

## **3<sup>rd</sup> OCHER workshop on Clinical Communication Research**

**January 15-17, 2014**

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

The aims of OCHER workshops are two:

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

### **Program**

Start: Wednesday 15 January, 10:00

End: Friday 17 January, 16:00

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

Address: Gamleveien 88

1476 Rasta

Telephone: +47 66 10 97 00

### **International guest lecturers and group moderators:**

**Mary Catherine Beach, MD, PhD, associate professor, Johns Hopkins University, Baltimore, USA.**

[http://www.jhsph.edu/faculty/directory/profile/4004/Beach/Mary\\_Catherine](http://www.jhsph.edu/faculty/directory/profile/4004/Beach/Mary_Catherine)

Beach conducts research on the theoretical foundations of respect and the impact of physician attitudes and patient-physician communication on patients in the primary care setting, in the treatment of HIV, and in the treatment of sickle cell disease.

**Paul Drew, sociologist, professor, Loughborough University, UK.**

<http://www.lboro.ac.uk/departments/socialsciences/staff/academicandresearch/paul-drew.html>

Drew uses conversational analysis to study both the basic practices and processes of ordinary social interaction, and the investigation of interaction in institutional and workplace settings; these include legal, educational, social welfare and especially medical interactions. Studies in the field of medicine include on cancer helpline calls; patient participation in decision making in oncology clinics; on seizure clinics; and on the assessment of dementia in memory clinics.

**Christopher Koenig, PhD, assistant professor, University of California, San Francisco, USA.**

<http://profiles.ucsf.edu/christopher.koenig>

Koenig is a conversation analyst who has done research on interprofessional communication and physician-patient communication in primary care and outpatient settings. He has looked into patient resistance, handoff communication and challenges in cross-cultural settings.

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

*Working languages: English, Scandinavian*

Contact information: **Pål Gulbrandsen**  
 Mobile/SMS: +47 9582 7288  
 Email: [pal.gulbrandsen@medisin.uio.no](mailto:pal.gulbrandsen@medisin.uio.no)

**Overview (abstracts follow below ordered by sessions)**

<b>Wednesday January 15</b>			
10:00	Mutual presentation of persons and projects. Aim of workshop.		
11:00	<b>Short coffee break — speak to people you don't know!</b>		
11:15	<b>Paul Drew:</b> An overview of the use of conversational analyses in medical interactions		
12:30	Plenary discussion: What can we learn from conversational analysis as a method		
13:00	<b>Lunch</b>		
13:30	Split in two groups		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>Session A1: Delicate interactions</b>  <b>Moderator: Gulbrandsen</b>  <b>Faculty: Drew, Koenig</b> </td> <td style="width: 50%; vertical-align: top;"> <b>Session A2: Decision making</b>  <b>Moderator: Svennevig</b>  <b>Faculty: Finset, Beach</b> </td> </tr> </table>	<b>Session A1: Delicate interactions</b> <b>Moderator: Gulbrandsen</b> <b>Faculty: Drew, Koenig</b>	<b>Session A2: Decision making</b> <b>Moderator: Svennevig</b> <b>Faculty: Finset, Beach</b>
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13:30	Heyn		
14:15	Mellblom		
15:00	Lindström / Iversen		
15:45	<b>Short coffee break — speak to people you don't know!</b>		
16:00	<b>Mary Catherine Beach:</b> The use of mixed methods to study clinical effects of communication in medicine		
17:00	<b>Group walk discussions, ending up at Pål's home for a get together with a drink and a snack, singing, and having fun</b>		
20:00	<b>Dinner at the hotel</b>		

<b>Thursday January 16</b>		
08:30	<b>Session B1: Language barriers</b> <b>Moderator: Finset</b> <b>Faculty: Svennevig, Drew</b>	<b>Session B2: Teaching communication</b> <b>Moderator: Gulbrandsen</b> <b>Faculty: Beach, Koenig</b>
08:30	Svennevig	Sundling
09:15	Gerwing	Steinsbekk
10:00	<b>Short coffee break</b>	
10:15	Skjeggestad	Bardel et al
11:00	<b>Christopher Koenig:</b> Verbal and embodied interactional practices for recommending treatment in urgent primary care visits	
12:00	<b>Lunch</b>	
12:45	<b>Paul Drew:</b> Patient initiatives in diabetes and ENT (ear-nose-throat) oncology clinics	
13:45	Plenary discussion: Challenges at the crossroads of methods	
14:15	<b>Short coffee break</b>	
14:30	<b>Session C1: Openings</b> <b>Moderator: Finset</b> <b>Faculty: Drew, Beach</b>	<b>Session C2: System evaluation</b> <b>Moderator: Gulbrandsen</b> <b>Faculty: Svennevig, Koenig</b>
14:30	Landmark Dalby	Andersen
15:15	Wingard	Waidtløw
16:00	Holmström	Broström / Hrubos-Strøm
16:45	<b>Short coffee break</b>	
17:00	<b>Mary Catherine Beach:</b> How can we study the effect of respect and empathy on medical outcomes?	
18:00	<b>End of day</b>	
19:00	<b>Dinner at the hotel</b>	

<b>Friday January 17</b>							
08:30	<b>Christopher Koenig:</b> Negotiating patient-centered communication in type 2 diabetes visits: An exploratory mixed-methods study						
09:30	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>Session D1: System improvement</b></td> <td style="width: 50%;"><b>Session D2: Caring</b></td> </tr> <tr> <td><b>Moderator: Gulbrandsen</b></td> <td><b>Moderator: Finset</b></td> </tr> <tr> <td><b>Faculty: Svennevig, Drew</b></td> <td><b>Faculty: Beach, Koenig</b></td> </tr> </table>	<b>Session D1: System improvement</b>	<b>Session D2: Caring</b>	<b>Moderator: Gulbrandsen</b>	<b>Moderator: Finset</b>	<b>Faculty: Svennevig, Drew</b>	<b>Faculty: Beach, Koenig</b>
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<b>Faculty: Svennevig, Drew</b>	<b>Faculty: Beach, Koenig</b>						
09:30	Hafskjold						
10:15	<b>Short coffee break</b>						
10:30	Vatne						
11:15	Skirbekk						
12:00	<b>Lunch</b>						
12:45	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>Session E1: Difficult tasks</b></td> <td style="width: 50%;"><b>Session E2: Patient understanding</b></td> </tr> <tr> <td><b>Moderator: Svennevig</b></td> <td><b>Moderator: Finset</b></td> </tr> <tr> <td><b>Faculty: Beach, Gulbrandsen</b></td> <td><b>Faculty: Drew, Koenig</b></td> </tr> </table>	<b>Session E1: Difficult tasks</b>	<b>Session E2: Patient understanding</b>	<b>Moderator: Svennevig</b>	<b>Moderator: Finset</b>	<b>Faculty: Beach, Gulbrandsen</b>	<b>Faculty: Drew, Koenig</b>
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<b>Faculty: Beach, Gulbrandsen</b>	<b>Faculty: Drew, Koenig</b>						
12:45	Korsvold						
13:30	Damsgaard						
14:15	<b>Short coffee break</b>						
14:30	Kale						
15:15	Future studies – potential for collaboration – multicentre studies – joint proposals? Chairs: Arnstein and Pål						
15:45	Round-up and evaluation						
16:00	<b>End</b>						

# Abstracts

## *Session A1: Delicate interactions*

### **Talking about emotion in follow-up cancer consultations. A case study combing different methods**

*Lena Heyn*<sup>1</sup> & *Arnstein Finset*<sup>2</sup>

<sup>1</sup> Lovisenberg Diakonale Høgskole, Oslo

<sup>2</sup> Department of Behavioural Sciences in Medicine, Institute of Basic Medical Sciences, Faculty of Medicine, University of Oslo,

**Background.** In follow-up consultations in cancer care, patients often express emotional concerns. These concerns may be related to fear of relapse or to other stressful themes. It is considered important that physicians and other health personnel help patients handle the emotional aspects of their disease. Different methods, both quantitative and qualitative ones, have been applied to investigate emotional communication.

**Objective.** The object of the present presentation is to examine if a combination of different methods may give an enriched picture of sequences of emotional communication not accomplished by each method alone.

**Methods.** For this presentation one consultation with a female cancer patient was chosen as an example from a dataset of 105 video recorded out-patient follow-up consultations in a major university hospital in Norway.

Three methods were applied to explore communication in the consultation:

1. Verona Coding Definition of Emotional Sequences (VR-CoDES). Quantitative data from VR-CoDES analyses have been published in peer reviewed journals.
2. Conversation Analysis (CA)
3. Recording of electrodermal activation (EDA)

**Results.** Five cues and three concerns were coded in the consultations. The oncologist gave little room for further disclosure of emotions expressed by the patient. In one segment of the consultation with two concerns and two cues CA analysis indicated conflicting preferences in the oncologist's responses. The EDA analysis indicated increasing EDA level during the patient's expression of her concerns.

**Discussion.** While VR-CoDES analyses render data on the number and nature of cues and concerns, a CA approach may provide a richer picture of the interactional dynamics. EDA data may give an indication of the level of activation during the sequences. The way in which the three different methods may contribute to a richer understanding of emotional communication will be discussed.

## **Patterns in talking about emotional concerns in follow-up consultations with adolescent childhood cancer survivors**

*A.V. Mellblom<sup>1</sup>, L. Korsvold<sup>1,2</sup>, H.C. Lie<sup>1</sup>, Loge<sup>1,2</sup> & A. Finset<sup>1</sup>*

<sup>1</sup> Department of Behavioural Sciences in Medicine, Institute of Basic Medical Sciences, Faculty of Medicine, University of Oslo, <sup>2</sup> National Resource Centre for Late Effects after Cancer Treatment, Oslo University Hospital, Radiumhospitalet, Norway, <sup>3</sup>Department of Paediatrics, Oslo University Hospital, Rikshospitalet, Norway.

**Background.** The majority of childhood cancer survivors appear to adjust well to life after cancer. However, a subgroup of survivors struggles and expresses a number of concerns to their oncologist at follow-up consultations. We know little of the patterns in which emotional concerns occur at follow-up and what the clinical practices are when emotional concerns are expressed.

**Objective.** This study aimed to explore patterns in how adolescent and their oncologist communicate about emotional concerns.

**Methods.** Sixty-six follow-up consultations between adolescent survivors of cancer and their oncologist were video-recorded and coded using Verona Coding Definition of Emotional Sequences (VR-CoDES). The seven consultations with many cues and concerns (7 or more) are being studied in closer detail according to methods and sequential approach of conversational analysis (CA) in order to explore the sequential patterns associated with emotional talk. The preliminary analysis of seven consultations with many cues and concerns focus on the forms through which the emotional concerns is expressed, and responded to (turn design), and the sequential patterns associating with initiating and disclosure of emotion.

**Results.** Results from this study will be presented in the OCHER conference

## **Dignity in action: A pilot study of encounters between older people and professionals in health care settings**

*Anna Lindström and Clara Iversen*  
Uppsalas Universitet, Sweden

Dignity is derived from the Latin dignus (worthy) and dignitas (merit) and means worthy of merit. In care for older people, dignity of identity is of special import. This is the dignity that we attach to ourselves as autonomous persons with a life history and relationship to others and it changes over time as we age. When older persons become more dependent on others to manage their everyday lives their dignity of identity can be threatened. The importance of social interaction for attending to dignity is underscored in interview research as well as in health care policies, legislation, and institutional guidelines. However, qualitative standards for upholding dignity are difficult to specify. To fully appreciate how health services can be delivered in ways that promote dignity of older people, interactional observational research is needed to compliment and extend existing findings. The aim of the proposed project is to explore the tacit, craft skills through which dignity is attended to, enacted, and accomplished in situ within the details of talk and social interaction. To this end, we will draw on documentaries from the Swedish Media Data base to build a corpus of video-clips of interactions between older people and staff in a range of health care settings. Social scientific methodologies will be applied to analyze these data collaboratively within group constellations that include researchers and stakeholders. We have recruited an international expert to ensure that our work resonates with international state of the art. In-depth research reviews, data analysis, and other collaborations in this project are expected to provide the foundation for a research application for an innovative interdisciplinary study of dignity in action based on new recordings of older people's care across a range of different settings.

## *Session A2: Decision making*

### **Identification, classification and distribution of clinical decisions in 380 hospital encounters**

*Eirik Ofstad, Edvin Schei, Jan C. Frich, Pål Gulbrandsen*

Akershus University Hospital, University of Bergen and University of Oslo

**Introduction:** Decision making is a key activity in health care and clinical decisions are central outcomes of patient-physician encounters. Although the importance of decisions and decision making-processes in medicine is widely accepted, the term decision is poorly defined and the word's meaning implicitly taken for granted in everyday language. To better understand how decisions affect medical encounters, we aimed to identify all signs of clinical decisions as they emerged as communicative actions, in order to classify them and describe how they are distributed across patient-physician encounters.

**Method:** Building on previous work by Braddock et al (1), we developed the tool DICTUM (The Decision Identification and Classification Typology for Use in Medicine) through a content driven iterative process informed by the experiences and perspectives of four doctors. The material comprised 380 videotapes with 71 doctors from eight specialties in a Norwegian general hospital.

**Results:** At the OCHER workshop we aim to present results from all 380 videos. In a subset of the 100 videos coded so far we found an average of 13 decisions per encounter. This is about four times as much as the number of decisions identified in other studies (1-3). The main reason for this is that we have developed and applied a broader definition of what is a clinical decision. DICTUM categorizes decisions according to ten topical categories (gathering information, simple evaluation, defining problem, drug-related, intervention, legally related, contact related, advice and precaution, treatment goal and deferment) and three temporal categories (past, present, future). Detailed presentations of how decisions are distributed in hospital encounters from three different settings (outpatient, ward round and emergency room encounters) will be presented.

**Discussion and implication:** Applying DICTUM to video-taped patient-physician encounters makes it possible to identify clinically relevant decisions. As expected, doctors convey a large amount of decisions during an encounter and we would like to discuss;

- (We will never stop asking) Is the typology presented sensible/acceptable?
- What do you think of the numbers presented? Do they give an impression of hospital encounters which concurs with your experience?
- Which variables in our data set do you think it could be interesting for us to look further into?

1. Braddock CH3rd, Fihn SD, Levinson W, Jonsen AR, Pearlman RA. How doctors and patients discuss routine clinical decisions: informed decision making in the outpatient setting. *J Gen Intern Med.* 1997;12:339-45.
2. Braddock CH3rd, Edwards KA, Hasenberg NM, Laidley TL, Levinson W. Informed decision making in outpatient practice: time to get back to basics. *JAMA.* 1999;282(24):2313-20.
3. Clayman ML, Makoul G, Harper MH, Koby DG, Williams AR. Development of a shared decision making coding system for analysis of patient-healthcare provider encounters. *Patient Educ Couns.* 2012;88:367-72



## **Shared decision making and health technology: The development and feasibility testing of a webbased decision aid for patients diagnosed with hip osteoarthritis**

*Espen Brembo*

Buskerud University College, Drammen, Norway

**Background:** Osteoarthritis (OA) of the knee or the hip is a prevalent source of pain and disability in elderly individuals (1). There are not currently any therapies that are known to stop or reverse the progression of OA, so treatment of the disease is largely centred on self-management strategies (2). Common treatments for early stage OA include physiotherapy, weight-loss, physical exercise and pharmacotherapy. At a later and more severe stage of the disease, joint replacement surgery is the standard (3–7). The optimal timing of these treatment choices can be difficult to make, as each individual have different prerequisites and motivation for managing behaviour change depending alternatives. Patients describe a constant struggle to make minimal use of drugs and maximum use of other management strategies such as resting and avoiding activities, in line with the belief that exercise increases the wear and tear of the joint (8). Patients express that their practitioners act as technicians, paying more attention to the knee than to the individual, and that not enough time is spent on information and counseling. Physicians emphasize the difficulty in elaborating treatment strategies and the need for a tool to help in treatment choice (9). Providing patients with the information they want at the time they want remains a challenge.

Patients' needs for information may be underestimated, or alternatively, the amount of provided information may be overestimated. The use of a difficult language characterized by medical terminology or jargon can also serve as a barrier for the patients understanding of the given information. Further, patients may be reluctant or otherwise feel unable to ask questions (10).

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

**Methods:** The study will involve a mixed methods approach and planning of the intervention will be guided by the steps described in the intervention mapping protocol (11). The first part of this study is approved by the regional ethics committee and will involve a qualitative evaluation study. Patients (N=14) experiences in living with hip osteoarthritis, health literacy skills and decision making aspects will be explored in individual qualitative interviews. Interaction with their GP's (7) and orthopaedics (N=7) will be observed using participant observation of clinical consultations. The second part will be based on results from the first part-study and will involve a detailed description of the iterative development-process of the web-based decision aid. The third part will explore the feasibility of the decision aid by exploring patients and health professionals experience and views on the usability of the web-based decision aid in decision making. To explore feasibility, video-recording of clinical consultations (N=20) and subsequent qualitative interviews with a sample of patients (N=5) and general practitioners (N=5) will be performed.

# Factors determining whether the parents accept BCG immunization of the new-born child in a high-income country

Gitte Thybo Pihl, PhD student

Health Services Research Unit, Lillebaelt Hospital/University of Southern Denmark

## Introduction:

In a large prospective randomised clinical trial in Denmark we are testing the hypothesis that compared to non-BCG-vaccinated infants, infants who are BCG vaccinated at birth experience less hospitalisations, use less antibiotics, and develop less atopic disease in early childhood.

My focus for this project is parents decision making and risk evaluation. I want to investigate how parents make their decision about letting their child get a BCG vaccination and how they evaluate the risk of side effects.

## Method:

Before the clinical trial was started, we conducted 5 focus groups with expectant mothers and fathers to discuss considerations for and against letting their newborn child vaccinate with BCG in order to achieve a non-specific stimulation of the immune system and to discuss their concerns about side effects.

The focus groups were analysed qualitatively.

## Results:

The pre-analysis of the results shows, that some danish parents are still concerned about non-described and non-specific side effects, even if the BCG-vaccine has been used for over 100 years and the side effects is well-described in medical research.

They express doubt about the medical descriptions of the side effects and wants to discuss it with a professional they trust before they can decide to let their child vaccinate with BCG or not.

I will show how parents try to make their own risk evaluation on the basis of a *lay epidemiology*, as described by Davison, Frankel and Davey Smith (1). They use their own interpretation of cases of illness and atopic diseases in their personal network and family to evaluate risk for their child to develop atopic diseases or get hospitalised. This lay epidemiologi forms the basis for their decision.

Davison C, Frankel S, Davey Smith G. Inheriting heart trouble: the relevance of common-sense ideas to preventive measures. *Health Education Research*1989;4:329–40

## ***Session B1: Language barriers***

### **Presenting complex information in installments**

*Jan Svennevig*  
University of Oslo

In conversations between first and second language speakers the parties often have to put in extra effort to assure mutual understanding. Especially when the second language speaker has limited proficiency in Norwegian, the interlocutor will have to adjust his or her language and style to that level of proficiency. In this presentation I will present one such adjustment in the speech of first language speakers, namely the practice of chunking complex information into smaller bits or “installments” (Clark 1996). The data come from video recordings of doctor-patient interaction (the AHUS corpus) and the method used is Conversation Analysis.

In doctor-patient interaction physicians will often need to inform the patient about a diagnosis or a treatment. The current analysis will address the question of how doctors speaking Norwegian as a first language present this information to patients with minority background in cases where understanding may potentially be at risk. They typically divide their turns at talk into shorter units that are produced with rising intonation, indicating that the turn will continue. After the unit is produced, the speaker pauses and monitors the interlocutor visually and aurally. This creates a slot for the interlocutor to provide evidence of hearing and understanding. This is displayed by the fact that interlocutors typically produce various acknowledgement tokens, both non-verbal (nods, gaze) and verbal (continuers, such as mhm, okay). However, they also get the opportunity to initiate repair at an early stage in the complex turn under production. Finally, they may also on some occasions fail to produce any such tokens, and this is treated by the speakers as indications of potential problems, leading them to revise or reformulate the prior contribution or ask explicitly for confirmation of understanding (understanding checks).

## Gestures as a semiotic resource in dialogues between hospital physicians and patients with limited Norwegian proficiency

Jennifer Gerwing

Akershus University Hospital

**Introduction:** Research on face-to-face dialogue has demonstrated gestures' capacity for conveying information that complements (and often supplements) speech. However, in the field of healthcare communication, the topic of hand gestures as a semiotic resource is relatively unexplored. Using an inductive approach, we adapted a framework from basic research to the healthcare setting. We will introduce our method and developing schema.

**Method:** From a database of videotaped in-hospital interactions, we selected eight with patients who had limited Norwegian proficiency. We combined Conversation Analysis and Microanalysis of Communication. To limit the scope of analysis, we focused on discussions of treatment plans. After identifying all physician gestures, we conducted a fine-grained analysis on those with potential for a semantic relationship to speech.

**Results:** Physicians used 332 gestures in the sequences analyzed, 160 of which were *semantic gestures* (i.e., those with a form related to the meaning conveyed in the accompanying speech). Of these, 66 had a *concrete referent*, including demonstrating actions (e.g., stretching, cycling) and indicating body parts or participants as their role in the plan was discussed. The remaining 94 depicted *abstract referents*, including indicating points in space to differentiate between concepts or alternatives, embodying metaphors (e.g., wiping the slate clean, reaching out), and abstracting motions (repetition, continuity). Deriving the meaning of these gestures depended on the accompanying speech, without which the gestures were potentially ambiguous.

**Discussion:** This analysis demonstrates that physicians use a rich array of semantic gestures. From a clinical perspective, awareness of the semiotic potential of gestures could encourage more strategic use and draw attention to patients' gestures. Gestures' integration with speech has implications for consultations in which there is a language barrier. From a research perspective, the method developed here opens the door to a variety of questions and provides a much-needed analytic starting point.

## **When a misunderstanding happens, how do immigrant doctors and their Norwegian colleagues handle them?**

*Erik Skjeggstad PhD. Student*  
HØKH, Akershus University Hospital

### **Background**

Sixteen percent of doctors working in Norway are foreign born and educated. Language barriers are commonly reported from doctors in their first practice. The Norwegian language is a challenge for most of these doctors in their initial work phase. We know less about other experiences and struggles during their first work practice in Norway. The aim of this study is to acquire insight about the experience of being an immigrant doctor in Norway.

The main research question for the study is:

How do immigrant doctors in Norway experience meeting their expectations and competence in practice, and is it possible to find strategies for how the quality of interaction in their professional practice can be further optimized?

### **Data and methodology**

We have done two qualitative interview studies. First, we interviewed 16 recently arrived foreign doctors in Norway. Furthermore, we interviewed 12 doctors, nurses, and health care leaders who have extensive experience in working with immigrant doctors.

We searched for common phenomena described by the participants in both studies. In particular, we looked for their strategies for coping with communication problems.

Analyses were done with a Giorgi inspired method for systematic text condensation.

### **Preliminary results**

Immigrant doctors say they are afraid to cause possible communication errors. Doctors are concerned about avoiding or reducing the negative consequences of situations that have caused errors or misunderstandings. It is unclear to doctors how their colleagues will react if they observe misunderstandings or errors.

Analyses of interviews with colleagues show that there seems to be no formal system for monitoring immigrant doctors during their first job. When immigrant doctors make mistakes or create misunderstandings, there are some strategies colleagues use. Some colleagues are aware when and how to use these strategies, but many of them do not.

### **Implications**

Feedback from colleagues appears to be random. This makes new immigrant doctors unsafe and also uncertain in dealing with situations where there is a risk of making mistakes or misunderstandings.

## ***Session B2: Teaching communication***

### **Person-oriented communication with elderly people (POKE)**

– *Development of research-based communication education for the bachelor programmes in nursing, optometry and radiography.*

*Sundling, V., Ruud, I., Hafskjold, L., Langeggen, I., Solheim, E., Vesterager, D., Eide, H.*  
Buskerud University College

#### **Introduction**

Communication is a core skill in person-oriented health care. Good communication is essential to disclose physical, emotional and spiritual needs and to improve medical care and social activities. Empathy is vital in all helping relations however; it is not sufficiently used in clinical practice. Mindfulness is important to be able to observe, describe and act effectively based on the perceived patient needs.

#### **Aims**

The aim of the study is to: (1) describe communication skills, empathy and mindfulness of bachelor students in nursing, optometry and radiography, (2) develop web-based video scenarios on one-to-one communication for student training and (3) develop a pre-practice course in communication using standardised patients

#### **Method**

Part 1 has a descriptive, quantitative design. Parts 2 and 3 have an experimental, quantitative design.

The study population is students in the bachelor programmes in nursing, optometry and radiography at Buskerud University College. The target population is students admitted in 2013.

In part 1, data on students' self-reported communication skills, empathy and mindfulness will be collected using three questionnaires: Ammentorp's "Klar tale med patienterne", Jefferson Empathy Scale and Langer 14-item Mindfulness Scale. Data will be collected at all 3 years of the bachelor programme.

Part 2 will use web-based scenarios to engage students in interaction with short video clips portraying an "analogue" older patient. The encounters will be video captured and saved for analysis of students' verbal and nonverbal communication. The study will be used as an evaluative indicator of change in communication skill performance.

In part 3 senior citizens will be recruited to act as "standardized" older adults in a theater based education using pre-set scenarios from health care in elderly. The student communication and interactions will be video-recorded and stimulated recall will be used to create reflective dialogue between the participating parties, peers, teachers, and simulated patients.

## **Følgforskning – revisjon av kommunikasjonsundervisning**

*Aslak Steinsbekk*

Norwegian University for Science and Technology, Trondheim

Ved medisinstudiet ved NTNU er det igangsatt arbeid for å revidere kommunikasjonsundervisningen. Blant flere ting skal Calgary-Cambridge modellene innføres som rammeverk for undervisningen og det skal legges mer vekt på hvordan innlæring av kommunikasjon skjer under uketjenesten i sykehus i 3. og 4. studieår. Arbeidet gjøres i samband med en gjennomgang av hele medisinstudiet som skal være ferdig til implementering fra studiestart høsten 2015.

I forbindelse med dette arbeidet er det under planlegging en studie om «effekten av og erfaringer med implementering av nytt opplegg for kommunikasjonsundervisning gjennom hele medisinstudiet». I utgangspunktet er det tenkt å bruke «realisticevaluation» som rammeverk. Denne metode er basert på realisme som filosofi, med en grunntanke om at det må settes opp mange såkalte «kontekst + mekanisme= resultat (KMR)» konfigurasjoner. Enkelt fortalt betyr det at ulike virkemidler må tilpasses ulike situasjoner og resultatet av disse må måles hver for seg. Det betyr at man må identifisere slike KMR konfigurasjoner for å evaluere hvilken betydning revisjonen har hatt.

I presentasjonen blir det er nærmere beskrivelse av «realisticevaluation» og tanker om hvordan et slikt følgeforskningsprosjekt kan se ut. Det vil også bli lagt opp til diskusjon for å få innspill.

# Är patienterna mer nöjda efter en konsultation hos en student med handledare med fördjupad konsultationsutbildning?

*Annika Bardel, Karin Björkegren, Bo Karlsson, Per Kristiansson*  
Uppsalas Universitet, Sweden

## **Syfte**

Att fördjupa lärares konsultationsmetodik för ökad konsultationsförmåga hos studenterna. Att studera effekter hos mottagare, patienter och studenter med i Norge och USA validerad metod.

## **Bakgrund**

Primärvårdens patienter har osorterade symtom, som kan vara del i något beskedligt eller allvarligt sjukdomstillstånd. Det ställer andra krav vid konsultationen än vid möten med patienter med redan diagnosticerad sjukdom.

Kommunikationen mellan läkare och patient är avgörande för hur väl patienten följer överenskomna ordinationer. Nuvarande kommunikationsträning på Allmänmedicinkursen bygger sedan 2006 på "Patientcentrerat arbetssätt". Över 200 handledare i primärvården har genomgått utbildning med videospelade patientsamtal. Ökande krav inom primärvård ger behov av förstärkt kommunikationsträning med fördjupad konsultationskurs för handledarna. Metoden "Fyra goda vanor" är prövad i Norge med gott resultat på sjukhus med sjukhusläkare. Vi planerar utöka arbetet kring konsultationen även till andra professioner inom primärvården. Det medför att studenterna får möta andra i sjukvården än primärvårdsläkare som använder dessa konsultationsmetoder. Att studenterna i hög grad lär sig för att klara examinationerna är känt. Videospelning av konsultationer är en vedertagen metod för utvärdering och används vid Köpenhamns universitet med gott resultat.

## **Frageställning**

Är patienterna mer nöjda efter en konsultation hos en student med handledare med fördjupad konsultationsutbildning?

## **Metod**

40 studenter på Allmänmedicinkursen genomgår vårdcentralplacering och väljer ett patientsamtal som videofilmas. Data från filmerna kodas och bearbetas för att få en uppfattning om spridningsmått. Vidare rekryteras 40 lärare, varav 20 utbildas enligt "Fyra goda vanor". På senare Allmänmedicinkurs utses hälften av de inkluderade studenterna till handledare med, respektive utan fördjupad konsultationsutbildning. Studenterna videofilmar patientmöten som analyseras. Resultaten mellan studentgrupperna jämförs.

## **Betydelse**

Studien kan öka kunskapen om integrering av samtalsmetodik och klinisk träning under primärvårdsplaceringar, vilket är av betydelse för att utveckla studenternas yrkesroll.



## *Session C1: Openings*

### **Opening up negotiation: formulating patients' stance towards treatment**

*Anne Marie Landmark Dalby*  
Akershus University Hospital

According to Makoul & Clayman (2006), “patient values/preferences” is a core element across definitions of shared decision making. However, fewer studies have explored ways in which patients' values and preferences are disclosed and oriented to, turn-by-turn in medical interactions. The aim of this ongoing study is to explore one resource physicians seem to use to make explicit patients' preference or stance towards specific treatment options; what might be described as *formulations of patients' stance*. Formulations have been identified as a resource in which speakers can summarize or explicate some parts of the conversation thus far to make explicit what has previously only been implicit (Heritage 1985). In this paper I broaden the sources for such formulations to also account for conversations from previous meetings (e.g. information noted in the chart).

Preliminary analyses suggest that physicians' formulations are oriented to the nature and strength of the patients' stances in that they seem geared towards slightly different courses of action: Formulations of *active wishes* for a specific treatment tend to be followed by active pursuits of patients' rationale (e.g. through direct questions) and/or by challenges of patients' treatment wishes. These efforts seem to work primarily towards altering or changing the patient's stance and in that way open up for negotiation on other treatment options. Formulations that on the other hand portray patients' stances as *reluctant or sceptical* towards a recommended treatment, tend to be followed by a more passive and limited pursuit of rationale or possible concerns, typically through minimal responses or pauses. Physicians instead seem to proceed by introducing additional evidence supporting their recommendation. This course of action may work to convince the patient to commit to the recommended option, and towards closing the negotiation.

The analysis so far suggests that formulations of patients' stance work as a powerful resource to get patients' preferences and underlying rationales on the table. This seems to be a crucial first step for working towards a decision about treatment.

## **The Blood Sugar Solicitation Sequence: An Opening Inquiry to the Diabetic Patient about Relative Blood Sugar**

*Leah Wingard*

San Francisco State University, California, USA

This paper analyzes a recurrent opening sequence in the type II diabetic visit between doctors and patients in which the doctor asks the patient about his or her current blood sugar levels. We call this sequence the: Blood Sugar Solicitation (BSS) sequence. The BSS sequence occurs at the beginning of the visit or at the start of the diabetes component of the visit and is consequential because it initiates talk about diabetes by topicalizing the patient's own measurement of blood sugar. When patients respond with normative blood sugar levels by providing evidence of having regularly checked blood sugar levels or a log with the numbers, and physicians can assess these levels as medically unproblematic, the physician is likely to move to a next activity, thereby closing the sequence and forwarding the overall progressivity of the visit. However, when patients respond to the inquiry with an assessment rather than the numbers themselves, or demonstrate not knowing the day-to-day blood sugar levels, the sequence is expanded. Through analysis of this sequence, we show that the BSS sequence is one technique that physicians regularly use to pursue a biomedical agenda and assess the patient's blood sugar levels. In this work we consider how the expansion of the sequence can be relevant for enacting patient centeredness in the diabetic visit as physicians assess and discuss blood sugar numbers with patients and help patients manage the complexities of life with a chronic illness.

## **Safe and unsafe communication practices in calls to Swedish Healthcare Direct**

*Inger K. Holmström*

Mälardalen University College, Västerås, Sweden

Telenursing is a rapidly expanding actor in the Swedish healthcare system, as in other Western nations. Currently, the national Swedish telenursing helpline Swedish Healthcare Direct (SHD) employs 1500 nurses and handle more than 6 million calls per year. The telenurses assess the callers' symptoms, refer the caller to appropriate healthcare provider to optimize healthcare resources, or give self-care advice. Although rare, adverse events occur also within this healthcare context, reminders of the importance of giving patient safety the highest priority. As telenurses' main sources of information are their dialogues with the callers, the provision of safe care depends on the quality of this dialogue. Hence, the aim of the present study is to analyse and compare the communication in malpractice claimed calls with "ordinary calls" which have not resulted in a malpractice claim. The ultimate goal with our large project about safety in telenursing is to establish the characteristics of good and safe communication practice in this context, to enable learning and clinical development. We conducted RIAS-analysis of the authentic communication from audio recordings of all malpractice claimed calls to SHD during 2003–2010 ( $n = 33$ ) and control calls. The controls were matched regarding main symptom and reason for calling, age and gender of the caller. Preliminary analyses show that the malpractice claimed calls were shorter than control calls, and telenurses mainly used closed-ended questions in the malpractice claimed calls. They used reassuring to a greater extent, but did not explore the callers' understanding of the symptoms and asked few follow-up questions. In the control calls, the telenurses used more open-ended questions which made the callers provide more information about their condition and previous treatment. During the presentation I want to discuss our further analyses, what the findings mean and how they can be used in a clinical context.

## *Session C2: System evaluation*

### **Implementation of a programme in training of communication skills at a large hospital**

*Troels Præst Andersen, PhD student*

Health Services Research Unit, Lillebaelt Hospital/IRS University of Southern Denmark

Advisors: Poul-Erik Kofoed, Kaj Sparle Christensen and Jette Ammentorp

#### **Introduction:**

In recent decades there has been an increasing interest in the communication between clinicians and patients. One of the most frequently used methods for improving clinical communication is participating in communication skills training courses. Studies show a positive effect on health professionals' communication skills and a positive effect on patient outcome.

Despite the positive results, there is no literature describing how the positive experiences can be transferred to the clinical practice in a larger organisation. This PhD study will measure the effect of the communication training course "Clear-cut communication with patients" which is currently being carried out at Lillebaelt Hospital. The effect will be measured at both clinician level and patient outcome level and will use quantitative as well as qualitative research methods.

#### **Objectives:**

The purpose of this study is to examine the impact of implementing a training course concerning communication skills of health professionals with patient contact in a large hospital:

- Will the health professionals' self-efficacy increase after participating in a communication skills training course?
- Does self-evaluated performance and self-efficacy scores correlate with scores of the actual communication with patients?
- Does the communication training course's patient-centered<sup>1</sup> approach result in that clinicians better meet the patient needs regardless of the patients' socioeconomic status, health literacy and/or other characteristics as e.g. gender, motivation or age?

#### **Methods:**

All health professionals with patient contact (approximately 3000) at Lillebaelt Hospital will be included in the study. They will receive lessons (2+1 day) concerning communication skills training based on the Calgary Cambridge-Guide. The impact of the course will be examined in a questionnaire concerning self-efficacy both before and after the course. The impact will also be measured via interviews and audio recordings before and after the course. The impact on patient level will be measured via interviews and maybe also via a survey.

#### **Issues for discussion:**

- Which additional methods and theories can contribute to reaching the objectives of the study?
- What are the pitfalls in this study?
- This part of the study is currently at its beginning (October 2013). Consequently, more specific questions will arise prior to the seminar in Oslo in January 2014.

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<sup>1</sup> Institute of Medicine (IOM) defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."

## **Patient complaints as an endpoint for measuring the effect of communication skills training**

*Karin Yde Waidtløw, Research Assistant, MHSc*

*Supervisors: Jette Ammentorp, PhD, MHSc, Poul-Erik Kofoed, Med.Doc., M.D., DTM, B.A.*

Health Services Research Unit

Lillebaelt Hospital / IRS University of Southern Denmark

### **Background:**

Since January 2012, employees in the Danish hospital *Lillebaelt Hospital* have been undergoing a mandatory communication programme in order to improve their professional communication skills. When launching the programme, one of the purposes was to monitor and compare the number and the character of patients' complaints before and after the hospital staff had undergone the programme.

The National Agency of Patients' Rights and Complaints estimates that approximately 40-50% of patients' complaints either originates from or is related to communication issues. However, even before the intervention, only 10% of the complaints at Lillebaelt Hospital were being categorized as "Health communication and documentation". It is therefore evident that there is a striking discrepancy between the national and the local statement of complaints. At Lillebaelt Hospital, the registration and classification of patients' complaints is being carried out by secretaries. This group of employees has no clinical experience and they express insecurity in carrying out the task of categorizing the complaints.

As we have an assumption that the actual number of communication related complaints is in fact higher than stated, we will have to review all of the complaints and if necessary re-categorize them before studying the possible effects of the intervention (the communication programme).

### **Purpose of the study:**

- To investigate if the registered patients' complaints at Lillebaelt Hospital are given the right classification.
- To investigate how the number of patients' complaints before and after the intervention can be used as an impact measurement.
- To investigate whether the mandatory communication programme has an impact on the number and content of patients' complaints at Lillebaelt Hospital.

**Questions:** The patients' complaints consists of subjective descriptions of events. How can we make these subjective data measurable? Can they be rated or coded using a particular system?

## **“Establishment of Habits in CPAP Treatment (EHCT)” and “Akershus Sleep Apnea Diagnostic and Treatment Evaluation (ASADaTE)” -Two projects joined in communication**

*Principal investigators:*

*EHCT: Professor Anders Broström*

School of Health Sciences, Jönköping

*ASADaTE: Harald Hrubos-Strøm, PhD*

Akershus University Hospital, department of otorhinolaryngology

Obstructive sleep apnea (OSA) is a common disorder. Without treatment the disorder is associated with increased risk of mortality and cardiovascular morbidity. Treatment with continuous positive airway pressure (CPAP) has been shown to reduce cardiovascular risk and to relieve symptoms. Despite this, adherence to treatment is low. Other treatments such as recommended weight loss or surgery have been shown to be inefficient.

Habits associated with CPAP adherence have not been studied in patients with OSA. A habit is a learned behavior that is performed more or less automatic as a response to external signals, “cues” (eg. a time, a place or a situation). The effect of clinical communication on the establishment of habits or CPAP adherence has not previously been studied.

### **Aims:**

To assess aspects of clinical communication between health personell and patients in order to improve the establishment of habits and CPAP adherence in joined Norwegian and Swedish projects.

### **Material and methods:**

A prospective, longitudinal design will be used. The EHCT is performed in CPAP outpatient clinics located in Linköping, Jönköping and Stockholm, Sweden. 400 treatment naive patients with newly diagnosed OSA will be included. The ASADaTE is located at Akershus University Hospital, department otorhinolaryngology, Norway. 1000 patients referred for suspected OSA will undergo diagnostic procedures and patients with OSA will receive treatment with recommended weight loss, surgery or CPAP. Physician-patient consultations at baseline (after diagnosis is established) and three nurse-patient consultations (at CPAP initiation, after 2 weeks and 6 months) will be video recorded and analyzed. All Norwegian physicians but not nurses have received a two day communication course through 2013. Swedish staff has not received any communication training. Instruments considered for use are the OPTION scale and the 4 habits coding scheme as well as CPAP Habit Inventory and subjective and objective CPAP adherence as dependent variables.

## ***Session D1: System improvement***

### **Communication in home health care, at the CT laboratory and at optometric consultations in Norway**

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

Buskerud University College, Faculty of Health Sciences

#### **Background**

Communication is a basic competence in health care, but few studies have systematically examined communication with older people who are receiving health services. There are no large observational studies of person centered and empathic communication in nursing, optometry or radiography-programs or studies that relate person centered and empathic communication skills to nursing assistants. The PhD-study is part of an international study of person centered communication with older persons (PCCE) performed in Sweden, the Netherlands, United States and Norway; with the main aim to enhance educational research relevant for person centered care and thereby to improve care, health and wellbeing for elderly.

#### **Aim**

The purpose of this study is to identify health personnel's competences in person centered and empathic communication with elderly patients.

#### **Materials and Methods**

The target population is older persons living at home ( $\geq$  65 years) who are in need of home health care, and the health personnel that provide this care respectively. The nurses and nurse assistants will be recruited in the two municipalities Drammen and Ål. Drammen municipality is sub divided into different city regions and from these where Hamborgstrøm, Fjell and Konnerud included. The elderly either receive home nursing care, a Computer Tomography examination or an eye examination in the period of November 2013 – April 2014.

A total of 20 nurses, 20 nurse assistants, 10 radiographers and 10 optometrists will be included. The health care provider will wear digital audio recorder when they perform their daily work. The digital audio recorder will be worn by the respective health care provider until at least 5 patient encounters have been recorded. This will accumulate a total of 300 audio tapes from patient encounters with older patients and will provide a rich material to be analyzed.

The audio files will be analyzed with VR-CoDES and with RIAS to capture and explore real communication challenges and this data will form the basis for developing the simulated training. Different characteristics of the elderly, i.e. being more or less dependent on care (frailty), their age, gender, living together or with a partner and their medical history will be taken into account. Linda.hafskjold@hibu.no

#### **Ethics**

The study is evaluated by the Regional Committee for Medical and Health Research Ethics (REC) and found not to need approval from REC. The study is therefore applied approved by the Data Protection Official for Research (NSD) in Norway.

## **Analyzing pro-social communication in support groups for siblings of chronically ill children**

*Torun M. Vatne<sup>1</sup>, Yngvild Haukeland<sup>2</sup>*

<sup>1</sup>Frambu resource centre for rare disorders

<sup>2</sup>Department of psychology, University of Oslo

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

**Aim:** To conduct a descriptive study to analyze how and to which extent children communicate with each other, respond empathically and find mutual experiences during support group sessions.

**Method:** In 2012 groups sessions of 11 support groups were videotaped. Each group met 2-3 times. The groups consisted of 5-8 children aged 8-16, all siblings of a child with a rare disorder. The groups were led by a psychologist or education specialist together with a facilitator. Data in this study is about 30 videotaped support group sessions lasting from 30-90 minutes.

We plan to analyze the communication in these sessions, with special emphasis on the interaction between group members and group leader communication style. Thoughts and discussions during the OCHER workshop about the analysis to be conducted in this study would be greatly appreciated.

**Results:** This study will result in new knowledge about how to conduct and lead the new group intervention for siblings of children with chronic diseases in ways that optimize the possibilities for pro-social interaction between group members.



## **“Likemannsprosjektet”. A qualitative study on voluntary peer support in cancer care**

*H. Skirbekk, L. Korsvold & A. Finset*

Department of Behavioral Sciences in Medicine, Institute of Basic Medical Sciences, Faculty of Medicine, University of Oslo

Having cancer, from the time of diagnosis to survivorship or death, is most often accompanied by serious physical, psychological and social concerns. Seeking assistance to help coping with the consequences of cancer can positively affect a patient’s quality of life. Peer support is one way of providing such assistance/social support.

Little is known about the characteristics of a “good” peer and what training and supervision would be beneficial for cancer victims and volunteers. In addition we know little about what motivates peers, and how peers and patients meet and interact. In Norway, peer support has traditionally been the responsibility of the different patient organizations. To be able to offer this service to a broader group of cancer patients and to promote the contact and collaboration between the patient organizations, the hospitals and The Norwegian Cancer Society, centers for peer-support have been established in major hospitals treating cancer patients in Norway, called “Vardesentre”.

This study has two aims: 1) to explore how patients and their relatives use and experience existing peer support centers, and 2) to explore what it entails to be a “good” peer, and to evaluate the organisation of existing peer support centers.

Five focus group interviews with peers, 12 in-depth interviews with users(patients and relatives), and observations of the daily work in a “Vardesenter”, have been conducted. Qualitative content analyses have been used to identify important experiences of peer supporters and users.

Five main issues have emerged, and will be explored during presentation. From the users’ perspective, 1) peer support brings hope, and 2) a sense of normality and solidarity contrasting hospital life. Users also pointed out that 3) some groups often fell through the cracks of peer support, notably teenagers and next of kin. From the perspective of peer supporters, 4) this role brought great meaning to their lives. However, many pointed out that 5) it could be a challenge to handle the role of a “professional unprofessional”, thus emphasizing 6) the importance of education and supervision.

This study is relevant for health care providers as peer support programs organized in conjunction with the hospitals can be seen as an innovation in delivery of healthcare. For the society and community, these results are of interest because peer-support programs represent an extension of the health care service, potentially improving the quality of life for cancer patients.

## ***Session D2: Caring***

### **Constructing symmetrical and asymmetrical relations in patient-caregiver closings**

*Shirley Näslund (collaborator with Anna Lindström and Clara Iversen)*

Uppsalas Universitet, Sweden

I am collecting closings at the hospital, how patient and caregiver are rounding off their interaction with words and touch. Elderly patients may express a great deal of thankfulness to the doctor or nurse, thus constructing an asymmetrical relation. How is this thankfulness met? I am specifically interested in when the caregiver thanks the patient, something which is done in various ways. I am also interested in phrases like *I hope not to see you again - I hope to see you again* - they are causing some trouble at the hospital.

## **Older adults in hospital encounters with physicians - communication of concerns**

*Hilde Eide, Rita Gorawara-Bhat, Pål Gulbrandsen, Linda Hafskjold, Vibeke Sundling*  
Buskerud University College, Drammen, University of Chicago, Illinois, USA, and University of Oslo

### **Background**

Research has suggested that the emotional context of care is conveyed especially through nonverbal communication skills, including exchanges of nonverbal messages, which are critical elements of empathic care. Therefore, there is a need to include the nonverbal dimensions of communication as the basic building blocks in any educational training. Most previous studies have examined the verbal and/or the nonverbal aspects of communication independently of each other. In this study we will jointly examine the verbal and nonverbal dimensions of communication.

### **Aim**

The aim of study 1 is to get an enhanced understanding of how older adults communicate their concerns to the physician through verbal, paraverbal and nonverbal communication.

### **Methods**

89 encounters with older adults are extracted from a larger study of 380 patients (The Ahus study). Of these encounters 49 are suitable for nonverbal analyses, 26 has clear eye contact view, and 23 shows unclear eye contact.

Steps in the analytical process:

1. First a pilot sample of 10 videotapes of older adults (>65) will be analyzed. Based on qualitative methodology, the pilot will help identify salient nonverbal themes in this population (in encounter with the research group).
2. All 49 consultations will be coded with The Verona Coding Definitions of Emotional Sequences (VR-CoDES), which has explicitly defined categories whereby a patients concern of hints to concerns can be detected.
3. This sample will also be studied for confirming and validating the above identified salient nonverbal dimensions (from step 1) using NDEPT instrument.
4. Overlay the verbal analysis (from Step 2) and the nonverbal analysis (from Step 3) to explore any emergent recurring patterns in which:
  - a) Patients' verbal cues and concerns occur with accompanying nonverbal signals,
  - b) Providers' verbal responses (to cues and concerns) occur with accompanying nonverbal signals, and
  - c) The interface of verbal/nonverbal signals between patients and providers.

Preliminary results from the coding of the first 10 videotapes coded both nonverbally and with VR-CoDES will be presented at the workshop.

## **Person centered communication with older persons in community care – the Swedish part of an international research project**

*Annelie Johansson Sundler & Inger Holmström*  
Mälardalen University College, Västerås, Sweden

### **Background**

Knowledge is needed on how person-centered care can be developed and how person-centeredness can be practiced in daily care, especially in the care of older people. The aging of the population is a worldwide challenge. The need for support and assistance among older people in Sweden, as well as in many other countries, will probably increase. In 2008 about 1.6 million persons in Sweden were aged 65 or older, i.e. 18% of the population were over 65. Of these, about 250 000 people were receiving care either through nursing homes or from community home care services. Aging with dignity is considered as a human right, and welfare and dignity are considered as important in the care of the elderly.

### **Aim**

The aim of this research project is to explore communication practice in home health care visits, and to contribute to knowledge on person-centered communication with elderly patients.

### **Methods**

This study is part of an international research project on person centered communication with older persons (PCCE), where data will be gathering on communications with older persons in home care services in three European countries.

We will conduct a data gathering of 200 tape-recorded conversations with older persons receiving home care services from caregivers in their daily life in each of the three countries. Conversations between the older person and their caregiver during home visits will be tape-recorded.

Qualitative analyses will be performed. Gender- and intersectional theories may be used in the analysis of the authentic communication between healthcare providers and older persons. We also planned to examine aspects of power and how power is constructed in the communication and the encounter between the older person and the health care providers.

### **Collaborative partners.**

This study is based on interaction and collaboration between educators and researchers in Norway (Buskerud University Collage, (BUC), and Ahus), Sweden, Netherlands and the United States, including undergraduate students, health care professions in European municipalities and hospitals, and patients encountered by the health care providers.

### **Ethics**

The study will confirm to the Declaration of Helsinki and ethical board review will be obtained before data collection.

## *Session E1: Difficult tasks*

### **Delivering bad news to an angry teenage patient – a case study**

*L. Korsvold<sup>1,2</sup>, A.V. Mellblom<sup>1</sup>, H.C. Lie<sup>1</sup>, J.H. Loge<sup>1,2</sup>, E. Ruud<sup>3</sup> & A. Finset<sup>1</sup>*

<sup>1</sup> Department of Behavioural Sciences in Medicine, Institute of Basic Medical Sciences, Faculty of Medicine, University of Oslo, <sup>2</sup> National Resource Centre for Late Effects after Cancer Treatment, Oslo University Hospital, Radiumhospitalet, Norway, <sup>3</sup> Department of Paediatrics, Oslo University Hospital, Rikshospitalet, Norway.

#### **Introduction**

The patients' responses to bad news vary but some get angry. Anger in adolescents or young adults (AYA) is clinically regarded as a particular challenge. Still there is a scarcity of empirical knowledge and guidelines on how to adequately communicate with angry AYA patients. The aim of this study is to investigate the delivery of bad news when the patient is an angry adolescent.

#### **Methods**

The case in this study is an audio recording of a medical consultation, 21 minutes long, where an oncologist delivers a cancer diagnosis and a treatment proposal to a adolescent boy. The patient in this case has a complicated prediagnostic trajectory including severe pain and enuresis.

The analysis was conducted in three steps using a transcript of the consultation and listening to the audio recording. At the first level of analysis the aim was to analyze the data in a way that the participants' of the communication would agree upon (level of self understanding). At the second level of analysis the aim was to interpret the results from the first level of analysis further in a way that is trustworthy (reliable) for the reader of the interpretations. The analysis was conducted looking at the interaction between the doctor and the patient (interactive analysis) but also looking at communicational themes of the interaction (thematic analysis). The third level of analysis was a theoretical discussion of some of the findings from the second and first level of analysis.

#### **Results**

Preliminary analysis indicates that the patient's anger adds an additional layer of difficulty to the doctor's delivery of bad news. The patient's anger blocks motivation for and adherence to treatment. The oncologist uses different techniques to restore trust and promote patient motivation: a personal communication style, acknowledging patient concerns, providing straightforward information with no premature reassurances and explicit appeal to the patient's commitment to treatment.

# Acknowledging The Back Patient. A Thematic Synthesis Of Qualitative Research. A Systematic Literature Review

*Janne Brammer Damsgaard<sup>1</sup>, Lene Bastrup Jørgensen<sup>2</sup>, Annelise Norlyk<sup>2</sup>, Regner Birkelund<sup>4</sup>*

1. Silkeborg Regional Hospital, Regional Hospital Central Jutland, Department of Nursing Science, School of Public Health, Aarhus University, Denmark - 2. Interdisciplinary Research Unit, Elective Surgery Centre, Silkeborg Regional Hospital, Regional Hospital Central Jutland, Department of Nursing Science, School of Public Health, Aarhus University, Denmark - 3. Department of Nursing Science, School of Public Health, Aarhus University, Denmark -4. Aarhus University and University of Southern Denmark & VejleSygehus, Vejle, Denmark

**Keywords:** Back Patient, Narrative, Biomedical, Marginalisation, Self-Identity, Ethical Responsibility, Acknowledgement

**Introduction:** Back conditions and back pain rank among the most common causes of reduced working capacity and lengthy, challenging and costly illness trajectories. In order to gain a better idea of the most ideal treatment process, it is important to first investigate what it feels like to be a back patient and what patients consider important when dealing with the healthcare system.

**Objectives:** The objective of this literature review is to get a deeper understanding of the illness trajectory for back patients. Thus, the literature review therefore seeks to locate, systematize and synthesize findings derived from qualitative research in order to visualize barriers or implications for intervention development.

**Methods:** The method draws on James Thomas' and Angela Hardens article "Methods for the thematic synthesis of qualitative research in systematic reviews". The synthesis takes form of three stages which overlaps to some degree: the free "line by line coding" of the findings of primary studies; the organisation of these "free codes" into related areas to construct "descriptive themes" and the development of "analytical themes". The integrations are more than the sum of parts, in that they offer novel interpretations and findings. These interpretations will not be found in any one research report but, rather, are inferences derived from taking all the reports in a sample as a whole.

**Results:** The thematic analysis reveals that many back patients feel that their experiences and perceptions are ignored by the health professionals, who are often concerned about identifying the cause. This can result in patients feeling mistrusted, marginalized and reluctant to speak out.

Therefore, telling about experiences and perceptions is important for back patients in order to feel accepted and acknowledged. But selfhood cannot be reduced to narrative identity since the identity of the self is only fully revealed the moment we include the ethical dimension including certain norms and binding. The health professionals must incorporate the patients' narratives as an integral part of the care and treatment.

**Conclusions:** In order to acknowledge the back patient the narrative must be complemented by a different perspective that includes the issue of ethical responsibility. It is therefore also a question of adopting certain norms as binding; to be bound by obligation or loyalty. Thus, the literature review argue for a more process-oriented patient approach that incorporates patients' narratives as an integral part of the care and treatment.

## **Can use of interpreters be helpful for “non-fluent patients” to express their emotional concerns in medical consultations?**

*Emine Kale*

Norwegian Centre for Minority Health Research

### **Background:**

Until now we have conducted two investigations on communication in hospital consultations with native and non native patients comparatively. In the first study we investigated patients' expression of emotional cues and concerns and HP responses by employing VR- Codes and VR- HP. Data material included 56 videotaped hospital encounters (30 consultations with non-native and 26 with native patients) collected at a hospital in Oslo region in 2006-2007. In this study we found that non-native patients with satisfactory language proficiency expressed significantly more concerns verbally compared to non-native patients with language problems as well as native patients (Kale et al. 2011).

Later we have conducted a study in a small strategic sample (12 consultations) drawn from the first sample by using a qualitative method, discourse analysis (DA). This analysis indicated that whereas VR-CoDES coding could miss some subtle cues to underlying emotions if these are communicated vaguely or veiled by language barriers, the DA still indicated the presence of emotionally salient expressions and themes. Further DA of HP responses indicated that non-fluent patients' expression of concerns can be at a higher risk for not being understood well by their doctors.

### **Aim:**

On this background we want to go further and look at the only consultation in the main sample with a non-fluent patient and an interpreter present in order to explore emotional communication in this context. We will look at the following moments:

1. How does the patient express his cues and concerns through the interpreter?
2. How the presence of an interpreter seems to influence emotional communication?
3. Does this consultation differentiate substantially from the the other consultations in the sample without a interpreter?

### **Method:**

CA will be conducted and the findings will be discussed at the OCHER workshop.

## *Session E2: Patient understanding*

### **Psychological Factors in Nutrition Interventions for Patients with Colorectal Cancer**

*Tonje L. Stensrud*

Dept of Behavioral Sciences in Medicine, University of Oslo

**Background:** Eating and drinking habits have been found important in etiology and treatment of colorectal cancer, and many patients are therefore offered nutrition counseling. Tailored counseling is considered to be most effective nutrition intervention. One might think that psychological factors such as motivation, self-efficacy, coping etc. may have impact on the outcome of such counseling, but we know little about the mechanisms and about which factors are most important. Psychological factors might also impact communication between nutritionist and patient. Knowledge on how psychological factors impact the counseling process could be of value in the development of tailored nutrition interventions.

**Objectives:** In this study we want to examine the relationship between different psychological factors and patient outcomes in a longitudinal design. The second objective of the study is to examine to what extent and in what way psychological factors influence the communication between nutritionist and patient.

**Methods:** The study is an integrated part of two randomized controlled intervention studies, examining the effects of two different nutrition interventions upon patient outcomes. We will examine which psychological variables work as moderators or mediators on two of these outcomes, in addition to possible interactions between the variables. Psychological variables will be measured with questionnaires.

The communication between nutritionist and patient will be studied by analyzing audio-tapes of the consultations to investigate if patients express 1) motivation for change, self-efficacy and other cognitive variables and 2) emotional communication in terms of concerns and distress. Each tape will be analyzed with VR-CoDES and thematic analysis.

Independent variables:

Motivation to change, Nutrition literacy, Self-efficacy, Perceived Benefit, Health worry, Intrusive thoughts, Emotional Approach Coping, Positive and negative emotions.

Outcome measures:

Life quality, Nutrition

- I would especially like to discuss how to conduct the communication part of the study.



# Does understanding why to take medicines lead to adherence?

Research on Antimalarial instructions indicate strong preference for including the “why”-factor, but –Health providers believe these cannot be understood by patients

Ane Haaland, James Moloney, Annemiek Hell  
University of Oslo

**Background:** Adherence to medicine instructions is a challenge, symptoms treatment being main reason. Many patients stop treatment when main malaria symptom – fever – decreases. Providers give brief instructions on how to use medicines, rarely explaining why to take the full course, or checking patients’ understanding.



Research shows: Patients adhere better when understanding disease and medical instructions well, and reasons why take medicines in a certain way. Patients want this information.

**Methods:** Action research was used to develop and test instructions for four malaria medicines (Lapdap, Coartem, Coartem Dispersibles and Ugandan artemeter-lumefantrine) in Kenya, Tanzania, Malawi, Uganda 2001 to 2008). Semi-structured interviews were held with 160 health providers, 461 community members and 110 community health workers to assess comprehension of 2 versions of instructions, using purposive sampling in rural and semi-urban areas and clinics.

**Findings:** Community members with lower schooling comprehended less than those who completed primary school. Average comprehension: 70% for final versions. Preference for instructions with parasites included: 85-97%: even those who did not originally understand instructions, preferred “parasite versions” because they showed why to take the full course. Majority of providers believed patients would not understand concept of parasites linked to treatment: suggested not to test parasite versions, as this would confuse patients.

**Conclusions:** Findings indicate providers’ beliefs re comprehension, perception and preference of community members for pictorial instructions do not correspond with community members’ abilities to understand instructions. Providers’ attitudes may be an important part of adherence problem.

**Our questions:** Can pictorial instructions enable patients to understand how and why take medicines correctly and thus increase adherence, almost independently of providers’ low quality guidance? Will such instructions also help forcing providers to explain why to complete course of medicine, as indicated by antimalarial medicines research? Questions are now being explored in Kenya with Amoxicillin syrup for childhood pneumonia.

<p><b>Development of pack: dispersible A/L: Introduction of parasites</b></p>  <ul style="list-style-type: none"> <li>• 2007, Tanzania: Middle pack compared with pack on left</li> <li>• Both packs understood by &gt;70%</li> <li>• Mother with child preferred</li> <li>• 2008, Uganda: Middle pack compared with pack on right</li> <li>• Understanding: 67%</li> <li>• Problem: Reading horizontally</li> </ul>	<p><b>Parasites preferred – square ones!</b></p>  <ul style="list-style-type: none"> <li>• More than 95% preferred versions with parasites to explain why to complete treatment</li> <li>• Details make a difference: Round parasites often misunderstood for pills, balls etc</li> <li>• “It is better to give the whole dose, because on day 2 the wadudu are just drunk, and will start to kill again.” – Women, 20 years, Tanzania -07</li> <li>• “When you see this, there is no way you can fool yourself to think you have cured your child, until you have given the last dose” – Women, 32 years, Tanzania</li> </ul>
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# **Prevention of hyperglycaemia in antenatal care using tailored communication strategies and mobile learning devices: a feasibility study of the use of structured conversations combined with digital learning objects by midwives in routine antenatal care**

*Lisa Garnweidner-Holme*

Oslo and Akershus University College of Applied Sciences

## **Background/introduction**

The growing prevalence of gestational diabetes mellitus (GDM) in pregnant women creates public health challenges. In addition to the shorter term health risks for both the mother and the fetus, women who develop GDM in pregnancy have an increased risk of later Type 2 diabetes mellitus (T2DM). Additionally, the offspring may have higher risk of developing T2DM and related conditions later in life due to the mother's nutritional status in pregnancy. Dietary advice, combined with physical activity, has been shown to increase glucose tolerance and reduce hyperglycaemia. Thus, preventive efforts in primary antenatal care may potentially reduce the number of women needing specialist care for GDM, while successful interventions in GDM women may prevent or postpone transition into T2DM. However, only few randomized controlled trials (RCTs) were found which investigate the effect of dietary and lifestyle advice for women with gestational diabetes.

Previous studies among pregnant women in antenatal care identified possible barriers to nutrition communication that can be addressed by tailored communication strategies. Cultural sensitivity as well as individual's nutrition literacy are important elements in tailored communication. Digital technologies supporting health professionals during consultations may be a useful approach to deliver tailored nutrition information aiming to promote healthy eating and patient self-care, particularly in diabetes care where improved disease control has been documented.

## **Aims**

The main aim of the feasibility study is to assess the practical feasibility of the nutrition communication strategy (NCS) consisting of structured conversations and digital learning objects on a tablet computer in routine antenatal care consultations.

Specific research questions are: How much time does the NCS take? Experiences of the use of the NCS in intercultural consultations?

The feasibility study will be conducted prior to a randomized controlled intervention study. The results of the feasibility study will be applied to further develop the nutrition communication strategy for a randomised, controlled trial within standard clinical care to women with GDM as well as to develop an App which will be made available to download by the women in the intervention group.

## **Methods**

**The development of the nutrition communication strategy:** A protocol for structured conversations between the midwives and the pregnant women will be developed. Digital learning objects (pictures, videos and audio files) on a tablet computer will be developed. These include simple tools to assess the current diet, a strategy to identify the most appropriate dietary behaviours to target and setting personal goals, and elements to raise risk awareness and motivation for change.

**The assessment of the feasibility of the nutrition communication strategy** involves to videotape consultations of trained midwives and pregnant women. The midwives and the women will receive a questionnaire after the consultation. The feasibility study will be conducted in 3-5 Mother and Child Health Centres in the area of Oslo, resulting in approximately 20 assessed consultations.