Wednesday January 11			
Time	**Activity**	**Plenary room / Room A**	**Room B**
1000	Plenary	Introduction, mutual presentation	
1045	Break	Talk to someone you don't know (much)	
1100	Plenary keynote 1	**Sandra van Dulmen** *Automatic medical language processing in clinical practice; Why?*	
1200	Lunch		
1300	Plenary keynote 2	**Sarah Bigi** *Models of interaction in healthcare communication studies: bringing the perspective of linguistics and argumentation theory to the field of healthcare communication*	
1400	Break		
1415	Groups	**Session 1A** **Primary care**	**Session 1B** **ICU**
		Östman	Schwarz
		Haraldsson	Karlsen
		Noordam	Deribe
1545	Break		
1600	**Networking**		
1700	Plenary abstract 1	**Extending the clinical consultation beyond the here and now** *Lindström*	
1730	End		
1800	Get-together at hotel		
2000	Dinner at hotel		
		Thursday January 12	
0830	Plenary keynote 3	**Sandra Van Dulmen** *Automatic medical language processing in clinical practice; How?*	
0930	Plenary workshop	**Effective communication in contemporary clinical encounters** *Makoul*	
1015	Break		
1045	Groups	**Session 2A** **New communication training (1)**	**Session 2B** **Treatment DM in oncology**
		Gregersen	Lauritzen
		Lindhardt	Wieringa & Pieterse
		Hjellset & Kasper	Kebede
1215	Lunch		
1315	Groups	**Session 3A** **New communication training (2)**	**Session 3B** **SDM patient views**
		Øvregaard	Sundkvist
		Knudsen	Orstad
		Egenberg	Kasper
1445	Break		
1500	**Networking**		
1600	Groups	**Session 4A** **Clinical teaching assessment**	**Session 4B** **Emotions in clinical care**
		Andersson & Kristiansson	Sundling
		Mandelkow & Reme	Sørensen & Wøien
1700	End		
1800	Dinner at hotel		

		Friday January 13	
0830	Plenary keynote 4	**Sarah Bigi** *What are people doing when they talk? Challenges in assessing what 'good communication' looks like.*	
0930	Break/ Check-out		
1000	Groups	**Session 5A Grasping patients' complexity**	**Session 5B Measuring adherence**
		Bjørnstad	Frigaard
		Ofstad & Landmark	Winsnes & Siddiqui
1100	Break		
1115	Groups	**Session 6A New trends**	**Session 6B Professional development (1)**
		Fleisje	Varga & Skirbekk
		Menichetti	Steinsbekk
1215	Lunch		
1315	Groups	**Session 7A Patient support initiatives**	**Session 7B Professional development (2)**
		Scheffer	Ruud
		Vitinius	Brembo
1415	Plenary abstract 2	**Making care fit** *Kunneman*	
1445	Plenary closing	Evaluation and round-up	
1545	End	**Safe travel!**	

Session 1A Primary care

The patient's first point of contact in primary care – registered nurses' communication and initial assessment

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Overall information: This is a postdoc project that includes three work packages (WP). The purpose of this research is to investigate key principles and conflicts of goals in registered nurses' (RNs) initial assessments and nurse-patient communication related to the priority of patients' needs and care provision in primary care. This abstract focuses on the first WP.

Background: Primary care is central to the Swedish healthcare system, for "good quality, local health care", with focus on accessibility and continuity. In primary care, RNs are usually the patient's first point of contact and those who carry out initial assessments and priorities. The RNs communication and interaction with the patient is important for the initial exploration and understanding about patient's health concerns, and RNs assessment includes data gathering, the interpretation of these data and decision-making on what action needs to be taken. Communication strategies used can optimize RNs assessment and clinical reasoning. However, assessments and priorities are complex, as health problems and illness severity must be weighed against accessibility and available resources. There is a lack of research on RNs communication strategies used to address individual patients' need in their initial contact with primary care.

Aim: To explore nurse-patient communication during initial assessments and RNs' priorities with focus on expressed needs and concerns.

Methods: The first WP is based on observational data, subjects for the project are RNs and patients from primary care units in Region Västra Götaland, Sweden. Data will be gathered on real time nurse-patient communication using audio recordings with ten RNs doing five recordings each. A purposeful sampling will be made to collect data related to patients with a first point of contact with different disease conditions and illness complexities. The processing and analysis of data collected on audio recordings will be coded with the Verona Coding Definitions on Emotional Sequences (VR-CoDES). The data will allow for both statistical and qualitative analysis.

Expected findings: This study can contribute to more knowledge about RNs communication strategies in relation to RNs' assessment in patient's first point of contact in primary care, but also whether gender differences or other inequalities exist.

Timeplan: The first WP will start in Spring 2023 and by the end of the year, reporting and dissemination of findings is expected to be possible

Request for feedback: We have planned to code the data with VR-CoDES. Other methods or approaches that may be suitable?

Adolescent males visiting the GP: Exploring the consultation and communication.

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Background: Unmet health needs are common among adolescent males, particularly in the area of lifestyle and mental health. Adolescent males report difficulties talking to a general practitioner (GP) as well as having doubts about what they can discuss with the GP. However, adolescent males who have established a relationship with a GP are more likely to consult for poor mental health and to have their anxiety symptoms discussed, which indicates that the GP's ability to communicate and establish relationships is a key feature to discuss sensitive health concerns.

Poorer communication with adolescent males than with females has been described in for example nephrology care. To the best of our knowledge, however, few studies have focused on adolescent males' consultations with GPs or how the GPs communication strategies affect the adolescent males' perceptions of being comfortable sharing their own concerns. Therefore, the preliminary aims in the current study are:

1. To explore and describe adolescent males' consultations with GPs.
2. To explore and describe how GPs' communication strategies affect adolescent males' GP consultations.

Methods: A qualitative research approach is used. Between March 4 and May 20, 2022, all males 15 to 19 years old visiting a GP at two healthcare centres in Sweden, were invited to participate. The consultations were video-recorded and individual semi-structured interviews were conducted with both adolescent males and GPs.

The video recordings and the interviews will be inductively analysed with qualitative thematic analysis. In addition, to study the GPs' communication strategies (e.g. asking for the patients' perspectives, use of confidentiality), and their relation to the health discussions a deductive qualitative content analysis will be conducted. A categorization matrix will be used to structure the analysis. The categorization matrix is based on core concepts from *European Training in Effective Adolescent Care, the Calgary-Cambridge Guide*, and *the World Health Organization's Youth-Friendly Health Service*, and was stepwise developed through discussions in the research team, at research seminars, and finally in a group of GPs.

Results: Nine consultations were video-recorded (lasting from 8 to 39 minutes), and 18 interviews conducted. Nine adolescent males participated. Their mean age was 17.3 years, and a third of them had parents born outside Europe. Four GPs participated once, one twice and one GP participated three times. The interviews with adolescent males lasted between 9 and 32 minutes and with the GPs 9 to 39 minutes. We will present preliminary results at the OCHER workshop.

Mental healthcare and shared decision-making in general practice: Experiences of clients, general practitioners and practice nurses mental health

Désanne Noordam[1]

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Background

In the Netherlands, the number of people visiting general practice with mental problems has increased over the years. Besides this general increase, throughput of people to specialized mental healthcare is limited, resulting in waiting periods ranging up to almost a year. Altogether, people with mental problems are thus compelled to receive (transitional) treatment in general practice. Little is known however about how clients and their primary caregivers, as well as general practitioners (GP) and practice nurses mental health (PNMH) experience receiving and respectively providing mental healthcare in general practice, specifically regarding making decisions about the course of treatment. The current exploratory study provides insights into their perspectives, and aims to answer questions such as: How do clients and GP/PNMH make decisions regarding course of treatment? In which way do the waiting lists at specialized mental healthcare institutions affect these decisions? And more in general, what barriers are encountered in daily practice?

Methods

Semi-structured in-depth interviews were conducted with clients and primary caregivers (n=21) and GP and PNMH (n=17). Data (interview transcripts) were analyzed by means of a thematic analysis, both in a deductive and inductive way.

Results

(Main result regarding shared decision-making:) GP and PNMH felt they had sufficient information provision at their disposal to inform clients about treatment options. They did find some information was lacking however, such as an up to date overview of waiting periods at specialized mental healthcare institutions. As a result, and to ensure a good match, GP and PNMH often instructed clients to do some research on their own. Clients were of opinion this task was mentally too strenuous at times, and indicated they 'just wanted help'. At such times, clients felt unable to make a truly informed decision about the course of their treatment as well. Interestingly GP and PNMH were of opinion clients are mostly able to make such (shared) decisions despite being mentally burdened. All GP and PNMH pointed out they practice shared decision-making and stated they prioritized the client's wishes. In certain situations, however, GP and PNMH would take on a more directive approach. This for instance was the case when a client requested more guidance, or when specialized treatment was more urgently needed GP would refer directly.

Furthermore, GP and PNMH indicated they have difficulty with providing transitional care to clients (lack of capacity within general practice), and especially to those with more complex mental problems (lack of knowledge and skills). This was also the case in providing (after)care to clients with chronic mental problems; GP and PNMH questioned what care they are able to offer this group that benefits them.

Discussion

At OCHER, we would like to discuss the implication of these results for mental healthcare in general practice and the process of shared decision-making in light of mental problems.

Session 1B Intensive care unit

Acute critical illness in the very elderly: Meeting the duty of providing the right level of care in a dissonant health care context. An ethical analysis of survey data from Norway

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Background: Despite high and rising numbers, the benefit of admitting very elderly patients to an intensive care unit (ICU) is heavily debated and remains controversial (1). Clinical decisions regarding admission of elderly patients to an ICU are usually multifactorial. Clinical decision-making is influenced by patient-related (2), physician-related and social, cultural and organizational factors (3). Especially in cases of clinical and/or scientific uncertainty, the patients' wishes and values are a paramount consideration. During an episode of critical illness, the patient's treatment preferences are frequently conveyed by a family member to the medical team.

Material and methods: We developed, tested and validated a questionnaire exploring very elderly patients´ ICU admission preferences and their proxies' ability to predict these preferences. We are currently administering a postal survey to a purposive sample of 200 very elderly Norwegian outpatients and their next of kin.
The respondents are asked to make treatment choices regarding three hypothetical scenarios, randomly chosen from 20 representative clinical vignettes. The questionnaires included questions pertaining to advance directives, intensive care experience, comorbidity, frailty, and health related quality of life and demographics. We provided space for free-text comments.

Results: Preliminary quantitative and qualitative data revealed marked discrepancies between the respondents' expectations and notions and several domains of intensive care provision, its regulatory framework, and health care governance pertaining to (i) capacity and informed consent, (ii) prognosis and prioritization, and (iii) decisional authority and family involvement.

Future Directions: We plan to describe these discrepancies and explore their underlying causes by conducting an ethical analysis of the survey results in relation to their clinical, social and legal context in Norway.

Communication with vulnerable patients- narratives from the intensive care unit

Marte-Marie W. Karlsen

Lovisenberg Diaconal University College
Supervisors during the PhD: Professor Lena G. Heyn, Univeristy of South-Eastern Norway, Kristin Heggdal, Professor at VID; Arnstein Finset, Professor Emerita, University of Oslo)

Introduction

Conscious and alert patients in the intensive care on mechanical ventilation often experience challenges communicating their needs. This can affect their psychological recovery and increase the risk of post-intensive care syndrome (PICS). The aim of this study is to capture the narratives of former ICU- patients, to better understand how they create meaning, order, and understanding of a chaotic experience.

Method

5 of 10 patients who were video recorded during their ICU stay were interviewed 2-6 months after they were in the intensive care unit. Both the videos and the interviews are transcribed. During the interviews they were offered to see segments of their own ICU-stay, including interaction with the providers. The analytic phase is in the starting process, but the plan is to use narrative analytic methods by Falconi. The analysis will focus on how they themselves construct their own ICU-stay, but also more specifically which part of the stories they talk about communication and interaction during this critical phase of their life.

This is an ongoing project, so the goal for the OCHER session is to get feedback on the analytic method and findings.

Stress and coping strategies among parents of children with cancer: A phenomenological study

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Background: Parents of children diagnosed with cancer are profoundly affected by their child's diagnosis and the associated demands of treatment. Limited research is available on parental stress relating to pediatric cancer in low-income countries in general and in Ethiopian pediatric care in particular. This study aims to explore sources of stress and coping strategies among parents of children with cancer receiving chemotherapy at Tikur Anbessa Specialized Hospital (TASH) in Ethiopia.

Methods: A qualitative phenomenological approach was used in the study. Fifteen in-depth interviews were undertaken among nine mothers and six fathers of children with cancer receiving chemotherapy at TASH from November 2020 to January 2021. Data were analyzed thematically using ATLAS.ti 8 software.

Results: The analysis identified four thematic areas that were related to parental stress and coping strategies: parents' understanding about cancer, sources of stress, conditions decreasing stress, and coping strategies. The severity of the child's illness, fear of treatment side effects, and fear of loss of body parts were reported as sources of stress related to the child's health condition. In relation to health facilities, long waiting times, prolonged hospital stays, Availability of chemotherapy drugs, and a lack of information or inadequate information were identified as sources of stress. Furthermore, parents reported a lack of social support and financial problems as sources of stress. Conditions decreasing parents' stress included the child starting cancer treatment, improvement in the child's health condition, knowing someone with a positive treatment outcome, receiving counseling from healthcare providers, getting social support, and the ability to buy drugs. Finally, praying and religious beliefs, crying, accepting the child's condition, discussion with healthcare providers, and denial were mentioned as coping strategies.

Conclusion: This study has identified the child's level of illness and the type and response to treatment, the availability and accessibility of cancer treatment services, and the availability of social/financial support as the main sources of stress among parents of children with cancer. To reduce stress, improving information sharing and communication between healthcare providers and parents, and parents to parent, establishing family support groups, improving the availability of chemotherapy drugs and education on coping strategies are needed.

Plenary abstract 1: Beyond the consultation

Extending the clinical consultation beyond the here and now: Safety-netting advice in Swedish primary care consultations for respiratory tract infection

Anna Lindström

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Safety-netting advice is information shared with patients to help them identify the need to seek further medical help if their condition fails to improve, changes or if they have concerns about their health (Beck Nielsen, 2018; Edwards et al., 2016; Roland et al., 2014). Cox (in preparation) studied safety-netting advice in the US primary care context. He found that the advice could be understood to manage clinical uncertainty regarding either diagnosis or treatment. Cox argued that the delivery of safety-netting advice can be a delicate matter since the advice can be heard to imply that the diagnosis and/or treatment recommendation during the visit at hand may have been inadequate (Cox, in preparation). Asking patients to be observant for complications or new signs of illness can also cause undue anxiety.

This study examines safety-netting advice in Swedish primary care. The data is drawn from a corpus of 67 video-recorded clinical consultations with adult patients who are seeking care for symptoms of respiratory tract infection. Safety-netting advice was delivered in 27 visits and several of these included multiple instances of "the same" advice. Most safety-netting advice highlighted clinical uncertainty regarding treatment rather than diagnosis. This finding resonates with research that has shown that treatment typically is prioritized over diagnosis in the respiratory tract infection primary care context (Heritage & McArthur, 2019). I document how safety-netting advice is initiated and the trajectories that the advice engenders. I also consider how the advice is positioned vis-a-vis patient preferences and different treatment outcomes. Preliminary analysis suggests that safety-netting advice is a resource for antimicrobial stewardship. In visits where patients have indicated a preference for antibiotics, safety-netting advice can be used to put antibiotic prescription on hold. Safety-netting advice is also used in consultations where physicians have prescribed antibiotics. In these contexts physicians start the patient on a narrow rather than broad spectrum antibiotic and use safetynetting advice to instruct the patient to return if the symptoms get worse or fail to improve.
The safety-netting advice thus allows physicians to avoid unnecessary prescription of broad spectrum antibiotics. The study contributes to basic CA research by illuminating the organization of requests that involve remote actions.

Plenary workshop: International consensus

Effective Communication in Contemporary Clinical Encounters: An International Consensus Workshop
Gregory Makoul

Faculty of Medicine | Yale University School of Medicine
Chief Transformation Officer | NRC Health

Consensus statements on communication in medical encounters provided useful touchstones for the field and serve as the foundation for curricula, standards, and research. Participants in a recent international consensus workshop held at the International Conference on Communication in Healthcare (Glasgow 2022) reviewed the Toronto consensus statement [1], International Consensus Statement [2], and Kalamazoo consensus statement [3] – each published decades ago – and took the first step toward creating an updated consensus statement that reflects the opportunities and challenges of contemporary healthcare such as digital health, health equity, and clinician burnout.

Participants in the Glasgow workshop agreed that an updated consensus statement should build on the Kalamazoo Consensus Statement by reflecting contemporary clinical practice, broadening the perspective from doctors and patients to clinicians and patients, and embracing diversity (e.g., involve people, including patients, from multiple countries). Participants also outlined the goals of clinical encounters and processes, guidelines and scope for the updated consensus statement, and key issues to address. With the in-person Glasgow workshop as a backdrop, the work of this group will continue virtually.

Attendees at OCHER 2023 could play a very important role in guiding the consensus process and outcome by getting involved. If there is time in the program, I would be happy to facilitate a workshop; this format would be preferable as it allows deeper discussion. If not, I could present a detailed status report and ask for input.

Session 2A New communication training (1)

Intra- and interpersonal communication in the clinical encounter
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There is a growing recognition of the importance of addressing the patients' context in the consultation, including managing emotions related to their fear, sense of losing identity, sadness, or anger. The consequences for both contextual errors, diagnostic errors, and patient safety are elucidated in recent research.

Consequently, we have established a 'Research Portfolio for Human Factors and Patient Safety' to develop solutions that promote safe patient communication through enhanced skills in addressing context and emotions. The aim is to create a culture with continuous competence development.

Subprojects

Communication training – HCPs' mental states, emotions and feeling

HCPs' personal experiences and history impact their competencies and challenges in the conversation with patients. Just as their mental states, emotions, and feelings influence the relationship with the patients and determine if and how they respond to the patient's feelings.

Aim: To explore how HCPs can recognize, become aware of, and work with their own emotions and feelings.

Communication training – the patient's context

Patients experiencing illness may find their identity challenged by the changes happening to body and minds. Thus, for the patients and the HCP, it can be essential to identify the personal resources of the patients and elements in their everyday life that increase their strength and support the development of health skills.

Aim: To explore how to stimulate curiosity and knowledge about the patient's context, e.g. patient's everyday life, perspectives, resources, and values.

Discussion points
- How can we promote awareness of the HCP's emotions and feelings in interacting with patients and relatives?
- How can we create awareness of the patients' context?
- Which methods and learning materials may best support this?

A new communication curriculum at a Danish medical school: relationship-centred medicine and blended learning

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Objective
In the past 10-12 years, the communication teaching for medical students at the University of Southern Denmark has taken place without significant changes in form and content. Therefore, a working group was established to bring the communication education "up to date," e.g., focusing more on the human-to-human relationship and how you can use yourself in the patient-centred conversation. At the same time, there was a desire to support the teaching with digital learning material, which, among other things, stimulates increased reflection on one's own practice, provides access to exercises that can be used in the clinic, and functions as a knowledge bank with concrete guidelines and other tools in communication

Methods
A working group, consisting of researchers and clinicians with expertise in patient communication, reviewed the existing communication curriculum at the medical education at the University of Southern Denmark, focusing on implementing digital blended learning modules, evidence-based knowledge about relationship-building, patient-centred communication, digital communication and how to best address and embrace student vulnerabilities.

Results
The design and content for a novel optimized curriculum was developed, both including bachelor- and graduate students:
Bachelor-level: students participate in a workshop, named "No doctor without communication". Through reflective exercises and training in relationship-building, communication is emphasized as foundational to medical practice.
Graduate level: students participate in a workshop named "Doctors are also humans", focusing on students' mental well-being, vulnerabilities, compassion, and self-compassion, preparing the medical students for their future career and identity as a doctor. Blended learning and patient actors are used in communication modules in the bachelor- and graduate modules. A Train-the Trainer program will equip the teachers for teaching the new curriculum and quality assessment and evaluation of the trainers and the program will be made on a continuous basis.

The new curriculum will be implemented from September 2023 at the medical education at the University of Southern Denmark and Esbjerg University Hospital, Denmark.

The structure of health communication research at the metropolitan university OsloMet?

Victoria Telle Hjellset and Jürgen Kasper

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Background

Health communication, health literacy, shared decision making, and biopsychosocial communication have in recent years become prioritized topics in the Norwegian health policies, and in the professional field. Tremendous efforts have been spent to develop and implement measures in order to better the health professional patient communication. To even better coordinate these movements, use synergies and strengthen the research methods, transparent academic structures would be advantageous, making health communication addressable.

We aim at orienting the OCHER about current developments and activities on the structural level at OsloMet which are relevant to the Norwegian health communication research community.

Methods

The faculty of health sciences at Oslo>Met has a new "umbrella" master in health science. Several master's and continuing education courses for health personnel have become specializations in the master's program in health sciences. All the master's students complete the same subjects in scientific theory and research methods, and not least in the subject of quality improvement and implementation of knowledge-based practice. For the first time, students have the opportunity to choose an elective master course in health communication (10 ECT). The subject is open for international students. A full master in health communication would be a logical next step.

And now the structure of the research. Health communication has been given a central role in the research landscape and is supposed to represent an excellence entity of national and international visibleness. Health communication is a central link for most processes within health, healthcare and health science. Communication can be an outcome, intervention, moderator or evaluation method. OsloMet also has an overall focus on health communication and health literacy. Regarding this, a research group are established, and they will explore how health communication can be optimized for relevant target groups, and how this can be evaluated. In addition, two new professors have been employed.

Discussion

With this we want to discuss synergies and modes of cooperation in the field of health communication between OsloMet and OCHER UiO as well as other facets of the Norwegian health communication research community.

Session 2B Treatment decision making in oncology

Communicating about the choice of surgical treatment to women with early-stage breast cancer: Experiences from surgeons` point of view.
Mirjam Lauritzen

Samvalgssenteret, Universitetssykehuset Nord-Norge

Introduction: Women who are diagnosed with early- stage breast cancer often has more than one option related to what kind of surgery they can receive to remove the cancer. Several medical factors influence the choice of treatment, like size and location of the tumor, the woman's anatomy and other sickness she may have. In addition, the choice is influenced by the women`s personal preferences related to the pros and cons with each treatment options. The treatment options available for most women are: 1) surgery to remove a portion of the breast tissue (lumpectomy), 2) surgery to remove the entire breast (mastectomy), 3) surgery to remove the entire breast and reconstruct a new breast in the same procedure. The three options have similar prognosis regarding survival and the risk for the cancer to spread. However, it differs how extensive the interventions are related to pain after the surgery, and how long the course of treatment is. In that sense, the choice of surgery is suitable for shared decision making (SDM). Whether a shared decision takes place, can among others depend on the surgeon's ability to communicate about the choices with the patient. This diagnosis is also subject to a time-limited national standardized patient pathway.

Aim: Explore breast cancer surgeons' experiences with involving patients in the choice of surgical treatment.

Method: A qualitative interview study based on hermeneutic theory of science was conducted. Semi-structured interviews with four breast cancer surgeons from various Norwegian hospitals form the basis for the text material. The analysis has been carried out based on stepwise- deductive indictive method (SDI).

Result: The concept of SDM was familiar to the surgeons, and all stated that it is part of their daily practice. Nevertheless, the study shows that they have different understanding of the term SDM and what it implies. The surgeon's goal is for patients to feel safe. To achieve this, they consider information sharing as one of their most important tasks. Surgeons are sensitive to patients' reactions and conscious of their own communication. The analysis highlighted two different concepts used in conversation about treatment options: dialogue-based and expert-driven communication. The two approaches have different characteristics and differ from each other in the way the choice of treatment is decided and communicated. The study also showed variations regarding the extent of patient involvement. The choice of communication approach seems to be influenced by how the surgeons interpret the patients' reactions to the diagnosis, and the view of their own role. The deadlines in the standardized patient pathway also makes it challenging to convey sufficient and good information and can lead to patients making choices that the surgeons do not agree with.

Conclusion: Shared decision making requires communication skills that facilitate patient participation. The surgeons in this study have different communication approaches that to varying degrees facilitate such participation. This study suggests increased focus on patient-centered communication and SDM is needed.

The role of time in patient involvement in cancer treatment decision making: A mixed methods study

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Background Cancer patients and physicians often mention time as a barrier to patient involvement in decision making. Yet, little is known about how patients and physicians perceive the role of time in involving patients in cancer treatment decision making, or which strategies can be applied to overcome time-related barriers. Our aims are to 1) understand how time may promote and/or hinder patient involvement in making decisions about their cancer treatment, and 2) identify strategies to overcome time-related barriers.

Methods We will hold individual interviews with newly-diagnosed cancer patients and their treating physician. Furthermore, we will ask patients to fill out a questionnaire three months after making the decision. To be eligible, patients should have faced one of the following decisions at most 14 (preferably 7) days before: whether or not to undergo intensive treatment for acute myeloid leukemia (age, ≥60 years), or adjuvant chemotherapy for stage II/III colon cancer (age, ≥18 years). Oncologists and hematologists are eligible if they made this decision with a participating patient.

In the interviews, we will ask participants about their experiences with and opinions about (the time for) decision making, and ways to improve (the use of time for) it. We will continue recruiting participants until we reach data saturation. We will record and transcribe the interviews, and apply open, axial, and selective coding on the transcripts.

In the questionnaire, we will ask patients about their experiences with (time for) decision making, when looking back on it. We will analyze the questionnaire data using descriptive statistics.

Findings We expect to complete data collection by January 2023.

Discussion The results will provide input for: 1) the development of a conceptual model of the role of time in patient involvement in cancer treatment decision making, and 2) a list of strategies to overcome time-related barriers.

Unpacking Decision-Making in Ethiopian Oncology Care

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Introduction. The aim of this study is to describe and analyze decision-making in oncologist-patient communication in Ethiopia. Cancer is a major burden in Ethiopia, and Tikur Anbessa (Black Lion) Hospital is its sole unit for cancer care. With a handful of oncologists, a lack of resources, and a huge patient influx, the work is challenging, especially achieving effective and ethical patient consultation. Patients, usually accompanied by family, wait for long times and often depart without treatment. Handling consultations well is essential in order to help them as well as possible within such limitations.

Methods. Data collection was conducted from 2016-2019 at the Chemotherapy and Radiotherapy Center of Tikur Anbessa (Black Lion) Hospital. The clinic treats about 10 000 cancer patients yearly, while the estimated incidence of cancer in Ethiopia is over 60,000 cases. Our data includes video recordings of consultations (38) between adult patients (20 male and 18 female) with different kinds of cancer and oncologists (6 male and 5 female). The recorded consultations were first-time meetings between the oncologists and their patients. Total recording time is 4 hrs 5 min. We also collected semi-structured interviews (16) with senior and junior physicians at the center (11 male and 5 female), with a focus on their experiences of patient communication and decision-making. Total interview time is 3 hrs 10 min. The recordings and interviews were transcribed verbatim and translated from Amharic and Oromo into English. Two researchers have identified clinically relevant decisions using the Decision Identification and Classification Taxonomy for Use in Medicine (DICTUM). The combination of interviews with video recordings of authentic interactions allows for gaining an understanding of both the participants' perspectives on decision-making and how they actually make decisions in interactions with patients. Ethics approval was obtained from the Ethical Review Board of BLH and of Western Sweden.

Preliminary results. Eight out of 10 DICTUM categories are represented in the data. The oncologists put time into gathering additional information as when patients are diagnosed outside BLH, little information is available in their charts. They also evaluate test results, define problems, and make decisions concerning drugs and radiation therapy. Further, the oncologists spend a considerable amount of time discussing legally and financially related issues, e.g., prescribing cheaper drugs as many patients cannot afford medications. Finally, the oncologists give advice and precautions while discussing treatment plans, especially focusing on the patients who might not follow treatment plans due to financial issues and religious beliefs. Two DICTUM categories are not represented in the data, such as treatment goal and deferment. The reasons mentioned in the interviews by the oncologists are many patients lack the resources to finance their treatment and often are not coming back. Further, the majority of decisions are taken "here and now", which can be explained by the uncertainty if patients come back, time pressure, and the influx of patients.

The study aims to contribute to the understanding of the complexity of decision-making in Ethiopia and the influence of cultural and socio-economic factors on oncologist-patient communication.

Session 3A New communication training (2)

Communication in veterinary medicine – results from a survey among veterinarians and other veterinary staff
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AniCura Norway

In 2020, we conducted a survey among animal health care professionals in AniCura. The survey was our first to address clinical communication skills as a quality factor with impact on medical outcomes and patient safety. The aim was to get an overall impression regarding respondents' perceptions of communication as clinical skills and the respondents' use of two specific skills: identifying problem list and clarifying cost.

We asked 350 European AniCura clinics to give the survey to their veterinarians who engaged in first line consultations, receptionists/nurses involved in patients' checkouts, and practice managers; 457 veterinarians, 505 receptionists/nurses, and 252 practice managers responded. In this presentation, we will concentrate only on veterinarians' responses.

In part one, we asked for respondents' background information; their general opinion about communication skills and their impact on quality of care, medical outcome, client satisfaction, and personal job satisfaction; and the degree to which respondents regarded teaching and learning communication skills as evidence based. Furthermore, we asked respondents to grade six "challenging situations" as never, sometimes, often or very often difficult. We also asked if some concepts or terms, commonly used when talking about communication skills, were familiar to the respondents.
Part two was a self-observation form focusing on the degree to which veterinarians thought they elicited the client's agenda, asked about additional issues and discussed costs. We wanted to know if eliciting additional issues led to new appointments or to veterinarians doing additional work on these issues during the same consultation. Regarding costs, we asked at which points in time during their clients' visits they had mentioned or discussed the costs.

The results of this survey offer some interesting perspectives. We would like to present selected results and discuss with OCHER participants how to use them as a basis for further investigations.

Mindfulness and Compassion in the healthcare system – An action research project about the impact of mindfulness training on clinical practice

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Background

The work environment in many hospital wards is characterized by a high degree of unpredictability and pace, which can challenge healthcare professionals' ability to maintain focus, calmness and be attentive in their encounter with patients. In addition, healthcare professionals are often confronted with suffering when caring for patients in difficult life situations, which can lead to stress and burnout. Mindfulness training has been suggested as a tool to support the caregiver's well-being, empathy and health while simultaneously improving relationship building, communication and patient care. Existing research on mindfulness training is dominated by quantitative studies, measuring the impact of mindfulness on stress and burnout and only few studies have focused on how the experiences from mindfulness training can be integrated and adopted in healthcare settings.

Aim and methods

In the first phase of the project, we explore healthcare professionals' experiences of how attending an 8-weeks course in Mindfulness-based stress reduction (MBSR) influence their work life, especially their interaction with patients and colleagues and in the second phase we explore how implementation of mindfulness can be supported in a healthcare context using future workshop methodology. Future workshop is a method linked to action research. The purpose of action research is to generate knowledge through its focus on empowering practitioners, by getting them to engage with research and thereby generate solutions to improve practice. This approach provides an opportunity to experiment with concrete actions in practice, developed by the practitioners to support mindfulness in healthcare settings. At the end of the project an evaluation of how the actions works, will be conducted.

Preliminary results

At OCHER we will present the preliminary results of the first phase of the project and our work with creating knowledge through future workshops.

Discussion

We would like to discuss using future workshops as a research method and pros and cons regarding involving the practitioners active in the research process.

Distilling experts' knowledge on clinical information sharing

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Objectives

It's important for health personnel to share information with patients. However, patients tend to forget or misunderstands the information given. We want to teach effective strategies for sharing information, but what excactly are those strategies? The current literature offers different strategies, like the four habits model, or the Calgary Cambridge Guide, as well as more specific advice like "ask-tell-ask", "chunk 'n check" and "teach back". The current field of knowledge is fragmented and the founding in research is weak. This study aims to distill the knowledge and experience of experts on information sharing strategies in clinical settings and provide guidance for teaching and further research.

Methods

This is a qualitative interview study in which we conduct semi-structured interviews with global experts on clinical communication training /information sharing. The interview guide was designed using guidelines from "Interviewing Experts" Bogner et al 2009. The main questions were "what are the most important strategies for good information sharing?" "How should information sharing be taught to medical students?" To find the experts we used our own networks and the snowball method. Recruitment will continue until data saturation.

The interviews are transcribed and analyzed according to principles of thematic analysis (Brown and Clarke), but using a more deductive – inductive approach. That is, we will focus on extracting information on strategies for information sharing and ways in which to teach these.

Results

Nine interviews have been conducted so far. We are in the process of transcribing the interviews and developing a codebook for the initial steps of analysis.

Practice implications

We hope the study will contribute to build knowledge of effective and actionable strategies for information sharing, and guidance for how to teach information sharing. We will evaluate the strategies from this study when co-creating and implementing a new course on information sharing for 4th year medical students in the University of Oslo.

Points for discussion

I welcome all feedback. This is my first article, so I am interested in: Am I doing any obvious research blunders? What are the weak points? What are the strong points? How can I improve my abstract-writing? What would make this study more exciting and powerful? How can I make this study simpler?

Session 3B Shared Decision Making: patient views

Patients attitude to Shared decision-making

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Introduction:
Shared decision making (SDM) has been a fundamental right for all patients in Norway since 2001. Unfortunately, the implementation process has been slow, and the majority of the patients are not familiar with the term "samvalg" (Norwegian for SDM). Myths and barriers towards SDM have also been reported in the literature, concerning both health professionals and patients. Therefore, as a part of implementation of SDM in hospitals, we wanted to conduct a survey among patients about their knowledge of, and attitudes to SDM.

Methods and results:
A simple feedback form was made, consisting six questions which were partly inspired by the campaign "Ask, share, know" from Australia. The survey ran for 20 weeks, with 10 respondents each week and data collected at randomized days. 197 patients answered the survey. All patients were recruited from an outpatient clinic (Division of surgery, oncology and women`s health). 86% of the respondents answered "yes" to the question "Do you want to participate in the decision about your treatment?". 23% of the respondents reported that they knew the term "samvalg". 80 % of the respondents reported "yes" to the question "Did you experience that you and the doctor made the decision about your treatment together?"

Discussion:
Clinicians who want to meet the patients request to participate may experience shortage of time and maybe uncertainty about when and how to apply SDM, especially in the standardized patient pathways. One way of addressing this challenge is to analyse the patient pathways and pinpoint where decisions that are SDM relevant occurs. This includes the recognition of the fact that patients must be invited by health care professionals to participate, and prepared by communication that facilitate patient participation.
80% of the respondents report that they are included in the decision-making process. Despite this, only 23% of the respondents state that they are familiar with the term "samvalg". We recognize that there are different ways to involve patients and different degrees of patient involvement. Sometimes, a friendly atmosphere in the communication between clinicians and patients might be mistaken for SDM. We therefore believe that despite the fact that many patients say that they participate, it is not certain that the right to SDM has been fulfilled.

At OCHER we want to discuss this with the audience.

"The challenge is the complexity" – a focus group study about decision-making in advanced lung cancer treatment

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Purpose The value of shared decision-making (SDM) and decision aids (DA) has been well documented, yet remain difficult to integrate into clinical practice. We wanted to investigate how patients, relatives and healthcare professionals experience needs and challenges in treatment discussions about advanced lung cancer, focusing on DA applicability.

Patients and methods Qualitative data from separate, semi-structured focus-group interviews with patient/caregiver- and healthcare professionals were analysed using systematic text condensation. A total of 12 patients with incurable lung cancer, seven relatives, 12 nurses and 18 doctors were recruited from four different hospitals in Western Norway.

Results The participants described the following needs and challenges affecting treatment decisions in advanced lung cancer: 1) Relationship as a basic framework for decision-making; 2) barriers to information exchange; 3) negotiation of autonomy; and 4) assessment of uncertainty and how to deal with it. Healthcare professionals feared DA would steal valuable time and disrupt consultations, and argued that such tools could not incorporate the complexity and uncertainty of decision-making. Patients and relatives reported a need for more information and the possibility both to decline and continue burdensome therapy. Participants welcomed an intervention supporting information exchange, like communicative techniques and organizational changes to allow continuity and more time for patient-doctor/nurse dialogue. Doctors called for a tool to decrease uncertainty regarding treatment tolerance and avoid futile therapy.

Conclusion Our findings suggest it is difficult to envision a DA that meets the needs reported by both patients, relatives and healthcare professionals. A decision support intervention for advanced lung cancer should address both organizational structures, communication training including existential and scientific uncertainty, and assessment of frailty and treatment toxicity.

Approaching to an abbreviated version to the patient self-administered scale of the MAPPIN'SDM inventory

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Background and aim. Amongst several approaches to evaluate the extent of patient involvement, the Multifocal Approach to the sharing in Shared Decision Making (MAPPIN'SDM) has been considered a reasonable choice. MAPPIN'SDM comprises five scales each employing the same set of 11 identical indicators to assess shared decision making (SDM) from three different perspectives on the communication of the health care provider (HCP), the patient and the dyad. Three of which are observer scales. In addition, the inventory includes a patient and an HCP scale for self-administered use. The entire MAPPIN'SDM inventory and in particular the observer scales have been extensively validated. Recently, requests have been raised with the originators to develop a shortened version of the patient questionnaire which would be even more feasible, particularly in benchmarking surveys. The current study will develop an approach to the validation of a short version of the MAPPIN'SDM patient questionnaire.

Methods. The study will use an explorative multimethod validation design employing various and alternative validation methods, due to the literature all having pros and cons and discussing results critically. In particular, we will use: firstly, item- and scale analytic methods like internal consistency, item total score correlation, main component analyses, but also methods based on item-response theory. Secondly, we will also use external quality criteria, like criterium validity related to the Control Preference Scale. Thirdly, we will use criteria beyond statistical relations to determine which items should remain in an abbreviated scale. These criteria are judgemental and based on theoretical considerations.
We will use data from a cross-sectional survey by the South-Eastern Norway Regional Health Authority, conducted in autumn, 2020 in one hospital trust. Data were collected using a postal and electronic survey distributed to all inpatients of at min. 16 years of age in selected wards.

Results. Of the 3434 included patients 1593 responded. 361 participants reported in free text to have experienced a decision between several options during the hospital stay. We identified 291 participants with decisions relevant for SDM. These patients had a mean MAPPIN´SDM score of 68.1 (theoretical range 0-100; SD 23.3). Results on item statistics will be provided at the OCHER conference. An abbreviated MAPPIN'SDM scale will be suggested, and psychometric properties illuminated from all aforementioned points of view.

Conclusions. Conclusions about the selection of items for the abbreviated scale will be presented and a critical discussion provided for and against the alternative validation approaches. Further necessary needs for validation will be specified.

Session 4A Clinical teaching assessment

Consultation skills of last semester medical students in Sweden: video-recorded real-patient consultations in primary health care assessed by Calgary-Cambridge Global Consultation Rating Scale, a pilot study.

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Introduction: Doctor-patient consultation is an essential element of high quality health care. Education and training of medical students in consultation skills is important. The aim of this study was to investigate the medical students' consultation skills before graduation by assessment of the students' video recordings of consultations with real patients at primary health care centres.

Methods: All students had to make a video recording of a meeting with a real patient for formative examination. 26 students participated in the study and delivered a video recording and a self-assessment. Four general practitioners assessed the video recordings by Calgary-Cambridge Global Consultation Rating Scale (CC-GCRS). Statistical testing included comparisons between groups of students and assessors using non-parametric methods.

Results: The average CC-GCRS-rating was higher for female students. The students' strengths were related to relation and problem exploration. Their limitations were related to patient's perspective, providing structure and providing information. The students assessed their consultation skills higher than the assessors did, while the relative levels were similar. The distribution of rating scores across the assessors was small.

Conclusion: Consultation skills were acceptable for most medical students, although there was room for improvement regarding patient centeredness skills. CC-GCRS was feasible and might be a valuable instrument to assess consultation skills for medical students at the end of their medical education.

Is the existential domain neglected in Norwegian clinical psychology training?

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Introduction
Professional sensitivity to diversity has been part of psychotherapy guidelines for decades (American Psychological Association, 2003). University training is expected to equip candidates with cultural competence involving a composition of knowledge, attitudes, and skills. The existential domain, including religion and spirituality, is part of the list of possible diversities among social, cultural, ethnic, or gender diversity (American Psychological Association, 1990; Deutsche Gesellschaft für Psychotherapie, 2016; Norsk Psykologforening, 2020). Nevertheless, diversity sensitivity in psychotherapy in general and religious sensitivity in particular seems difficult to achieve for several reasons. In Norway, both patients and practitioners report a lack of confidence in appropriately addressing existential and spiritual questions in psychotherapy (Holmberg et al., 2017; Ulland & DeMarinis, 2014). A persisting religiosity gap between psychotherapists and the general population might add to the challenge (Mandelkow et al., 2021).

Method
15 years ago, a national survey collected data from Norwegian psychology students and reported low levels of representation and acceptance of religion as a topic in psychological teaching, contrasted by the high interest of the students (Reme et al., 2009). In 2020, we replicated the study as part of a wider PhD project. 650 students from all relevant universities participated in an online survey. Personal religiosity was compared to national norm data, coverage of religion and experienced sensitivity in teaching was compared to 2005 data descriptively, sumscores for attitudes were compared between 2005 and 2020 samples using t-tests.

Results and discussion
The results show mostly little change. However, there are signs of opening towards cultural diversity teaching that includes religion, spirituality, and other existential issues. Some results suggest an increase in disrespect towards religious people.

At OCHER, I would like to present the results and discuss possible implications as well as the transferability from psychotherapy to other areas of health care.

Session 4B: Emotions in clinical care

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

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Background:
Person-centred communication is essential for eliciting patients' needs in the process of making decisions, as well as in providing information about choices and options. The aim of the proposed study is to identify expressions of positive and negative emotions during the eye examination, the response to these expressions and to explore the latent function of emotional communication in optometry.

Methods: The study will have an exploratory mixed methods design. The data consists of 34 video-recorded eye examinations, including 34 patients and 11 optometrists. We propose to use a two step-approach to investigate expressions of positive and negative emotions during the eye examination. First, positive emotions will be coded using the Positive Emotion Communication (PEC) coding system (Terrill et al., 2018) and negative emotions using the Verona Coding Definitions of Emotional Sequences (VR-CoDES) (Del Piccolo et al., 2011; Zimmermann et al., 2011). Second, the context and content of positive and negative emotions are further proposed to be analyzed inductively. The coding will be done independently by three coders. Coding disagreements will be discussed to reach a consensus. In collaboration, the three coders will analyze the content of the expressions to identify themes.

Our focus on OCHER: We would like to discuss the feasibility of the proposed study design to understand the function of emotional communication in optometry

Just a little needle stick - Pain and fear related to long-term needle injections in children with rheumatic diseases: An exploratory study

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The aim of this study was to explore needle-related pain and fear in children with rheumatic diseases who requires long-term injection-based treatment. Furthermore, to examine the injection training at the hospital and the experiences of children and parents who manage the treatment at home.

We obtained data using video observations of training sessions, individual interviews with children and parents, as well as focus groups with children, parents and nurses.

The findings provide insights into the complexity of the training sessions and the demands placed on nurses to manage both technical and emotional challenges. Fear of needle-pain often remained unaddressed and continued at home, even if the children reported the pain less intense than expected. Nurses' acknowledging communication tended to influence the child's emotions positively, involving the child in decision-making. The families need comprehensive information and guidance, and although the nurses consider their educational role important, they lacked pedagogical competence.

Preliminary idea for a new study:
In the thesis, we suggested that further studies are needed to examine the impact of nurses' communication skills. In the first published paper from the study described above, we aimed to explore the negative emotions of pain and fear (1). We only briefly commented on how the children tried to become involved and showed engagement in the procedure, which can be interpreted as positive emotions. However, we did not examined positive emotions in-depth. Positive emotions may affect people's emotional and physical state, and promote an opportunity to build relationship, increase patient's well-being and coping (2). Positive emotions have earlier been investigated in adults by using the Roter Interactional Analysis System (RIAS) (2, 3).

Verona Coding Definitions of Emotional Sequences (VR-CoDES) has recently shown to be a reliable tool for coding emotional cues and concerns in children during needle procedures (4). So far, there is a lack of research on how nurses respond to children's positive emotions.

Therefore, we aim to re-examine the video recordings from sub-study I in the doctoral thesis, and explore positive emotions more in-depth.

We appreciate to discuss this idea with expert communication researchers at the OCHER-conference.

Session 5A Grasping patients' complexity

Contextualization of Medical Decisions observed in doctor interactions with heart failure patients.

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Contextualizing medical decisions involves taking a patient's individual life circumstance into account and addressing how non-biomedical factors may interfere with their treatment plan. Such factors have been termed *contextual factors*. This is an important yet often overlooked aspect of clinical practice that has received increasing interest in medical research, particularly in the United States.

This PhD project is part of MAPINFOTRANS, a longitudinal observational study which follows old (65+) patients with heart failure admitted to a cardiology unit at Akershus University Hospital during their hospital to home transition. We are collecting audio recorded interactions between these patients and doctors at 3-time points: their first interaction after admittance, their discharge conversation, and their follow up conversation with their GP. We also conduct semi-standardized interviews with the patients and doctors after all interactions, as well as a home interview a week after the interaction with their GP. Additionally, we collect the patient records for admittance and discharge, medicine lists from the cardiology unit and GP, questionnaires, and a cognitive assessment.

The aim of this PhD project is to use these materials to develop a coding tool to (a) identify and classify contextual factors which may influence patient outcomes, (b) document how they are revealed in the patient records or doctor-patient interactions, and (c) ascertain whether and how medical practitioners address these factors.

At OCHER I will present a conceptual framework for identifying and classifying contextual factors revealed in clinical interactions and utilize examples from the existing data set to demonstrate how they appear as well as how practitioners contextualize medical decisions. As the pioneering work on this topic is from primary care interactions in the US, we are particularly interested in what contextual factors might emerge in these particular interactions in the Norwegian setting. Conference participants at OCHER are invited to discuss and reflect on strengths and limitations as well as future directions for this framework. In particular:

- How can we best evaluate the relevance of specific contextual factors for drug-related patient outcomes?
- How can we best classify and categorize the contextual factors we are observing?
- How can we reliably determine whether or not a medical decision has been contextualized?
- Any suggestions for improvement and generalization of the tool to other settings are warmly welcome.

Improving diagnostic precision and management for patients with acute chest pain. A multidisciplinary conversation analytic intervention

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Background

Chest pain is one of the most common causes for hospital admissions in the Western world, and re-admission rates are high. The management of chest pain traditionally targets ruling coronary artery disease in or out. Research on this high-volume, potentially life-threatening condition focuses on improving laboratory- and imaging tests. Little emphasis has been offered symptom talk between patient and physician, beyond identifying basic symptoms. Moreover, most chest pain patients do not have coronary artery disease but a myriad of other causal explanations to their symptoms and are commonly discharged shortly after admission with unspecific diagnoses and explanations. Building on findings from neurological disorders with unclear etiology, we hypothesize that there are undiscovered linguistic features of how patients with chest pain describe their symptoms, that might yield diagnostic information leading to a causal explanation of the patients' symptoms.

Methods

A multidisciplinary approach developed within neurology (1,2), combining medicine and conversation analysis will be used for analyzing video-recordings of naturally occurring encounters with patients admitted in the emergency departments with chest pain in three Norwegian hospitals. So far, 19 of 40 encounters have been collected.

Aims

The main objectives are to improve diagnostic precision for patients with non-coronary chest pain in the ED and to improve physicians' diagnostic explanations to patients with non-coronary chest pain at discharge. For achieving this, we will:

1. Identify diagnostically relevant features of talk in chest pain patients, which may differentiate between coronary and non-coronary causes of their symptoms.
2. Identify efficient physician questioning techniques for soliciting diagnostically relevant features of talk.
3. Identify characteristics in effective diagnostic explanations to patients about (non-cardiac) chest pain.
4. Develop, deliver and evaluate a training intervention for physicians targeting information exchange between physicians and patients.

Discussion

At OCHER, we would like to present preliminary observations on patients' symptom description of chest pain (aim 1), and discuss methodological challenges and opportunities in this study.

Session 5B Measuring adherence

Medication adherence among heart failure patients – a longitudinal study of hospital to home transitions

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Aim

The overall aim of MAPINFOTRANS is to improve the quality of communication about drug information in the hospital to home transitional phase by describing links of the information exchange chain, identifying weaknesses, and using findings to target improvement efforts.

MAPINFOTRANS is a longitudinal observational study with data collection at 5 timepoints. We recruit old patients (+65 yrs) who are admitted to hospital from home due to heart failure. Data is collected for each patient at the following times: 1) hospital ward round visit 2) hospital discharge visit 3) first GP visit after discharge 4) home visit approximately one week after the GP visit to assess medical adherence, and 5) patient records 6 months after hospital discharge to assess readmittance/death. The dataset for each patient will consist of audiotaped doctor-patient consultations with synchronized observation notes, relevant documents from the patient record, post-consultation interviews with doctors and patients, semi-structured home interview, questionnaires, and written information given to the patients.

Points for discussion

Medical adherence is central to this exploratory study, and we seek ways to assess it from different perspectives. The patients fill in a validated questionnaire that provides a self-reported adherence measure. With the data from the doctor-patient consultations and the home visit we can establish self-reported and observed medical adherence. We will also have available data that describes barriers and facilitators of adherence for each patient.
We would like to establish a multi-dimensional tool that incorporates relevant elements (observations/barriers/facilitators) from our rich dataset to provide a more nuanced picture of medical adherence.

At OCHER we wish to present a draft and invite the conference participants to discuss and offer feedback on the strengths and limitations of such a tool;
- o Does it seem like a useful addition to self-reported adherence measures?
- o Are the proposed elements relevant? Anything superfluous or missing?
- o Any modifications that should be considered?

We are also interested to learn if anyone at OCHER is aware of tools that would suit our purpose, or researchers that may be worth contacting.

Follow- up study of discharge conversations between hospitalised older patients and specialists-physicians

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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 at home and to the available support system.
The purpose of this study is to study how well geriatric patients remembered and followed the treatment plans discussed during their discharge conversations with specialist physicians.

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. We conducted a six-week follow-up interview from seven patients that were discharged from the hospital.

Analyses and themes of interest: Data are the discharge conversations between older in-patients and specialist-physicians (which were analysed previously) and the follow-up interviews conducted six weeks afterwards. We are analysing the follow-up interviews for the patients' *recall* of their treatment plans and how closely they *adhered* to the treatment plan (e.g., about medication, plans for future contact). The aim is to gain a detailed understanding of the relationship between how the activities and information were discussed at discharge and the patients' reports of their recall and adherence.

Besides providing a guide for what interviewees asked about at home, the discharge conversations demonstrate current practice. Comparing these conversations to what the patients report in the later interviews may offer insight into what could constitute best (or better) practice in discharge conversations (e.g., how physicians structured the talk, how they secured the patient's understanding, what materials might have been helpful for recall, cues in the discharge conversations that the patient might not adhere to some of the proposed activities).

Feedback: Discussion on preliminary results and definitions of recall and adherence to treatment plan.

Session 6A New trends

Don't throw the paternalist out with the bathwater

Anniken Fleisje

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The shift from medical paternalism to patient-centeredness and respect for patient autonomy has brought obvious advantages for patients. However, has paternalism acquired an undeservingly bad reputation in the process?

For the present study, I reviewed approximately 200 videorecorded doctor-patient encounters. 18 were identified as cases where the doctor displayed a paternalistic communication style by pushing the patient to a treatment course s/he expressed reluctance towards. Based on these cases, four main types of paternalists were identified. In addition to the 18 cases of paternalism, a few encounters stood out as cases where the doctor could – and maybe should – have taken on a *more* paternalistic approach. This set of cases was used to characterize a fifth "paternalist type." I will sketch out the five paternalist types and engage in a normative discussion on the strengths and weaknesses of each, with the aim of answering the following question: What characterizes a good paternalist, and what characterizes a bad one?

I argue that by banning paternalism altogether, we risk throwing the baby out with the bathwater. Instead, we should discuss how doctors can display good paternalism. This does not imply a return to "old school" paternalism with questionable use of power on the doctor's part, but a "new school" paternalism consistent with respect and sensitivity towards patients and their needs.

Curiosity as a core quality for meeting each patient: Revealing tacit knowledge of physicians and patients

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For physicians, curiosity makes the difference between "automatic pilot" practice and expecting to meet a new challenge, a new learning opportunity, and a new person in each encounter. Medical associations have recognized curiosity as a desirable attribute of medical professionalism, and experts have pointed to the healing potential of this quality, calling for empirical studies.

We have developed an interdisciplinary research proposal focused on how physicians' curiosity is understood in the medical field and what it looks like in the medical interaction, why it is of value for physicians' practice and continuous learning, and how to nurture it. One study within this proposal aims to elicit the tacit knowledge on curiosity of physicians and patients, as from their own experiences. To boost integration and elicitation of physicians' and patients' views, we plan to take a completely novel approach. Such approach lies on the idea that we can capture a deeper understanding of a phenomenon if participants can (i) live it together, (ii) reflect together on it, (iii) bring to light their meaning-making processes.

We will invite dyads of physicians and patients to do three activities:

1.   We will conduct semi-structured, qualitative, individual interviews. With physicians, we will explore (a) how they understand curiosity, (b) the sources and influences on their curiosity, (c) what they think is the value of curiosity. For patients, we will explore (a) their lived experiences with physicians showing curiosity for them, (b) the related perceptions and influences on their own behaviours, and (c) the expectations for physicians' curiosity.

2.   Based on Participatory Action Research, and informed by "improvised participatory theatre", we will video-record the physician and the patient in a role-play together, in which they act as themselves – extemporaneously- within a curiosity-rich simulated scenario. The scenarios will be based on clinical cases and the previous interviews.

3.   The physician and the patient will have the opportunity to participate in a joint interview, in which they can share their feelings, thoughts and perceptions about the curiosity-oriented interactions, where the video of the simulated interaction will be actively used to discuss specific moments in the interaction.

This third part of the study is the innovation. Our goal will be to anchor the joint interview on a tangible shared lived experience, to facilitate the expression of the internal processes behind specific experiences and stimulate a shared reflection on lived experiences of physicians' curiosity so to create a common meaning of the phenomenon.

For OCHER, we would like specific feedback on the simulation activity + joint interview with video-elicitation design, particularly what value/opportunities OCHER colleagues see in the approach, what challenges we should consider, and whether others have familiarity with this or similar approaches.

Session 6B Professional development (1)

Trustworthy management in hospital settings. A systematic review

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Background: Trustful relationships play a vital role in successful organisations and well-functioning hospitals. While this relationship between patients and providers has been widely studied, trust relations between healthcare professionals and their supervisors have not been emphasized.

Methods: We searched 10 databases up until Aug 9, 2021. Empirical studies written in English, undertaken in a hospital or similar setting, and addressing trust relationships between healthcare professionals and their superiors were included, without date restrictions. Records were independently screened for eligibility by two researchers. A narrative approach, which involves textual and tabular summaries of findings, was undertaken in synthesizing and analysing the data. Risk of bias was assessed independently by two researchers using two critical appraisal tools. Most of the included studies were assessed as acceptable, with some associated risk of bias.

Results: Of 7414 records identified, 18 were included. 12 were quantitative papers and 6 were qualitative. The findings were conceptualized in two categories that were associated with trust in management, namely leadership behaviours and organizational factors. Most studies (N=15) explored the former, while the rest (N=3) additionally explored the latter. Leadership behaviours most commonly associated with employee's trust in their supervisors include a) different facets of ethical leadership, such as integrity, moral leadership and fairness; b) caring for employee's well-being conceptualized as benevolence, supportiveness and showing concern and c) the manager's availability measured as being accessible and approachable. Ethical leadership, caring for employees' well-being, manager's availability, competence and an empowering work environment are characteristics associated with trustworthy management.

Discussion: A leader without trust is paralysed. Without trust, people will not listen to a leader, so trust is important in all kinds of management. In the health services, the relationship of trust between employees and managers becomes even more complicated. Managers depend on the trust they receive from employees to be able to lead. The employees depend on the trust they receive from the patients to be able to do their job - diagnosis, treatment and follow-up. And patients depend on trust to be heard and to meet their needs. In other words, there is a triangular relationship between management, patients and health professionals. Future research could examine whether health professionals need more autonomy than other employees; or other relationships of trust between management, patients and health professionals.

Deaf people and health care consultations. Introduction to a discussion
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In Norway, close to 300 000 persons have hearing disabilities, and 5000 of these are deaf. It is estimated that 16500 persons use sign language. They use various methods to communicate with their health care providers, e.g. sign language interpreter, lip reading and written communication. Having been a supervisor on a medical student's (Hanna Gravem) research thesis investigating how people who are deaf or hard of hearing experience digital and physical health care consultations, has inspired me to raise this as a topic for discussion. What is needed in terms of research and education to improve clinical communication with this group.
A main finding in the thesis (N=130) was that the respondents clearly preferred physical consultations over digital consultations. They also gave physical consultations a significant higher score on the Communication Assessment Tool (CAT, physical 34% excellent vs. digital 20% excellent, difference 13,5%-points, 95% confidence interval 7 to 19). This also shows that people who are deaf or hard of hearing have a lower CAT score than what is usually reported by other groups.

There was a large increase in digital consultations during the Covid-19 pandemic and the prediction is that there will be more digital consultations in the future. Given the findings in the thesis, this could be an additional challenge for people who are deaf or hard of hearing. But also, the skills needed for physical communication should be looked at. It can not be expected that all health care personnel should learn sign language and identifying which skills that are needed and how they can be learned is relevant to discuss.

Session 7A Patient support initiatives

Talking About Macular Degeneration: Improving Communication with a Question Prompt List

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Background: Age-related macular degeneration (AMD) is one of the principle causes of irreversible visual impairment in the older adult population. This vision-threatening condition often requires ongoing treatment and monitoring to control disease activity. The impact of the disease and treatment on the daily lives of patients is significant. It is therefore important to ensure that patients are well-informed and receive guidance when needed.

Earlier research: Our recent research shows various shortcomings in patient-provider communication during the entire AMD care trajectory. Many patients experience that information about the long-term and invasive character of treatment is unclear. Moreover, the majority did not receive (timely) information about the possibilities of visual aids and rehabilitation. Patients also reported that they are not consistently involved in treatment decisions and do not always dare to ask their healthcare provider questions.

Study aim: To improve information provision and communication, we will develop and test the Question Prompt List (QPL) 'Talking About Macular Degeneration'. With the QPL, we also aim to stimulate shared decision-making between patients and healthcare providers.

Methods: The research consists of four phases: (1) We will collect the communication needs, experiences and wishes of patients with AMD using a systematic literature review and questionnaire; (2) Together with patients, informal caregivers and healthcare providers, we will design the QPL by means of focus groups and validate the tool using cognitive interviews; (3) We will analyse the effect of the QPL using video recordings of consultations; and (4) We will investigate strategies to stimulate and support the implementation of the QPL in practice.

Results and discussion: We will present the results of the first research phase. We would like to discuss how these results can be applied to the next phase: the design of the QPL.

Personalised self-management support programme for diabetes and coronary heart disease: P-SUP study protocol and experiences with implementation during Covid-19 pandemia

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Objective. Disease management programmes successfully help patients in dealing with their disease. Nonetheless, patients could benefit from these programmes even more by enhanced self-management. This project aims to support patients with type 2 diabetes and coronary heart disease in a multimodal stepped care programme funded by the German Innovation Fund (8.5 million Euro). The Innovation Fund is administrated by the Federal Joint Committee (G-BA), which is in charge for deciding which healthcare services are covered by the German statutory health insurance funds.

Methods. The programme comprises peer support groups (PSG) with weekly meetings for joint physical activity and monthly sessions focussing on subjects including nutrition and motivational support. The PSG leaders are patients with one or both of the above-mentioned diseases trained by the project group. In the PSG meetings, they will support health behaviour changes together with experts. Additionally, an online platform will be established, personalised for PSG attendees and PSG leaders. It will provide evidence-based information on physical activity, nutrition and motivational support. Furthermore, patients will receive personalised feedback reports by their general practitioners. Patients with decreased health literacy and low activation level additionally receive (bi-)monthly telephone coaching by trained mentors. Elements of the coaching are: Motivational Interviewing, Shared Decision Making, Collaborative Goal Setting, development and implementation of intention.

Results. The study protocol for a multicentre randomised controlled trial with 1001 patients and the experiences with the implementation during Covid-19 pandemia will be presented. Primary endpoint is the number of hospitalisations.

Conclusion. If the programme is successful, the G-BA will consider its implementation into routine care.

Session 7B Professional development (2)

Barriers and enablers for e-learning among pharmacy employees

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The use of over the counter (OTC) analgesics has increased considerably among Norwegian adolescents the last years. Pharmacy employees have an important role in identifying the customer's needs and contributing to the correct use. In this role good communication skills are important. To meet the challenges with increasing OTC drug use among adolescents, all pharmacies in Norway have committed to a digital training intervention in September 2022. The intervention, referred to as «Bransjefelles løft – Ung kunde», consists of two video lectures followed by discussion exercises. The first video focuses on the overuse of OTC analgesics among adolescents and the need for guidance at the pharmacy. The second video presents tips on how to initiate a dialog with adolescents who want to buy OTC. Despite the increasing use of e-learning, there is still limited evidence on how and when it works. This pilot study is aimed to identify barriers and enablers for e-learning among pharmacy employees completing the training intervention «Bransjefelles løft – Ung kunde».

Materials and methods
All pharmacy employees will be encouraged to answer electronic questionnaires before and after the training intervention. Furthermore, pharmacy employees in selected pharmacies will be observed during the training and interviewed before and after the intervention. The questionnaires and interview guides focus on the pharmacy employees' current practices and experiences in customer meetings with adolescents, as well as their expectations and satisfaction with the training intervention. In addition, electronic questionnaires will be distributed to adolescents to explore their attitudes, expectations, and satisfaction with their meetings with pharmacy employees.

Our focus at OCHER
We would like to discuss the interpretation of our preliminary results and potential implications for future digital training interventions and consecutive studies.

Task-shifting using videoconferencing technology - developing learning resources for digital peer-supervision

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Background: Chronic leg ulcers are the largest group of treatment-requiring wounds. Among patients over the age of 65, the prevalence of foot and leg ulcers is 5%. The incidence of wounds is assumed to increase in line with the aging population. Older people may have complex health challenges. Diabetes, cardiovascular and lung disease plays a significant role in wound development and healing. Moreover, severe wounds can lead to dysfunction and reduced quality of life and entail large socio-economic costs.

Task shifting consists of delegation and (re)sharing roles between health professions or shifts from professionals to patients and their carers or machines[1]. The use of video consultations connecting specialist- and municipal healthcare services can enable effective interdisciplinary collaboration and has the potential to facilitate competence sharing, user involvement, and consequently task-shifting in the long term, thus increasing the continuity and overall quality of the provided wound care. However, relatively few health professionals have been formally trained in peer supervision using videoconferencing technology. The main feature of the successful implementation of collaborative practice is good communication between teams[2].

Aim: This project involves wound care in the municipal health care system; supported by specialized personnel situated at an outpatient clinic, using real-time video communication[2]. It is selected as a pilot in the EU-project TaSHI - Empowering EU health policies on Task SHIfting which is co-funded by the 3rd Health Programme of the European Union[3]. To achieve task-shifting there is a need for health professionals to develop peer-supervision skills, and the particular part of this project aims to develop tailored learning resources for digital communication skills and supervision training. We have identified relevant learning outcomes based on a workshop with stakeholders, but have not yet determined appropriate methods for this development.

Our focus on OCHER: We would like to present and discuss the project with a methodological lens, hoping for feedback about the development and scope of such resources, as well as evaluation methods.

Plenary abstract 2: Making care fit

Patient and clinician efforts of making care fit

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INTRODUCTION. Care plans are often designed for 'patients like this', rather than for 'this patient'. Patients and clinician can work together to make care fit for each person. This mostly takes place during clinical encounters at the **point of care**. As patients implement the plans in their personal environment, they work to make care fit at the **point of life**. The patient is usually the one person bridging these two worlds, and whatever is left undiscussed with their clinician at the point of care, is also left unconsidered when designing care plans. This in turn leads to care plans patients do not need, want, or implement well, a result that is both wasteful and harmful.1
We aim to understand what it actually means when patients and clinicians work together to make care fit. That is, we aim to understand the concept of making care fit, and the occurrence of efforts to make care fit, both in extant research and in clinical practice.

METHODS. In this research line, we have three current projects. 1) In the last year, we organized expert meetings with patients, caregivers, clinicians, researchers, policy makers, quality improvement specialists and healthcare designers. Together, they wrote the 'Making care fit Manifesto', identifying and reflecting on the necessary conditions for making care fit for each patient. 2) We conducted a systematic literature review, looking for measurement instruments and items to assess dimensions of making care fit, and to identify relevant (measurable) behaviours. 3) We qualitatively analysed encounters between patients with diabetes and their clinicians.

RESULTS. The expert 'Making care fit collaborative' identified 8 dimensions relevant to making care fit (dimensions 1-7 and 9 in the Box). In the systematic review, we included 189 of 13.338 papers, reporting on the use of 1243 measurement items from 151 measures. Most items focused on the content of patient-clinician collaboration (dimension 5) and the act of informing. We identified one additional dimension (dimension 8 in the Box). The encounter analyses are ongoing, and we expect to have reached data saturation late autumn. Data suggests that the dimensions and their descriptions will need to be adjusted based on how patients and clinicians collaborate in clinical practice.

DISCUSSION. The three studies focus on the conceptualization of making care fit and its occurrence in extant research and clinical practice, each from a unique perspective: expert opinion, scientific literature and clinical practice. We aim to combine the results of the three studies to draw a concept of patient and clinician collaboration to make care fit. We have recently secured funding for a 4-year project in which we will use survey-, photovoice- and video-reflection techniques to uncover best ways to support young adults with type 1 diabetes and their clinicians in making care fit. During OCHER, we would like to work together with communication experts in drafting our conceptual model, which will be the base of the upcoming PhD project and, hopefully, for many other projects to follow in this line of research.