and later on, detect late effects of the treatment; physical and mental health problems that can impact their physical, psychological and social functioning. The time of transition is often associated with great relief, but also anxiety, and for some, a sense of abandonment when no longer being in close contact with health care personnel (HCPs) (1, 2). Re-entering "everyday" life after being in a state of crisis for months or years can therefore be very challenging (3, 4). There is currently no formal process for preparing the patients and their families for this transition.

The aims of this study is to:

A. Explore the experiences related to the transition phase from active treatment to outpatient follow-up in adolescents with cancer and their families as well as involved HCPs.
B. Develop and feasibility test a nurse-led intervention to help patients and their family prepare for the transition off treatment through tailored, nurse-led consultations addressing the adolescents' needs and preferences. It will also include a Survivorship Passport containing treatment history, risks of late effects and follow-up care recommendations for the patients.

Methods: The study has a qualitative design. The first phase will include individual interviews with approximately 15-20 CCSs` in the age group 13-19 years and one of their parents. We will conduct focus groups with interdisciplinary health care personnel from different parts of Norway experienced with this patient group. Lastly, we will use knowledge generated from the interviews and a co-design process to develop the intervention and then complete a feasibility test. The interviews are currently being conducted. The co-design will include workshops with CCSs, multidisciplinary health care personnel and researchers.

At OCHER we would like to discuss and get advice regarding how to design and conduct the intervention:

- We are interested in including a communication tool to prepare the adolescent for the nurse consultations. Do you have ideas for communication tools that can facilitate the meetings between the youth and the nurse?
- How can we present topics the adolescent find relevant and useful to discuss in a good way?
- Opportunities for the use of relevant eHealth applications to support the adolescent through the transition phase and beyond?
- Opportunities for studying the communication between the adolescents and the nurse.
- How can we best feasibility test this communicative intervention? (Ex: acceptability, demand, practicality and limited-efficacy testing).
- How can we train the nurses to attain good communicational and self-management support skills that will gain the adolescents trust and make the intervention effective?

Plenary workshop 2

Independent multidisciplinary examination and synthesis

of shared decision making in two hospital encounters

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Background:

Shared decision making (SDM) is a complex process that has gained some momentum the last decades. Video observation methods shed light on the process of decision making, demonstrating a large variety of approaches and conclusions. We propose that a group of video analysts explore two carefully selected consultations independently, using theoretical and analytical approaches from their various disciplines. Subsequent collaboration and synthesis could render fruitful understanding of SDM and possibly produce more coherent descriptions.

Methods:

Interested researchers will gather in a parallel session at OCHER 2020 to discuss which videos to study, agree on the goal of the project, discuss potential challenges, present ways to study SDM in this project, agree to a time frame and several meeting points. The intention will be to present results at OCHER 2021 and finish a paper by the summer 2021.

We will present the main content and issues related to a subset of videos from hospital encounters made in 2007-08 at Akershus University Hospital, in order to make the most promising selection for this study. We hope to attract people from a variety of fields (e.g., medicine, nursing, psychology, sociology, linguistics, anthropology) who feel decision making is important part of medical practice today. Attendees at this session can include those who would like to participate directly in the endeavor as well as those who would like to discuss it without committing to direct involvement.

Challenges in establishing mandates of trust in the doctor-patient relationship: A qualitative secondary analysis

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Objectives: This is a secondary analysis of the qualitative data we collected for the paper "Mandates of trust in the doctor-patient relationship". We aim to examine challenges and difficulties in opening up mandates of trust between doctor and patient. We will examine how disagreement challenges establishing common ground.

Methods: The study was conducted using video observations and qualitative interviews with patients and doctors in general practices in urban and rural Norway 2004-2006.

Results and discussion: A mandate of trust is the patient's way of defining how far and in what areas the doctor is allowed to exercise his judgement in matters of concern to the patient. A patient consulting a general practitioner will normally extend a mandate of trust just by consulting the doctor. However, this mandate of trust is limited to role expectations to a practitioner of modern medicine. But sometimes the patient's concerns needs to be addressed on a more personal level. This may require a more open mandate of trust. We now analyse consultations to examine disagreement between doctors and patients, and challenges in developing open mandates of trust.

Temporary conclusion: Disagreement between doctor and patient poses a challenge, but if the mandate of trust is not limited to strictly biomedical topics in the communication, then disagreement does not necessarily disrupt the trust relationship. Disagreement may even strengthen the trust relationship if it is built on a sense of common ground.

Questions: Problems related to a secondary analysis of data gathered 14 years ago.

Patient autonomy – a utopian ideal for patients with advanced cancer?

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Introduction

Respecting patient autonomy has become both an ethical and a legal obligation in health care worldwide. National guidelines in Norway underline the significance of this imperative in cases of severe illness and short life expectancy, such as in advanced cancer. Shared decision-making (SDM) has been promoted as the preferred approach for respecting patient autonomy. However, there are considerable conceptual difficulties related to what SDM looks like in clinical practice and how it should be implemented. For example, Gulbrandsen et al. emphasize that becoming a patient also represents an existential problem in several ways and that illness may (temporarily) reduce a person's autonomous capacity, which is often ignored in the SDM approach. The authors claim that SDM has the potential to restore this autonomous capacity but also to further reduce it, e.g. by ignoring the power imbalance in the patient-physician-relationship or by inadequate information-provision. They propose that the aim of SDM should be, not only respect for, but also restoration of, the patient's autonomous capacity. To do so, the care needs to encompass existential aspects.

Objectives

The aim of this study is to explore the information exchange between seriously ill cancer patients and their attending physician, with a particular focus on existential aspects. The findings will be discussed in light of the ideal of patient autonomy.

Methods

The study has a qualitative, exploratory and descriptive design. In a previous project, recordings were conducted by videotaping authentic consultations between patients and their attending physician in an outpatient hospital setting in Norway. In the present study, we are interested in encounters with adult cancer patients who were in a situation with a poor or uncertain prognosis at the time.

Preliminary results

A first step in the analysis revealed that existential issues are surprisingly absent (apparently), given the serious situation of the patients. In the further analysis we will go more into detail in the information exchange to study both the patients' and the physicians' contribution: what do they focus on; are there any attempts to address existential issues; if so, who initiates it, what happens prior to and after these attempts, does it seem to affect care plans? etc.

For discussion at the workshop

How to describe something that is not there? How to recognize, describe and interpret attempts to address existential issues? Input on the relation between existential aspects of serious illness and implications for patient autonomy.

Introducing Advance Care Planning in the hospital setting for patients with advanced pulmonary disease – a pilot study

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Background and aim: Advance care planning (ACP) is communication about wishes and preferences for end-of-life care. ACP is not routinely used in any Norwegian hospitals. We performed a pilot (2014-2017) introducing ACP on a thoracic medicine ward in Norway. The aims of this study were to explore which topics patients with advanced pulmonary disease discussed during ACP conversations; and to assess how patients, relatives and healthcare professionals (HCP) experienced the contents and the feasibility of the pilot.

Methods: Using a semi-structured guide, participating patients could elaborate on topics of importance. Each conversation was summarized in the patient's medical record. At the end of the pilot, ward staff discussed their experiences in focus group interviews. Summaries and transcribed interviews were analyzed using systematic text condensation.

Results: 51 patients participated (41-86 years; 9 COPD; 41 lung cancer; 1 lung fibrosis; 11 females), 18 accompanied by a relative. Four themes emerged: (i) Disturbing symptoms, (ii) existential topics; (iii) care planning, and (iv) important relationships. All participants appreciated the conversations. HCP (1 physician, 7 nurses; 25-58 years; 7 females) participated in two focus group interviews. Additional comments were collected from 4 male physicians. Summaries revealed patients' values previously unknown to HCP; important information was passed on to primary care. Fearing they would deprive patients of hope, HCP acted as gate-keepers in the recruitment process. Although several reported barriers during recruitment, many saw ACP as pertinent and called for time and skills to integrate it into their daily clinical practice.

Conclusion: Both patients, relatives and HCP showed a positive attitude towards ACP. Focusing on present and future symptom control may be an acceptable topic for both patients and HCP when introducing ACP. Important aspects for implementing ACP for this patient group are management support, education, training, feasible routines, and allocated time to perform the conversations.

Session 5B Methodology in development

Developing a codebook for a quantitative content analysis of how women and men use language in physician-patient interactions

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BACKGROUND. Differences between women and men have been found in all stages of the medical trajectory, from symptom presentation and health care seeking behaviour, to diagnosis and treatment. A substantial amount of previous research has focused on 'what' women and men communicate in physician-patient interactions, by analysing instrumental and affective aspects of communication behavior, e.g., giving information, or showing concern. However, research on 'how' women and men communicate and what linguistic and interactional variables they use, is scarce.

AIM. In the current quantitative study we aim to investigate whether sex and gender play a role in differences between women and men presenting common somatic symptoms, particularly focusing on the communication between general practitioners and patients. By means of a quantitative content analysis we will systematically study whether female and male general practitioners and patients differ in language use, and to what extent these differences relate to relevant patient outcomes.

METHODS. The data for our quantitative study consists of 100 video recorded Dutch consultations in the general practice. The linguistic and interactional variables that will be included in our codebook are mainly based on the findings of our previously conducted scoping review. In this review we have synthesized a broad range of linguistic and interactional variables that were empirically examined in relationship with sex/gender in the last two decades. The review's findings provided little evidence for overall differences between women and men in language use, although tentative evidence was found for more supportive turn-taking in women than men. In the current quantitative study we will further investigate to what extent women and men differ in supportive turn-taking and other interesting linguistic variables.

POINTS FOR DISCUSSION. At OCHER we would like to discuss some methodological issues, in particular the development of our codebook (e.g., number of variables, refinement) and how to deal with complex variables such as interruptions and overlap, and possible practical implications.

Biofeedback and shared decisions in co-morbid insomnia and obstructive sleep apnea (COMISA)

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Background: Obstructive sleep apnoea (OSA) is a highly prevalent sleep disorder associated with an imbalance between respiratory flow and respiratory effort. The most effective treatment, positive airway pressure (PAP), is cumbersome and poorly accepted.

Patients with PAP non-adherence need personalized treatment. Personalized medicine refers to "a **medical model** using characterisation of individuals' phenotypes and genotypes for tailoring the right **therapeutic strategy** for the right person at the right time, and/or to determine the **predisposition to disease** and/or to deliver timely and targeted prevention (www.icpermed.eu)." The phenotype targeted in this study is co-morbid chronic insomnia and OSA (COMISA).

Non-pap treatment for OSA may be invasive strategies such as oral devices or surgery. Alternatively, highly motivated patients may benefit from weight reduction, positional therapy or orofacial myofunctional therapy (OMT). Biofeedback from sensors or from a sleep diary may be useful for patients and providers when evaluating effect of non-invasive interventions.

The aim of the current study is to explore clinical communication between doctors and highly motivated patients with COMISA treated with a biofeedback-based self-management tool and a sleep diary.

Material:
Approximately 30 Participants of the Akershus Sleep Apnea Diagnostic and Treatment Evaluation with COMISA, willing to participate in a feasibility study.

Methods: All included patients will complete an electronically sleep diary for 12 weeks and a fully automated self-management tool based on biofeedback for 8 weeks. A polysomnography will be performed before and after the intervention. A consultation with a certified otorhinolaryngologist after the second sleep registration will be video filmed. Type of video analysis and measurements from patient and physician is still unclear.

A survey investigating the quality of clinical communication in veterinary clinics and hospitals across Europe

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The recognition of clinical communication as a core clinical skill is relatively well established in human medicine. In veterinary medicine, however, this is far from being a natural part of the universities' curricula. This said, the Calgary-Cambridge guide has been used as a basis for communication training of veterinary students in some countries and universities since 1998. The communication tasks and challenges faced by veterinarians in consultation with clients/ pet owners, have many similarities with the human doctor's, with some significant exceptions. Therefore, it is natural to lean on the vast amount of research done in human health, when searching for evidence-based communication methods.

AniCura is a group of veterinary establishments throughout Europe, counting around 6000 employees. Since 2015, a medical quality program is established, aiming to increase patient safety and improving medical outcome. Improving professional communication skills is identified as one of nine areas with particular importance. The last years, all clinics have participated in a large quality survey every quarter. Topics like antibiotic treatments and surgical site infections have been investigated using quantitative measures.

In 2020, we will look at the quality of communications skills. Designing questions in a way that provides useful answers in this field is challenging. A possibility is comparing answers from veterinarians, nurses, receptionists and technicians with answers from clients, looking at the perception of own communication skills related to the client's experience. I would be grateful for inputs and ideas regarding a survey like this, from researchers with experience with similar projects.

It is also interesting to look for differences between the participating countries, especially related to the impact of investment in communication training during the last years.

Framing strategies for understanding and decision-making:
The case of metaphors in ART consultations

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Framing strategies as metaphors are important persuasive tools in allowing understanding and decision-making, especially when information to be shared is complex and/or charged with a high emotional impact: as a result of their exposition, people can change their intentions, beliefs, and behavioural attitudes. Proposing an interpretation of the unfamiliar concept (target) through the familiar one (source), metaphors can be used to explain new concepts and gain knowledge. Moreover, proposing to look at the target from a specific (but also partial) perspective, metaphors can be used to favour a perspective change on something, promoting some inferential pathways at the costs of others.

However, persuasion through metaphorical framing is often also implicit, or even worse, manipulative, having the power to introduce biases within the communication process thus posing the autonomy of patients at risk. Indeed, metaphorical frames (and the implicit arguments of which they are made) may be improperly used, also against the part who introduced them at first. Following this line of reasoning, I argue that persuasion should be obtained within an ethical framework and, as far as concerns the purpose of this contribution, by means of the ethical use of metaphors. Adopting a patient-centred model of care, I try to distinguish between cases in which the adoption of a metaphorical frame is ethically acceptable from cases where it is not. More specifically, I discuss as a case study an example drawn from the context of Assisted Reproductive Technology (ART) where a doctor calls into question the metaphorical frame used by a patient in a way that does not seem to be ethically legitimate. Avoiding to provide further medical information that would have helped the patient to re-assess her convictions, I show why the doctor's argument seems to be not free of value judgments that implied a strong delegitimization of the preferences and worries previously expressed by the patient.

Examining the ART case study, I would like to propose a new research line based on the idea that it is possible to distinguish best practice from malpractice concerning the use of framing strategies and metaphors. Finally, I offer arguments why a more aware and informed use of framing strategies and metaphors should be suggested and why training for healthcare providers should be provided.

Understanding "How are you?" in different settings

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The standard process for starting anamnesis in the follow-up cancer consultation is for the doctor to ask a 'How are you?' (HAY?) question. This question gives the patient the opportunity to give a gloss of their general condition and offer the first topic of discussion. Findings in earlier analyses of US and UK data in a broad array of medical contexts show that patients may interpret the HAY question as social rather than medical. This paper shows that the HAY question in the context of Dutch follow-up cancer consultations is consistently interpreted by both doctor and patients as a holistic medical question, making relevant a – frequently complex and nuanced – medically-oriented response. This difference may have to do with the interactional norms of hospital visits in the Netherlands, and with the specific contextual parameters of return visits, which affect the way the HAY question is placed, intended and understood.

It would be interesting to see whether the openings of taking history that are witnessed in Scandinavian hospitals are similar to the US or the Dutch 'model'.

Shared decision making and treatment adherence in patients diagnosed with obstructive sleep apnoea

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Background: Non-adherence to treatment with positive airway pressure (PAP) or weight loss is a major clinical challenge among patients with obstructive sleep apnoea (OSA). Approximately 25% do not adhere to treatment and patients who adhere use the PAP machine less than described. Weight loss is recommended to all overweight or obese patients with OSA, including those using PAP. PAP in combination with lifestyle interventions is the most effective therapy for patients with moderate to severe OSA. Informed patients may go for more conservative treatment options. There is lack of studies connecting SDM to treatment adherence.

Hypotheses: Aim: We want to study the relation between shared decision making at time of diagnosis and treatment adherence. Hypothesis 1: Shared decision making assessed by analysis of videos and self-report obtained at the time of diagnosis is related to PAP adherence in OSA. Hypothesis 2: Larger degree of shared decision making assessed by analysis of videos and self-report obtained at the time of diagnosis is related to at least 5% weight loss.

Material: The Akershus Sleep Apnea Diagnostic and Treatment Evaluation (ASADaTE) is a prospective observational study of 275 consecutive individuals referred to the ear-nose- and throat (ENT) department with suspected OSA. Patients underwent sleep registration and clinical examination between August 2015 and September 2016. Of 275 patients, 28% were female, mean age was 47 and mean body mass index 30. Among screening positive patients, 46 (38%) had clinically significant insomnia, 4 (1%) restless legs, 22 (25 %) anxiety and 13 (22%) depression. 22 video recordings were collected. Shared decision making was measured with video recordings of clinical encounters at the time of diagnosis and by patient self-reports in the CollaboRATE questionnaire.

Methods: A five year follow-up study will be performed. Treatment adherence will be recorded by technical registration (memory card data) and self-report (questionnaire). Degree of shared decision making will be based on observer rated video analysis and self-report. We will use the OPTION 5 to measure SDM.

The OPTION 5 measurement is based on five items scored between 0 to 4 with the maximum score is 20. For ease of interpretation, we will rescale this score to be between 0 and 100. Each decision focus in the video recordings will be timed. Then two raters will independently assess each specific decision focus in the clinical encounter. Five and five video recordings will be scored until Intraclass Correlation Coefficient (ICC) are above 0.6. We will take detailed notes of conversations and examples of language used to differentiate between a score of 1 vs 2 and so on. Both raters will first complete «Observer OPTION 5 training» via Google classroom.

Timeline: The video analysis by OPTION 5 will be scored this Autumn, 2019. The results of the video analyzes will give us an indication of the extent of SDM in a common ENT department. The data collection of PAP adherence and weight loss by the follow-up study will be performed in 2020/2021.

Reasons for low compliance using positive airway pressure devices: Exploratory study of patients with COMISA and poor CPAP adherence

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Background: Co-morbid insomnia and obstructive sleep apnoea (OSA) is termed COMISA. The latter is treated with positive airway pressure (PAP) and lifestyle changes. However, co-morbid insomnia is related to PAP non-adherence.

Poor CPAP adherence has been of significant concern (Møkleby & Mengshoel, 2019). Several studies conclude that no single factor, such as patient characteristic, disease severity or technological factor has been identified as a significant predictor of PAP adherence. In addition, adherence is elated to experiencing social support and a good collaboration with health personnel (Weaver & Sawyer, 2010). People who do not use their PAP device reports factors such as the PAP mask is too big and uncomfortable, that it reduces their self-esteem and cohabitation. Educational, supportive and behavioural interventions have been shown to increase adherence (Møkleby & Mengshoel, 2019), but further development is needed.

Aims: To explore patients experiences and reasons why patients with Comisa have low PAP adherence. Moreover, we aim to enrich the further understanding of PAP adherence and the absent use of PAP devices among people living with co-morbid OSA and insomnia.

Design: A qualitative design based on individual thematic interviews. Interviews will be recorded, transcribed and thematic analysed.

Methods: Patients with OSA and insomnia were recruited through purposive sampling, and were recruited from a follw up esamination in the Akershus Sleep Apnea agnostic and Treatment evaluation. (ASADaTE).

Møkleby, M. & Mengshoel, A. M. (2019). Devoted or negotiated routes of adherence: Narratives of patients with obstructive sleep apnoea using a continuous positive airway pressure device. *Nursing Open, 6*(3), 1237-1244. https://doi.org/10.1002/nop2.325

Weaver, T. & Sawyer, A. (2010). Adherence to continuous positive airway pressure treatment for obstructive sleep apnoea : implications for future interventions. *The Indian Journal of Medical Research, 131*(2), 245-258.

Brain-behavioral mechanisms supporting the impact of clinician warmth and competence on pain treatment outcomes

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The patient-clinician relationship can powerfully impact adherence to treatment, patient satisfaction and even clinical outcomes. It is a source of variability in both clinical trials and clinical practice. This is pertinent in Low Back Pain, which ranks at the top as the most burdensome health issue globally, with its cost to Western countries comparable with that of diabetes and cancer combined.

However, surprisingly little research has investigated

1) how specific aspects of the clinician's behavior (e.g. expressed warmth-empathy and display of competence) work under different contexts

2) the neurobiological mechanisms underpinning these effects.

To understand how the patient-clinician interaction influences patient outcomes and to harness this untapped potential, research into the psychological and brain mechanisms of the clinical encounter is sorely needed.

Here, we aim to 1) determine how the clinical encounter may differentially impact acute and chronic pain, and 2) investigate the brain-behavioral mechanisms underpinning the effects of therapeutic alliance on pain outcomes. We combine an ecologically valid assessment of a clinical interaction emphasizing either clinician warmth or competence, with follow-up recording of patients' and clinicians' brain activity during pain therapy, using two-person fMRI of patient-clinician dyads. With this novel and groundbreaking technique, we can determine the brain mechanisms involved in both providing and receiving treatment.

Our main objective is to provide rich mechanistic data on the behavioral and brain mechanisms that determine the therapeutic alliance and treatment outcomes for chronic pain patients, by measuring the synchronous and asynchronous processes occurring in patients and clinicians during a real treatment encounter. Specifically we aim to determine the importance of clinicians exhibiting warmth-empathy versus competence on therapeutic alliance and patient treatment outcomes in acute vs chronic pain.

Efficacy of an online module for training physicians in shared decision-making - protocol for a randomized controlled trial

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Norwegian physician need mandatory training in shared decision-making (SDM) during their specialization. We developed an online training program that adheres to a six step-model of SDM. Its structure is analogue to a German module developed as part of the SHARE TO CARE program that is used to implement SDM at the entire University Medical Center Schleswig-Holstein, Kiel. The German version has proven effective. We aim to evaluate the efficacy of the Norwegian adaption.

The training is composed of different video examples of 1) a suboptimal SDM performance, 2) a multiple-choice question (MCQ) about the skill to be improved, 3) a discussion between the physician and a communication coach, and 4) an optimized SDM performance of the physician. The training ends with a certifying test.

Physician from the University Hospital of North Norway will be randomized to either intervention- or control group. An 8-item MCQ assesses physician' SDM knowledge (endpoint 1). Their accuracy (endpoint 2) while judging the SDM performance in a video consultation by use of MAPPIN'SDM compared to an expert rating will also be compared.

A total sample size of 102 is needed, given a power of 80%, a significance level of 0.05 and an effect size of 0.5 (the German version realized d=0.75 for knowledge and d=0.5 for accuracy).

We invite the audience to discuss training and protocol critically and to add important ideas.

Shared decision-making supported by decision coaches - evaluation of a training module

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Background

Patient participation in healthcare decisions is a crucial part in succeeding with the Norwegian motto "the patient's health care". Concurrently, patient decision aids (PDA´s) are being developed and published on the Norwegian national platform. However, patient decision aids are rarely used and shared decision-making (SDM) is obviously not part of the communication routines in daily clinical practice. Hence, there is a need to identify effective interventions to support patients' involvement in SDM. A nurse-led decision coach training module was drafted as a supplement to implementation of three existing PDA´s. The training was designed using the Ottawa Framework for Decision Coach-mediated SDM and the doktormitSDM training approach. We aimed to evaluate the piloting of this training module as a complex intervention to measure its relevance perceived by the nurses, knowledge gain, behavior change, and quality.

Methods

A descriptive study, following Kirkpatrick's evaluation framework and recommendations by the Medical Research Council Complex Interventions Framework, is currently being conducted. The training is two-fold and provided at the trainees' work place. The first component is a 6-hour training workshop focusing on SDM basics and behaviour skills. The second component is a follow-up session involving individualized expert feedback, based on an analysis of an audio-taped decision coaching session recorded by the trainees within their clinical setting.

All four levels for evaluation recommended by Kirkpatrick (reaction, learning, behavior and results) are measured using questionnaires with Likert-scale and multiple-choice items immediately after the first training and also after the follow-up session. Behavior change is assessed as the number of performed SDM consultations based on the trainees' reports. Quality of the communication is assessed using the MAPPIN'SDM observer scale on one audio-taped decision coaching session. The verbatim suggestions to improve the decision coaching will be explored Using content analysis. Participants will be conveniently recruited from medical domains where PDAs already exist.

Expected results

The development contributes to a comprehensive Norwegian curriculum called "*Klar for Samvalg*" (Ready for SDM), which uses generic methods and provides guidance to tailor SDM training for health professionals to particular needs. The new module is closing a gap and is expected to facilitate the use of PDAs. The results will inform SDM implementation strategies and further refinement of the Norwegian "Ready for SDM" framework.