Annual OCHER workshop on clinical communication
Thon Hotel Arena, Lillstrøm, Norway
January 10-12, 2024

	Wednesday, January 10		
Time	**Activity**	**Plenary room / Room A**	**Room B**
1000	Plenary	Introduction, mutual presentation	
1045	Break		
1100	Plenary keynote	**Lorraine Noble (1)** ***Examining power by counting doctors' verbal markers of structure***	
1200	Lunch		
1300	Plenary keynote	**Paul Han (1)** ***The nature and management of medical uncertainty***	
1400	Break		
1415	Groups	**Session 1A** **Methodological foundations**	**Session 1B** **Conceptual foundations**
		Janneke Noordman & Marij Hillen	Connie Timmermann & Jette Ammentorp
		Marte-Marie Wallander Karlsen & Kari Sørensen	Mirjam Lauritzen
		Elna Leth Pedersen	Helge Skirbekk
1545	Break		
1600	Networking		
1700	Groups	**Session 2A** **Uncertainty in pediatric transgender & DSD/intersex care**	**Session 2B** **Tailoring information**
		Mieke Breukelman	Julia Menichetti
		Casper Martens	Anna-Lea van Ooijen
1800	Break		
2000	Dinner at hotel		

	Thursday, January 11		
0830	Plenary keynote	**Rebecca Barnes (1)** ***The management of primary health care in interaction: A retrospective***	
0930	Plenary keynote	**Lorraine Noble (2)** ***Exploring whether doctors mean what they say***	
1030	Break		
1045	Groups	**Session 3A** **Older patients**	**Session 3B** **Asking questions**
		Tahreem Siddiqui	Marit Nygård Halvorsen
		Monique Heijmans	Anne Marie Dalby Landmark
		Gabriele Leonie Schwarz	Anna Lindström
1215	Lunch		
1315	Groups	**Session 4A** **Communication training at national level**	**Session 4B** **Reflection/interviews on interaction data**
		Miral Alabbasi	Charlotte Hedberg
		Frank Vitinius	Malin Östman
		Simone Kienlin	Lene Tandle Lyngstad
1445	Break		
1500	Networking		
1600	Groups	**Session 5A** **Training connection with patients**	**Session 5B** **Video-based studies with children**
		Sylvie Lafrenaye	Sandra van Dulmen
		Margrethe Aase Schaufel	Lena Hedén
1700	Break		
1800	Dinner at hotel		

	Friday, January 12		
0830	Plenary keynote	**Paul Han (2)** ***Understanding medical uncertainty: the importance of language and a linguistic approach***	
0930	Plenary keynote	**Rebecca Barnes (2)** ***Applying Conversation Analysis: Practical steps towards making an impact on healthcare***	
1030	Break/check out		
1100	Groups	**Session 6A** **Training medical students**	**Session 6B** **Older patients with heart failure**
		Aslak Steinsbekk	Eirik Ofstad
		Guro Haugen Fossum	Christine Frigaard
1200	Lunch		
1300	Groups	**Session 7A** **Early stage research projects**	**Session 7B** **Early stage training projects**
		Monika Overå	Christina Louise Lindhardt & Trygve Skonnord
		Daniel Skog	Lars Mandelkow
1400	Break		
1415	Groups	**Session 8A** **Qualities for shared decision making**	**Session 8B** **Patient factors affecting care decisions**
		Arwen Pieterse	Herman Bjørnstad
		Andrea Bruun & Margrethe Aase Schaufel	Berit Seljelid
1525	Plenary closing	Evaluation and round-up	
1600	End	Safe Travel!	

Session 1A: Methodological foundations

Guidelines for reporting research using Systematic Coding of Observed human Behaviour (SCOBe)

Janneke Noordman[1], Marij A. Hillen[2], with international and interdisciplinary working group: Evelien Hoeben, Rianne Kok, Calum McHale, Melissa M. Sexton, Sabine van der Asdonk, Daphne van de Bongardt, Brett Bowman, Richard Brown, Susan Branje, Jill Chorney, Monika Donker, Peter Ejbye-Ernst, Sanne Geeraerts, Danielle van der Giessen, Gerald Humphris, Helle Larson, Richard Philpot, Mariona Portell, Siyang Yuan, Chiel van der Veen

[1]Nivel, The Netherlands; [2]Amsterdam Medical Center, The Netherlands

Aim

Systematic coding of observed human behaviour (SCOBe) is used across disciplines and topics but methodological reporting is often incomplete. We developed internationally generated, interdisciplinary guidelines for methodological reporting of SCOBe research.

Methods

Using Delphi methodology, a working group of 22 experts sought group consensus in three rounds. Participants first assessed an initial set of reporting criteria (round 1). Next, in interactive meetings participants revised these criteria and reached consensus on reporting content (rounds 2 & 3).

Results

We present 20 criteria constituting the first comprehensive reporting guidelines for SCOBe research using existing, newly developed, or modified coding systems. The criteria encompass three procedural domains: 1. Context; 2. Properties of coding scheme; and 3. Application of coding scheme.

Discussion

The presented guidelines will assist in substantiating and assessing the quality of SCOBe research. We encourage researchers to adopt these guidelines, to enhance quality of mono- and interdisciplinary research. Additionally, we acknowledge that SCOBe is an evolving approach. As such, our reporting guidelines may not prove exhaustive or immutable. For example, the exponential advances in machine learning and AI will likely result in increased use of automated video coding procedures. Moreover, the development and use of hardware (e.g., smartphones) that enables audio and video recording is rapidly growing, as is dissemination of data through social media platforms. As a result, we expect a proliferation of the kinds of data that are amenable to SCOBe. To cater to this vastly changing landscape, we created an openly accessible directory in which interested SCOBe researchers can further discuss, comment on and update our guidelines.

We welcome suggestions from OCHER-attendees on how to optimally disseminate our newly developed guidelines, to enhance their implementation throughout healthcare communication research.

Ethical considerations are methodological considerations: the importance of ethical reflections using video recordings as a data collection method

Marte-Marie Wallander Karlsen[1], Lena Günterberg Heyn[2], Jennifer Gerwing[3], Berit Hofset Larsen[4], Kari Sørensen[1,5]

[1]Lovisenberg Diaconal University College, Norway; [2] University of South-Eastern Norway, Norway; [3]Akershus University Hospital, Norway; [4]University of Oslo, Norway; [5]Oslo University Hospital, Norway

Background

Using video recordings allows observation of social actions and interactions in a natural environment, providing access to investigate ongoing communication, interaction, and behavior in detail. It also makes it possible to review and scrutinize the recordings countless times. Collecting video recordings are therefore a very powerful method for learning more about clinical interactions. However, involving especially vulnerable patient populations in research using video recordings requires careful and continuous ethical reflection. Such patients may have reduced consent competency, not understanding the implications of participation. Worse yet, they could even feel pressured to participate.

Studies of clinical communication that focus on how interaction between practitioners and patients works often depend on the possibilities video recordings offer. Guidelines to follow are aimed at novice researchers who are interested in this data collection method, allowing for a highly individualized assessment of very complex ethical considerations in this setting.

Aim

This presentation aims to reflect upon methodological and ethical considerations when including vulnerable patients in studies using video recordings.

Methods

We will present the choices made in three separate video recording studies with vulnerable patients, each of which was focused on different observable phenomena within the interactions. We will discuss the different approaches and compare them to other researchers' experiences and methodological literature. Finally, we will recommend topics to consider in the various phases of a study using video recordings.

The presentation at OCHER

The goal is to get feedback both from other experienced researchers using video recordings as a data collection method or from novice researchers who are interested in engaging in this method.

Exploring ways to establish collaborative relationships in a new participatory health research project

Elna Leth Pedersen[1], Jette Ammentorp[1], Torkell Ellingsen[2], Connie Timmermann[1]

[1]Centre for Research in Patient Communication, Odense University Hospital of Southern Denmark and Department of Clinical Research, University of Southern Denmark, Denmark; [2]Department of Rheumatology, Odense University Hospital of Southern Denmark, and Department of Clinical Research, University of Southern Denmark, Odense, Denmark

Background and aim

The preliminary phase in participatory health research has been identified as the most critical for motivating patients and relatives to become involved in research. In this phase, the researcher must negotiate the research design, focus, relevance and appropriate methods with patients and relatives. Consequently, the flexibility of the researcher and willingness to share control is an essential part of conducting participatory health research. However, there is limited focus on the process of establishing relationships with patients and relatives and of ensuring equitable participation and collaboration.

This study explores the process of establishing relations of equity and collaboration in a new participatory health research project.

Methods

In a new Ph.D. project, framed by epistemology and methods of Participatory Action Research, we carried out a process of finding co-researchers and inviting them to become involved in the research. In a pre-Ph.D.-phase of 6 months phase, we combined ethnographic fieldwork with participatory methods, starting with a participatory “World café” workshop. Subsequently, we held formal meetings with patients and relatives from the research boards of two clinical departments and informal meetings with patients and relatives who responded to advertisements at hospital departments and on social media. A total of 15 patients and relatives in the Region of Southern Denmark were involved in the preliminary phase of the PhD project in 2023.

Results

Patients and relatives questioned the relevance of the research project and expressed a need for adjustments of terminology to avoid exclusion and promote an accurate understanding of the purpose. They furthermore suggested broadening the possible forms of participation to improve stimulation and maintenance of motivation for patients and relatives to become involved in the project. Three themes emerged: 1) questioning the meaning and relevance, 2) adjustments of terminology and 3) broadening the possible forms of participation. Relations were established with six of the 15 patients and relatives, who have committed themselves to be involved in the project on long-term basis.

Discussion at OCHER:

1. **What are your experiences of involving co-researchers in research projects?**
2. **How could an article be framed based on these finding in my PhD project?**

1B: Conceptual foundations

Exploring curiosity from various perspectives – what to ask and how to listen?

Connie Timmermann[1], Julia Menichetti[2], Jennifer Gerwing[2], Terese Stenfors[3], Elna Leth Pedersen[1], Jette Ammentorp[1]

[1]Centre for Research in Patient Communication, Odense University Hospital of Southern Denmark & Department of Clinical Research, University of Southern Denmark, Odense, Denmark; [2]Health Services Research Unit (HØKH), Akershus University Hospital, Norway; [3]Department of Learning, Informatics, Management and Ethics, Karolinska Institute, Sweden

Background and aim

Evidence shows that involving patients in their treatment significantly improves patient safety, satisfaction and health. However, in today's fast-paced healthcare environments, it is easy to be entangled in the complexities of medical procedures and diagnostic protocols and to forget to be curious about the patients and their perspectives, experiences, hopes and resources related to the illness.

This project explores curiosity as a crucial communication skill to facilitate a deeper understanding of patients' contexts and values, promoting a safer and more satisfactory treatment trajectory.

Methods

The project is conducted as part of an international research collaboration originated from OCHER. It includes patients, relatives, health professionals, and researchers in an interactive process of three participatory workshops, each informing each other.

The three participatory workshops are:

1) An initial ""World café"" workshop explores how patients and relatives experience curiosity and why it is important to them in communicative encounters (February 2023)

2) A national participatory theatre workshop investigating HCP experiences on essential aspects, facilitators and barriers related to curiosity in conversations. This workshop is based on patients' experiences elaborated in the ""World café"" workshop and patients' complaints collected at OUH on 'relational aspects' and 'responsiveness' (December 2023)

3) The OCHER workshop aims to bring together reflections from the two previous workshops while adding new knowledge and perspectives from an international angle on exploring curiosity. This includes identifying communicative and relational skills and behaviours in play (OCHER 2024)

The workshop

Ten minutes: Based on a short presentation, the workshop participants will be presented with data from the two previously held workshops and three reflection questions related to the preliminary results/themes.

Ten minutes: The workshop participants are divided into groups of 5-6 persons. Each group gets a pre-printed sheet of reflection questions on which to write.

Ten minutes: The main points from each group are brought together in a short joint reflection in plenary.

Perspectives

The study will inform the development of material for blended-learning communication skills training as a supplement to existing training of students and healthcare professionals.

Same same, but a little different

Mirjam Lauritzen

Centre for Shared Decision Making, University hospital of North Norway

In Norway, the patients right to participate is firmly anchored in both legislation and political policy documents. Still, we are far from the goal of a person-centred healthcare system. Nevertheless, there is a significant amount of commendable work being done across the country to achieve this goal:

- Several hospitals provide training and skill development in clinical communication for healthcare professionals. Methods such as Six steps to SDM and Four habits are examples of courses being offered.
- What Matters to You? is a national initiative for improving patient pathways.
- Choosing wisely is a campaign by the Norwegian Medical Association aimed at reducing overtreatment and overdiagnosis in healthcare. The four questions encouraged by the campaign significantly overlap with three questions from the Australian campaign ""Ask Share Know,"" which is also used in Norwegian as an aid for patients who wish to participate in decision-making.

These, and many other initiatives, share the same goal: providing a person-centred healthcare service. To achieve this, we use different terms, and describe different methods. Our experience is that both users/patients, students, and healthcare professionals find it challenging to navigate in the various terms describing almost the same. In a meeting recently with the Directorate of Health's user council, where shared decision-making was in focus, the council articulated the challenge like this: "There are too many terms - do not spend resources on making one term well-known - it's about patient involvement. Use that instead of many different method names."

The feedback is understandable, but by labelling everything as patient involvement, we are afraid we might lose important nuances.

At OCHER we seek input on:

- **How can we, in an organized manner, illustrate and explain the relationships between the various terms and tools/methods?**
- **Is there a hierarchy, or do they all overlap partially or entirely with each other?**
- **How can we avoid tripping over each other in our eagerness to communicate precisely what each of us is working on, and instead move together towards the goal?**

Trust and health literacy

Helge Skirbekk

OsloMet, Norway

Trust in the healthcare system, in healthcare personnel and in health-related information are important factors that affect patients' ability to understand and use health information. Trust can have a significant impact on patients' health outcomes. For most people, an encounter with the healthcare system may be the cause of both hope and fear. Patients will of course hope to get help with a disorder, perhaps healing, assistance or support. But the patient can also face healthcare personnel with fear, fear of incorrect treatment, memories of previous humiliations, a lack of faith in getting help, or similar.

A good trust relationship is important for the implementation of treatment, because weak trust can lead to the patient being less able, or willing, to follow the healthcare personnel's advice. When individuals have confidence in the healthcare system and the information they receive, they are more likely to follow instructions and advice from healthcare professionals. A relationship of trust built up through a long and continuous relationship will mean that patients and healthcare personnel get to know each other. The patient can feel safe and openly talk about even stigmatised disorders. In other words, trust based on continuity is of great importance for diagnosis and follow-up. On the other hand, a lack of trust can lead to skepticism and mistrust of health information, which can make it difficult for individuals to make informed decisions about their own health.

Studies have shown that patients with higher levels of health literacy are more likely to have a higher degree of trust in healthcare personnel and the healthcare system. Patients with higher health literacy are better able to understand and interpret health information, which can increase their understanding of and trust in the decisions made, and the information provided, by health professionals. Health literacy can help individuals manage their own health and make informed decisions. It provides a basis for better critical evaluations, the ability to navigate in very complex organisations and structures, and the opportunity to understand jargon that is difficult to access.

I aim to discuss the connections between trust and health literacy:

-Does high health literacy correlate with high trust beacuse of similarities between the sociodemographic groups?
-If health literacy and trust is low, what are the effects on large-scale healthcare projects, such as COVID-19 vaccination?

2A: Uncertainty in pediatric transgender & DSD/intersex care

Uncertainty in sex/gender categorization in pediatric transgender and DSD/intersex care

Mieke Breukelman, Wyke Stommel, Anke Oerlemans, Chris Verhaak

Radboud UMC/Radboud University, The Netherlands

In healthcare for transgender children and children with a Differences of Sex Development (DSD)/intersex condition, sex/gender attribution is even more pervasive than in everyday contexts. In these settings, the way in which people treat and conceptualize ’female(ness)’ and ‘male(ness)’ has implications for diagnoses, treatments and futures (cf. Timmermans et al., 2019; Turowetz & Maynard, 2016). As in everyday life more broadly, categorization in these healthcare settings is predicated upon (implicit) assumptions and norms about what is ‘male’ and what is ‘female’ (West & Fenstermaker, 2002; West & Zimmerman, 1987). The elusive, unpredictable and polarized nature of sex and gender makes that categorization practices are laden with (moral) uncertainty (cf. Naezer et al., 2021; Oerlemans et al., 2023; Timmermans et al., 2019). How do participants in pediatric transgender and DSD/intersex care, in the context of such uncertainty, deal with sex/gender categorization in interaction?

Our study employs conversation analysis (CA) on a data set of clinical consultations between children/adolescents, parents and healthcare providers in transgender and DSD/intersex care. The analysis displays how the interlocutors orient to categories of ‘male’ and ‘female’ in interaction. The use of CA entails that sex/gender is in this study primarily approached from a participants’ perspective (cf. Fukuda, 2023; Stokoe & Smithson, 2001). Drawing on membership categorization analysis, the analysis also applies data-external cultural knowledge in recognizing what features are treated by participants as being typically associated with categories of ‘male’ and ‘female’ (Jayyusi, 1984; Stokoe & Smithson, 2001).

The analysis shows that children/adolescents, parents and healthcare providers in transgender and DSD/intersex care achieve clinical goals that call for sex/gender categorization without making sex, gender or its distinction explicitly relevant. Rather, they mainly ground their collaborative categorization in category-tied predicates (Stokoe, 2012), i.e., specific features that are associated with ‘male(ness)’ or ‘female(ness)’ like anatomical aspects, behavior, appearance and individual wishes. In selecting ‘male’ and ‘female’ features, participants implicitly draw on normative assumptions of sex/gender. While these tacit assumptions are interactionally confirmed or challenged, uncertainties regarding sex/gender are hardly made explicit in consultations.

Data extracts will be shown to discuss questions such as:

- **How to identify/operationalize uncertainty in the data?**
- **How to deal with limited/binary language to describe diversity in sex/gender, inside and outside of these healthcare settings?**
- **If sex and gender are not treated as distinctive notions in interaction, is it efficacious to maintain and use this distinction in healthcare?**

Healthcare providers’ experiences with and reflections upon uncertainty in transgender and DSD/intersex care for children

Casper Martens[1], Marij Hillen[1], Anke Oerlemans[2]

[1]Amsterdam Medical Center, The Netherlands; [2]Radboud Medical Center, The Netherlands

Uncertainty is pervasive within healthcare for gender and sex diverse children, i.e. care for transgender children and children with differences in sex development (DSD)/intersex conditions. Healthcare professionals (HCP), parents and children have to collaboratively make far-reaching decisions regarding possible treatment. However, evidence from longitudinal studies about these relatively new and evolving treatments is lacking (shuster, 2016; Timmermans et al. 2019) and various ethical dilemmas are present within these healthcare contexts (Naezer et al. 2021; Oerlemans et al. 2023). The uncertainty HCPs experience can be medical, psychological, societal, ethical and communicative in nature, but we currently lack a comprehensive understanding of uncertainty within this context (Oerlemans et al. 2023).

This interview study explores how HCPs experience and reflect upon uncertainty in pediatric transgender and DSD/intersex healthcare. We purposively selected a sample of 21 healthcare providers including pediatric urologists and endocrinologists, gynaecologists, clinical geneticists, plastic surgeons, psychiatrists and medical psychologists working within two specialized healthcare centers in The Netherlands. We conducted a thematic analysis of the interviews.

The analysis shows that the absence of studies investigating long term outcomes appears to elicit ethical uncertainty on how decisions should be made. Three (provisional) levels of experienced uncertainty are distinguished. Firstly, the as of yet unknown future of children leads to questions about the likelihood that a certain intervention is going to lead to favorable outcomes and about which outcomes are pertinent. Secondly, uncertainties are present in HCP regarding which role each participant within the HCP-parent-child triad should have. Thirdly, HCPs experience uncertainty regarding their role and responsibilities in collaboratively providing care and deciding when treatment is indicated and providing care.

Based on the data presented we hope to discuss questions such as:
-In the interviews, we see an interwovenness of both factual and moral uncertainty. How should we understand this relationship and is this present in other healthcare settings as well?
-At a later stage we hope to link the data from these interviews with data from recorded consultations, how could we methodologically combine the data?

2B: Tailoring information

On what basis do physicians frame medical information? Distribution of information framing practices across tasks, patients, physicians, and settings

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[1] Health Services Research Unit (HØKH), Akershus University Hospital, Norway; [2]Institute of Clinical Medicine, University of Oslo, Norway

"It is not (only) a matter of what you say, but of how you say things". In the COME INFO project, we have identified 66 different information framing devices that physicians use spontaneously and intuitively while sharing information with their patients. Information framing devices are any dialogic mechanism used to present information in a particular way that shapes how the patient might perceive and interpret it. For example, physicians can accentuate a message, be directive, make it relevant for the patient, or use precise terms. Here, we refer to these, whether single devices or clusters of devices, as framing practices.
As a last phase of the project, we are exploring how these information framing practices are distributed based on interaction-, patient-, doctor- and setting-related variables. In particular, we seek to find answers to:

1) Are there specific (combinations of) framing practices used for specific interactive functions (informing, reassuring, inviting, convincing, meta-communicating)?
2) Are there framing practices that reflect individual physicians' styles?
3) Are there framing practices that are more sensitive to the individuality of the patient?
4) Are there specific framing practices more frequently used in specific clinical settings?

We have collected 45 videotaped interactions between 14 physicians working in four different hospital settings (gynaecology, orthopaedic surgery, oncology, gastroenterology) and meeting a range of 2-5 patients each. We are now extracting and counting the different information framing devices used by physicians when providing medical information to patients.
In parallel, we are discussing the possible analytical plan: from using cluster and/or factor analysis to first identify groups of framing devices with similar properties to describe frequencies of framing devices based on function- interaction-, patient-, doctor- and setting-related aspects.

For OCHER, we would present some preliminary findings. The specific question we are asking is: what is the most promising direction for the analysis?

Clinicians' communicative practices to tailor health care information during the clinical encounter: A Scoping Review

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[1]Amsterdam UMC (location AMC), The Netherlands; [2] Health Services Research Unit (HØKH), Akershus University Hospital, Norway

Giving health care information that is in harmony with patients information needs and processing capacities is a complex task for clinicians. Clinicians need to judge their patients' information desires as well as their ability to work through and understand the information provided. Much research demonstrates that there is discordance in the information dynamic between patients and clinicians, pleading for information to be more tailor-made, accustomed to the individual patient. This approach is argued to positively affect patient outcomes, such as patients' health-related quality of life. However, the actual practice of how clinicians can concretely tailor health care information to each individual patient remains understudied. Especially, communicative practices to tailor such information have not been summarized before and lack evidence-based indications.

Therefore, this scoping review synthesizes scientific knowledge about the communicative practices used by clinicians to tailor health care information to individual patients during the clinical encounter. Gaps in the literature on this topic are highlighted, guiding future research.

Points for discussing could be the following:

1. **The 'added' value of the scoping review for the larger research project (PhD track)**
2. **Presenting preliminary findings on the definitions of tailoring, communication practices used by clinicians to tailor health care information and implications thereof for clinical practice.**

3A: Older patients

Development of Brief Intervention for discontinuing prolonged z-hypnotics use among older adults

Tahreem Ghazal Siddiqui[1], Maria T. Bjelkarøy[1], Tone B. Simonsen[1], Socheat Cheng[1], Julia Menichetti[1], Jennifer Gerwing[1], Christofer Lundqvist[1,2]

[1]Health services research unit (HØKH), Akershus university hospital, Norway; [2]Medical faculty, University of Oslo, Norway.

Background

Communicating effectively with patients is crucial for successful clinical interventions. In the case of insomnia treatment, prolonged use of z-hypnotics could lead to severe health risks. The aim of this study was to develop a brief behavioural intervention that uses communication to encourage older adults to discontinue prolonged z-hypnotics use.

Methods

Using the UK Medical research council guidelines, we developed a theory-driven communication-based intervention. We employed an iterative approach that included a literature review to identify theoretical foundations, preparatory research studies, and feedback from user and expert groups to refine the intervention plan.

Results

In the literature, while existing studies focused on discontinuing anxiolytics and sedatives, none solely addressed z-hypnotics. Most studies provided information to the patients on the risk of prolonged use and the benefits of discontinuing. We adapted our intervention based on the Brief Intervention (BI) manual and related studies, utilising nine of our prior research studies involving older patients to tailor the content. User group and expert group input supported the need for short simplified patient information. The structured BI includes: (i) identifying at-risk patients using a validated tool, (ii) offering personalised evidence-based information based on assessment, (iii) discussing patient goals and options, and (iv) creating a treatment plan for z-hypnotics discontinuation with the support of the physician.

Conclusion

Our intervention provides evidence-based knowledge for patients and physicians, as well as a systematic approach to discontinuing z-hypnotics use. This patient-centric consultation-based intervention could serve as a standard treatment to reduce prolonged z-hypnotic use and lower the risk of adverse events related to prolonged z-hypnotics use in older patients.

Future work involves testing its effectiveness in an RCT study design. We plan a cross-over design, where we will have the opportunity to make changes to the intervention the GPs receive.

Our questions for OCHER pertain to this:

1. **Should we invest in a design where we videorecorder the GP-patient conversations?**
2. **Any feedback about the communication strategies used in the intervention and about how to tailor content is welcome.**

Ageist attitudes among healthcare providers as a barrier to healthy aging: how to recognize and tackle them?

Monique Heijmans, Janneke Noordman, Sandra van Dulmen

Netherlands institute for health services research, The Netherlands

People with chronic diseases are confronted with a number of challenges in the daily management of their disease like following medical advice, changing lifestyles, communicating with health care professionals, finding their way in health care and dealing with the physical, social and emotional consequences of having one or more diseases. Given these challenges, it is not surprising that many people find this difficult and need self-management support. This support should be given on an equal basis, irrespective of age, gender, health status, or other characteristics.

However, the reality is different. Especially older people, who constitute the largest group within the population of chronic diseases patients, seem to be at risk of an unequal access to preventive, promotive, and curative treatment options that help them in their self-management and contribute to their possibilities of active and healthy aging. In a recent study on self-management in COPD, heart failure and diabetes type 2, we found that older people often felt stigmatized by their health care professionals and considered as being too old or too frail to take an active role in their own treatment. They felt that options for treatment and self-management were less offered to them unless their expressed motivation to engage in self-management behaviours or to explore other treatment options. This resulted in negative evaluations of the treatment received by these patients with terms as “disrespectful” “baby talk” and the shrugging off of patients’ complaints and concerns as “just old age”. Within the context of an aging population, getting the best of an older age and contributing as much as possible to active and healthy aging is urgently needed.

In my presentation, I would like to discuss these ageist attitudes as experienced by patients along the following questions:

- **Do ageist attitudes towards self-management support of older patients indeed exist among healthcare providers, either conscious or unconscious?**
- **Can we transform negative age-based categorizations or stereotyping into more positive ones and what is needed for that?**
- **In the context of self-management support: how can we take advantage of an older age of patients?**

The autonomy conundrum in intensive care: Do recognized sources of judgment error also affect proxy statements made by next-of-kin regarding patients' treatment preferences in an event of life-threatening illness?

Gabriele Leonie Schwarz[1], Margrethe Schaufel[2]

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Introduction

In very elderly (> 80 years) patients the benefit of intensive care remains unclear, and the risk of overtreatment is high with harmful consequences to both patients, families and society. Many very elderly regard survival to permanent care dependence a less favourable outcome than death. In an event of acute critical illness very elderly patients frequently do not retain capacity, and patient preferences are communicated by family members. Proxy accuracy in comparable settings has shown to be weak.

Methods

We conducted a mailed survey among very elderly outpatients and their next of kin, and included 140 dyads, exploring treatment preferences in hypothetical cases of acute critical illness. We calculated percentage agreement between choices made by the very elderly respondents themselves and choices made by their proxies.

Results

We found only weak agreement between the very elderly respondents own ICU admission preference, and the preference as stated by their proxies. The proxy statements made on behalf of the elderly respondents showed significantly higher agreement with the proxies own preferences. Both very elderly and proxy respondents expressed high levels of confidence in proxy judgements.

Discussion

The proxies made their judgment based on their own preferences rather than true knowledge of the very elderlies` preferences, indicative of an underlying cognitive error frequently described as assumed similarity. Assumed similarity is known to increase within close relationships, in collectivistic individuals or contexts, and when the object of judgment is value laden.

There is a large body of evidence regarding these kind of ubiquitous errors of judgment, when assumptions or decisions are made on behalf of others, but surprisingly little is known about their role in medical settings, and they are largely not acknowledged in clinical practice and health care governance.

Questions to discuss:

- **How can patient autonomy be valued and ensured in cases where stakes are high, and decisions are made under significant uncertainty?**
- **How can family members contribute to medical decision making, when proxy accuracy is low, and the risk of judgment errors is high?**
- **How can weaknesses in proxy judgment be communicated to the public and policy makers?**

3B: Asking questions

The Difficult Conversation: How and when do midwives introduce the topic of violence in antenatal care?

Marit Nygård Halvorsen

Oslo Metropolitan University, Norway

In 2014, the Norwegian Directorate of Health introduced new guidelines in which health professionals should ask pregnant women about exposure to violence. Introducing such a topic is difficult, and previous studies have demonstrated the need for further education and organizational support for midwives in antenatal care. As a part of my PhD project, I aim to discover how and when midwives introduce the topic of violence by using CA – conversation analysis, as my theoretical and methodological framework. My data is video recordings from first, - and second consultations of pregnant women in antenatal care. Current analyses show two main approaches when asking about experiences of violence: 1) moving on to the next topic after the women have rejected previous experiences or 2) continuing talk about the topic, despite rejection. The midwives also show some differences when introducing the topic: 1) as part of habitual questions regarding topics such as previous diseases, living situation, and diet or 2) as a topic of its own with several pre-expansions and preparations before introducing the question.

I plan on showing some of my findings, and want to discuss the following questions:
1) How: Which of the various approaches makes it the most manageable and likely for pregnant
women to talk?
2) When: Which of the various approaches makes it the most manageable and likely for pregnant women to talk?

How do physicians ask about acute chest pain? First observations from video-recorded encounters in three Norwegian hospital emergency departments

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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. However, 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 the diagnosis unspecific chest pain. Nevertheless, little research has been offered symptom talk between patient and physician in the emergency department. 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 and ways in which physicians elicit this, 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 64 video-recordings of naturally occurring encounters involving 46 physicians and 52 patients admitted to the emergency department in three Norwegian hospitals.

Aims

At OCHER, we aim to explore how physicians ask patients about their chest pain, and what interactional consequences various questioning techniques may have for patient responses.

Questions for discussion

- **What methodological challenges and opportunities should we be attentive to?**
- **Do you see any potential and obstacles for communication training based on these data and preliminary findings?**
- **How - and in specifics with regards to chest pain - could physicians improve their history taking with chest pain patients?**

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Asking about allergies: Implementing safe prescribing of antibiotics in primary care

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Background

Although approximately 10% of patients in Europe and North America report allergy to penicillin, only 2-10% have a true allergy. This is seldom tested, so clinicians rely on patient/caregiver reports. Many patients may be being unnecessarily prescribed second line broad spectrum antibiotics when they could be having first line treatment. This is associated with increased risk of treatment failure, higher costs, and implications for antibiotic resistance.

Methods

The data are drawn from detailed transcripts of video and audio-recorded consultations with adult patients for common respiratory infections in in-hours and out-of-hours primary care settings in Sweden and England. The data were collected between 2014-2020. We screened (n=67) Swedish and (n=98) British consultations for questions about allergies to antibiotic medicines. Questions in search for a possible cause or diagnosis of patients' problems were excluded. We applied conversation analytic (CA) methods making case-by-case observations. and built a CA-grounded coding scheme to help search for patterns across the data.

Preliminary observations

In terms of frequency, drug allergy questions were asked in 21/67 Swedish and 33/98 British consultations. They were more likely to be asked when the consultation resulted in an antibiotic prescription. Questions could be asked pre-diagnosis, as part of history-taking or post-diagnosis in advance of prescribing treatment. Most questions were optimised toward a 'no problem' outcome e.g., "Du tå:l allt? You tolerate everything?" or "you're not a:llergic to any medication at a:ll?" Depending on position and composition, the agenda of the questions was sometimes misunderstood. Most patients reported no allergy, although often expressed uncertainty e.g., "inte vad jag vet" or "not as far as I know?" Patient 'no allergy' reports were sometimes contested by clinicians on the basis of what was recorded in their medical records. In the Swedish data the drug allergy questions were predominantly located post-diagnosis. In the British data they were asked both during history-taking and during the treatment phase. Swedish drug allergy questions were more likely to be framed as to whether the patient tolerated antibiotics. In contrast, British clinicians tended to ask patients whether they were allergic to antibiotics.

Discussion

We welcome any feedback on our findings.

4A: Communication training at the national level

Enhancing Pharmacy Practice: Assessing an E-Learning Course for Foreign Pharmacists

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Pharmacy practice in Norway requires an understanding of regulations, healthcare systems, and language proficiency. Given the national shortage of pharmacists, the recruitment of pharmacists trained outside Norway has become crucial. While this brings the sector valuable health care resources, immigrating pharmacists may face challenges related to patient communication. APOKUS, the Norwegian pharmacy competency and development center, has created a course designed to support pharmacists in their transition into the Norwegian pharmacy workforce. This research project focuses on evaluating the effectiveness and impact of this course.

The project aims to address the following research inquiries:

1. Effectiveness of E-Learning; How effective is the online course in preparing pharmacists for pharmacy practice in Norway, including preparing them for communicating with patients in Norwegian pharmacies? To gauge this, we will assess participants' knowledge acquisition, understanding of regulations and their ability to apply this knowledge practically.
2. Integration and Adaptation; To what extent does the course assist pharmacists in adapting to the healthcare system and integrating into the local pharmacy workforce? We will explore participants' experiences and perspectives on adaptation and integration.

To assess knowledge acquisition and retention we will gather data through pre and post course assessments. Additionally, we will conduct interviews with course participants to gain insights into their experiences, challenges they face and perceived advantages of the course.

Research questions:

- **What are recommended communication training interventions for foreign trained healthcare workers who are starting to work in Norway?**
- **What are the preliminary results and possible interpretations?**
- **Based on the evaluation of the E-learning course for foreign pharmacists, what recommendations can be suggested to improve the E-Learning course?**

OKRA: orientation compass for the preparing, delivering and following-up of breaking bad news conversations in pediatric oncology

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Purpose

In pediatric oncology, breaking bad news (BBN) is particularly challenging. Failure to address pediatric patients/children's and their relative's specific needs might negatively impact on both the BBN recipients and providers (e.g., physicians). Pediatric-specific BBN support tools lack in Germany. The project OKRA – Orientation Compass for BBN in the pediatric oncology – aims to develop a tool to prepare, guide and further support BBN providers, funded by the German Leukemia Research Aid. OKRA consists of two-phases: knowledge generation and product development. Outcomes of its first phase are presented.

Methods

In a five step Participatory Group Delphi (PGD) multiperspective knowledge was systematically generated through interviews, focus group discussions and surveys. Qualitative thematic analyses are conducted. Four groups participated: (1) experts on their own behalf (organizations representatives on behalf of affected children and their parents), (2) BBN providers from pediatric oncological teams and representatives of national professional societies, (3) psychosocial support organizations, and (4) health system researchers. The PGD culminated in the formulation of theses for the high-level performance of BBN.

Results

Fourteen organizations contributed their knowledge from their perspective. After exploring the emerging themes around the categories preparing, delivering, and following up a BBN the OKRA theses were formulated.

Discussion

A systematically designed tool for BBN preparation, delivery, and follow-up in pediatric oncology is of outstanding interest. It may reduce BBN-provider's emotional distress and lead to improved quality of care. A well performed BBN may impact on recipients' ability to cope with the disease and increase psychosocial well-being.

Conclusions

Exploring the requirements from multiple perspectives leads to a comprehensive understanding of the crucial issues to be addressed around the BBN. The PGD process was helpful for generating pediatric oncology-specific theses that build the foundation for the BBN guiding tool OKRA.

Questions for discussion:

(1) What issues (e.g., structure, suitability criteria, etc.) should be considered when developing the compass?

(2) What are critical aspects when piloting the compass in the pediatric oncology?

(3) What else seems to be important to equip multidisciplinary team for the BBN?

(4) How should a capacity building activity be designed (e.g., content, implementation criteria, didactic, etc.)?

Ready for SDM - Development and evaluation of a meta-curriculum for training healthcare providers in shared decision making

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Background: Training healthcare providers in SDM is considered key to implementation of shared decision making (SDM). In response to specific needs of the Norwegian health system we aimed to develop and evaluate a meta-curriculum consisting of several evidence-based SDM training modules designed to facilitate patient involvement in decision making.
Methods: The Knowledge-to-Action framework (KTA) guided both the development of the meta-curriculum and its implementation. KTA integrates knowledge production and -use, and defines the interfaces between these two processes as essential for implementation. Individual components and entire modules for the meta-curriculum were evaluated using mixed and multiple study designs including piloting, pre-/post-test and RCT.
Results: Using a generic pedagogical approach the new “Ready for SDM” meta-curriculum was developed while concurrently considering implementation to enhance SDM in clinical practice. It consists of seven training modules addressing several target groups nurses. The modules employ combinations of learning formats, learning activities, and behaviour change techniques. All materials are made available on the online platform, klarforsamvalg.no. Ready for SDM, hitherto evaluated in six studies (N= 717 participants) and several quality improvement projects (N=456), was acceptable to participants, feasible to deliver, and demonstrated effective for increasing SDM competencies. The curriculum is adaptable to varying needs of particular healthcare professions, settings, formats and timeframes, and learning progression is facilitated by allowing individual learning pathways regarding the order within which the modules are attended. Implementation is carried out by ambassadors, certified in the train-the-trainer module. To tailor training to the needs of end-users, ambassadors can add or modify material on the learning platform.
Implications: To the best of our knowledge the meta-curriculum is the first and only one of its kind. It is likely to overcome many of the known obstacles related to implementation of SDM training for several reasons: Firstly, its multi-modular adaptive architecture is facilitating implementation. Secondly, the curriculum is addressing multiple professions and using an interprofessional approach. Thirdly, assurance and maintenance of quality is achieved by constructing the curriculum as feedback-driven continuous learning system rather than as a fully standardised curriculum. Further evaluation is required to determine if “Ready for SDM” as part of a multifaceted SDM implementation strategy will improve the quality of healthcare decisions.
Discussion:

- **the way we explain the methodological approach to the development of the meta-curriculum**
- **in particular, whether it is traceable and understandable.**

After publishing many single steps separately, this is our first attempt to explain the approach from a meta perspective.

4B: Reflection/interviews on interaction data

Reliability of a patient-centered template for self-instructed feedback in medical students' consultation

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Background. Patient-centeredness has a 50-year history but has been difficult to implement in clinical practice. Possible reasons are unclear definition, lack of criteria and too little training. Here, the methodology with generic three-phase consultation provides a constructive input for assessment and feedback. At Karolinska Institutet, a structured reflection template with self-instructed feedback has been developed and introduced within the medical curriculum. The template is not validated or tested for reliability.

Question. Can self-instructed feedback of medical student's audio-recorded consultations in clinical practice facilitate knowledge, understanding and skills in patient-centered work and be followed-up as progression over time?

Methods. At the ninth of eleven semesters 160 medical students audio-recorded a student-patient encounter at a primary health care center. The students scrutinized the audio recording and followed the template's written instruction to transcribe critical parts of the consultation. Subsequently, the teachers gave written feedback to each student. To assess the reflections, the consultation process was divided into 10 different critical communication skills and if present the teachers assigned one point for each item. To investigate the interrater reliability seven teachers at three medical schools in Sweden were involved. Each teachers' points were summed to a maximum of 5 points for the patients' part and 5 points for the shared part. To achieve best possible consistency the teachers discussed 15 student reflections in a test round before study start. The reliability testing was performed by weighted Kappa analyses.

Preliminary results. In the patients' part, there was substantial inter-rater agreement between teachers with the same experience of using the template (κ=0.65-0.77). However, there was fair to moderate agreement between teachers with different experience with use of the template (κ=0.38-0.62). In the shared part, the respective κ-values showed the same trend although lower values (κ=0.24-0.36 and κ=-0.09 to 0.34, respectively).

Discussion. The instructions for assessment and feedback in the template may be one reason to the lower reliability between teachers with different experiences. This gives hope of reaching a generally high inter-rater reliability among different assessors following amendments of the template.

Question

To assess patient centered communication and its progression, is the consultation template relevant?

Nurses' clinical reasoning and decision-making during initial assessments in primary care

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Overall information: The overall postdoc project includes three work packages (WPs) within the project ‘The patient's first point of contact in primary care – registered nurses' communication and initial assessment’. This abstract focuses on the second WP.
Background: Primary care is central to the Swedish healthcare system, for integrated care, with focus on accessibility and continuity. In Swedish primary care, over 36 million health visits are made annually, and more than 10 million of these are visits to RNs. RNs are usually the patient's first point of contact and the ones who assess patients’ needs and complaints. The way the interaction and communication between RNs and patients proceed is crucial for a proper exploration and understanding of patient’s health concerns and the need for follow-up care. There is a lack of research on RNs communication strategies used to address individual patients’ needs during these initial contacts. Such insight is needed to strengthen RNs' competence and skills which, in the long term, will benefit patients as well as the scarce primary care resources.
Aim: To explore RNs’ clinical reasoning, decision-making and patient involvement in patient-RN consultations in primary care.
Methods: The second WP is a qualitative study involving primary care units in a Swedish Region. The RNs in this region are asked to reflect on their clinical reasoning and decisions as observed during audio recordings of their own consultations as collected as part of WP1. These stimulated recall interviews will be audio recorded and transcribed verbatim. A qualitative thematic analysis based on descriptive phenomenology will be used to analyze the transcribed interviews. In addition to interviews, the ‘Observing Patient Involvement in Decision-Making’ (OPTION)5 instrument will be used to explore to what extent RNs involve patients in shared decision-making in the consultation. This will be assessed and scored by one or two researchers.
Expected findings: This research will gain knowledge about RNs' communication strategies, clinical reasoning, decision making, and patient engagement in patient-nurse primary care consultations.

Request for feedback:
Tips or experiences using the OPTION instrument and stimulated recall in a similar context.

Nurse-parent communication and interaction in Single Family Room NICUs in Norway (NPAC study)

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Background

The growing trend toward single family room (SFR) Neonatal Intensive Care Unit (NICU) design and continuous parental presence is driven by the awareness of how important the sensory environment is to the preterm infants' brain growth and early developmental needs, as well as a desire to provide environments that support and encourage parental participation. The SFR requires a substantial change in NICU culture and interaction with parents. Lack of support and poor communication from nurses is perceived by parents as an obstacle for involvement in care. Interaction with parents in SFR is reported as challenging for the nurses. The project will provide important knowledge of the parent-nurse interaction in SFR and in what way the NICU culture influences the nurse-parent partnership.

Aim and research questions

The overall aim of this study is to obtain in-depth knowledge of the communication and interaction between nurses and parents of preterm infants in SFR NICUs.

The study has three sub-studies:

Sub-study I: the aim is to explore the interaction between the parents and nurses during guided interventions in SFR in three different phases of the NICU stay; 1) the first week- "to settle in" 2) moving on from the first intensive care phase to a more stable phase- "find their own way" and 3) the week before discharge- "to take over responsibility" Method: video-recording of nurse-parent interaction.

Analysis: Inductive, interaction.

Sub-study II: the aim is to explore and get a deeper understanding of the parents`experience of interaction with the nurses in SFR.

Method: In-depth interview with parents.

Analysis: Inductive, content.

Sub-study III: the aim is to explore how the nurses experience the interaction with the parents in SFR and how culture influences the parent-nurse interaction.

Method: stimulated-recall interview with nurses.

Analysis: Context, thematic.

Questions for discussion

1. General thoughts.

2. Analysis of the nurse-parent communication (videorecorded).

5A: Training connection with patients

LOOK and listen: How the coldness of health care providers is modifiable

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PURPOSE

To explore how we can make health care providers (HCP) more conscious of their gaze and to encourage HCPs to make more eye contact with their patients, making them better suited to promote meaningful lives for them, and thus strengthening the patient-provider relationship.

METHODS

Mixed quantitative and qualitative descriptive experimental design with narrative data analysis. 40 participants (23 HCPs and 17 chronic pain patients) viewed standardized videos depicting a patient-provider interaction in which the HCP did not look at the patient. Self-assessments and reflections were obtained.

RESULTS

Most HCPs recognized the clinical approach as cold, whereas 41% of patients recognized it as “normal”. When looking into patient’s eyes, 44% of HCPs were incapable of identifying the patients’ emotions, nor their own feelings. Powerlessness and vulnerability were felt by the HCP. Patients and HCPs agree that better addressing meaningful activities in a patient’s life, as well as looking at the patient more, would positively impact patient outcomes and pain management. At the one-month follow-up, 74% of HCPs did increased amount of eye-contact during their encounters and paid more attention to the relational aspect of their care.

CONCLUSION

We succeeded in making HCPs more aware of the gaze they hold onto their patient, thus encouraging them to change their actions. We attributed the lack of eye contact and lack of focus on meaningful activities to a sense of vulnerability felt by HCPs. We believe that non-verbal communications skills should be more overtly taught in medical school.

QUESTIONS

In this numeric era, many organizations oblige physicians and therapists to write notes directly on the screen. Doing this deviates the HCP’s gaze from the patient, neglecting nonverbal communication. However, the patient, now more than ever (post-pandemic), wants a rich encounter with his/her physician to manage existential topics. How do we tie down those two perspectives? One way would be to write our note at the end of the encounter, but this way, either the encounter is shorter in time, or we can see fewer patients.

How do we convince that taking care of the relational aspect of a medical encounter is a better bet than neglecting it?

Ethics and communication training as part of pulmonologists’ required teaching activities in a university hospital in Norway

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Background

From 2017, the doctors at the Department of Thoracic Medicine at Haukeland University Hospital, Norway, invited staff from the hospital´s Section for hospital chaplaincy and ethics to facilitate regular meetings about existential, communicative, and ethical challenges. The aim for this study was to explore what they find as their major learning outcomes of the meetings and which of the mandatory learning objectives in ethics, communication and palliative care they struggle with the most.

Methods

The training was implemented as part of a palliative care strategy to improve doctors’ competence supporting patients who experienced existential suffering in life-limiting pulmonary diseases, and at the same time build resilience and coping among the doctors facing their patients’ suffering. The meeting format is structured around a case study presented by one of the doctors who has experienced the case ethically, communicatively and/or existentially difficult, followed by a discussion and reflection on the topic in plenary, as well as contributions on ethical theories and models that can be useful for analysing the situation, provided by ethics consultants/members of the Clinical Ethics Committee. An email with a link to an anonymous questionnaire was sent to all doctors at the Department to evaluate the learning outcomes, including open ended questions.

Results

16 (1/3) doctors responded (9 consultants, 6 junior doctors, 1 leader). Sessions had been useful in increasing their competence across a variety of topics, like analysing ethical dilemmas in clinical practice, priority setting, dealing with «difficult» deaths/existential challenges, developing their professional identity, and being more comfortable sharing uncertainty with colleagues. 88% wanted the sessions to continue in its current form. Suggestions for improvement included more time to learn about tools, more structured case presentations and more involvement of junior doctors.

Discussion

1. **What would be the most “beneficial” way to further develop these sessions to improve learning outcomes regarding medical uncertainty?**
2. **Input on what to omit from the extensive topic list, and other topics that ought to be included?**

5B: Video-based studies with children

Featuring ADHD in children; identifying challenges in interactions between child, parents and healthcare provider

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Attention Deficit Hyperactivity Disorder (ADHD) is diagnosed in 7.6% of children aged 3 to 12, and in 5.6% of children aged 12 to 18. Child psychiatrists often prescribe medication to these patients. To monitor the adequacy and effects of the medication use, children and parents are offered periodic medication control visits. During these visits, the child is examined physically (length, weight, blood pressure) and the actual use, effectiveness and experienced side-effects of the prescribed medication are discussed with the healthcare provider. So far, insight is lacking into the way the triadic communication proceeds and the potential impact of ADHD symptoms. The behavioral symptoms of the ADHD, such as being unable to sit still and concentrate, excessive talking and interrupting conversations, are likely to interact with the communication that takes place during these medication control visits. As the communication during the medication control visits determines how parents and child cope with the ADHD (medication) until the next control visit, it is important to investigate how ADHD challenges the communication and how the communication can be enhanced given these challenges.

To this purpose, fourteen medication control visits with children using medication for ADHD, their parents and their healthcare provider were video-recorded. The recordings were analyzed qualitatively on the potential impact of ADHD symptoms on the flow and content of the communication. So far, the observations yielded communication challenges being more or less related to ADHD symptoms: being distracted by noises, not being able to concentrate for the full visit, walking around, disagreeing with the parents, questioning the relevance of the treatment policy, and attributing symptoms to contextual factors. In my presentation, I will give several examples of these observations and would like to discuss with the participants how these should be interpreted and used to enhance the communication during ADHD medication control visits with children and their parents.

Issues to be discussed:

- **What characteristics of ADHD are (not) relevant for (observing and interpreting) child-parents-HCP communication during medication control visits?**
- **How can these challenges be overcome with the purpose to enhance communication during medication control visits?**

Prerequisites for shared decision making during vaccinations in children and adolescents

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Background

Complying with vaccinations is crucial in view of prevention of infectious diseases. However, needle fear is known as an obstacle and appears to be quite prevalent in children. Children most often communicate fear and negative emotions non-verbally and these concerns are seldom acknowledged by healthcare providers (HCPs). Performing vaccinations in school where the child (aged 7 years or older) often visits the HCP without the parents, may be even more demanding. To support children, shared decision-making (SDM) should become common practice in pain management and vaccination consultations. Previous research shows that children like to be involved in decision related to care involving minor risks, which the needle procedure during vaccination is considered to be. To offer a communication style that acknowledges child preferences as well as SDM in vaccination procedures may help children to better cope with future medical procedures.

Aim

The main aim is to investigate prerequisites and mechanisms of HCP-child communication and SDM during scheduled vaccinations in school health or primary care. The second aim is to identify suggestions for child engagement in decision-making, harmful and supportive communication, and a trustful HCP-child relationship.

Methods

Data will be gathered in school health and primary care context and analyzed with both statistical and qualitative approaches. Data from child (7-16 yr), parent and HCP will be collected to address the aim.

Video recordings of the child-HCP communication during vaccination will be made and analyzed with the ‘Observing Patient Involvement in Decision-Making’ (OPTION) 5 instrument to explore to what extent HCP involve patients in shared decision-making.

Child self-report reflecting SDM during routine vaccinations.

Semi-structured interviews with children, parents and HCP will add a deeper understanding regarding decision levels, harmful and supportive communication, and trust in HCP relations.

Request for feedback:

What barriers and facilitators can be expected for evaluating SDM in primary care involving children?

Suggestions of an evaluating questionnaire for child self-report on SDM (7-16yr)?

OPTION 5 validation and experiences in children?

6A: Training medical students

Learning communication procedures in virtual reality (VR)

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There is a range of approaches for communicating patient information between healthcare personnel. However, the successful use of these approaches depends on providing large numbers of personnel with learning activities that require few resources and are effective. One novel learning technology which holds such potential is virtual reality (VR). In the www.virsam.no project, solutions for self-practice in groups of the ISBAR approach (Identification-Situation-Background-Assessment-Recommendation) have been developed. The challenges encountered, and the solutions chosen will be presented. This includes results from the development process and studies on usability (human centred design) and effect (randomised controlled trial).

The RCT showed that the short-term learning effect of the developed desktop VR application was superior to traditional learning practices. Thus, the choices made in the development to ensure that health care students and personnel can self-practice communication procedures, was successful. Some of the challenges encountered during the development phase, were related to how to structure the game, balancing the focus on and time for initial learning of the procedure and practicing it, and how to make it interesting enough to ensure repeated use. The solutions included an easy onboarding and getting to know each other set up within a relevant clinical situation, having individual training first followed by both practicing one-self and observation of others, and providing automated feedback and time and prompts for identifying what to focus on when doing it again.

The presentation of the experiences from this work can provide a good opportunity for discussing how competencies in structured procedural communication should be taught. Does self-practice increase wrong learning as there is no expert available to correct mistakes? What are the pros and cons of a virtual setting and acting through avatars compared to a physical learning environment? Should it be a focus on training on isolated communication competencies or should it only be done as part of a broader communication training?

Teaching shared decision-making to medical students – evaluation of an adapted teaching model originally made for junior doctors

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Background

There is an increasing focus on shared decision-making (SDM) as the model of choice for physicians and their patients when health-related decision are needed. Key elements of SDM includes introducing patients to a choice, describing the options and furthermore exploring the options and possible consequences with the patients. The Norwegian term for SDM, “samvalg” was introduced in 2014. South-Eastern Health Norway Authority has developed and validated a meta-curriculum consisting of several evidence-based SDM training modules designed to facilitate patient involvement in decision-making. This curriculum includes several training modules, among others, addressing junior doctors across all medical specialities. During the spring of 2022, an SDM teaching module was adapted from the teaching program for junior doctors, and introduced to 4th year medical students at the University of Oslo. The SDM sessions consists of an introductory didactic teaching, followed by role-play exercises in smaller groups.

Aim

To evaluate the SDM teaching for 4th year medical students at the University of Oslo.

Methods

We used an adapted survey, where we re-used questions from previous research on SDM for junior doctors, as well as adapted questions from SDM surveys for patients. We asked questions based on the two first levels of the Kirkpatrick model for evaluating teaching. This includes level 1 “reaction” and level 2 “learning”.

The students were asked to participate immediately after they completed the role-play exercises during the spring and autumn of 2023. Students not attending the role-play exercises were offered to participate in the survey by e-mail.

Results

Data collections continues through the autumn of 2023, and preliminary results will be presented at the workshop.

Discussion

- **How can we use this evaluation to change our teaching sessions of SDM?**
- **How can we use this evaluation to guide the evaluation of similar communication teaching sessions?**
- **In one year, these same students will do 12 weeks of clinical training at local hospitals and GP offices – means for follow-up after this?**
- **In three years, many of these students will meet the next level of SDM teaching in their first year as medical doctors – what can we expect?**

6B: Older patients with heart failure

Prevalence and Continuity of Medical Decisions Made in Encounters with Heart Failure Patients

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Background
Patients with heart failure (HF) are faced with a lot of tough decisions. Treatment of HF has made great advancements, largely due to scientific studies proving significant effects of drugs aimed at HF improvement, and increased life expectancy. Still, treatment is rigidly guideline directed, which may come at the expense of patient autonomy. Our study aims to investigate the prevalence and continuity of medical decisions in consecutive encounters with HF patients.

Method
We've analyzed 74 transcribed encounters between physicians and 25 HF patients, in both hospital and general practice. In these transcripts we've identified and categorized medical decisions with the Decision Identification and Classification Taxonomy for Use in Medicine (DICTUM) and evaluated shared decision-making (SDM) for drug related decisions using OPTION5 on a 0-100 scale.

Results
In the preliminary data consisting of 32 encounters/11 patients, we identified 453 clinically relevant decisions, averaging 14.2 decisions per encounter. Drug related decisions (DRDs) were most frequent (21.4%), with 58.8% being made at discharge. The majority (48.5%) were about drug therapy initiation. We found 13 (12.0 %) attempts of SDM concerning DRDs in ten (31.2%) different transcriptions; six of which were from encounters with the general practitioner (GP). The mean OPTION5-score was 15. We found eight (1.8%) instances of prognosis related decisions. At OCHER we will present data from the remaining body of data.

Discussion
Our study demonstrates that most decisions made in encounters with heart failure patients revolve around drug therapy, and that patient involvement is in these decision-making processes are minimal. The limited involvement may be due to rigid guidelines, and insufficient focus on shared decision-making. Furthermore, an important finding is that physicians talk too little about the prognosis with their patients. Early conversation about prognosis can promote patient understanding and may facilitate their participation in shared decision-making.

Questions:
- How can we best present our results (visually)?
- How should we frame our article (title/results/discussion) to have chances of getting the study published in a cardiology journal (with hopes that cardiologists read it)?

How do doctors respond to issues that patients with heart failure disclose about their adherence to medications?

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In the MAPINFOTRANS project, we seek to understand why patients with heart failure might struggle to use their medications as agreed. To meet this aim, we study how patients and clinicians discuss medication adherence. During an interaction with a patient, the clinician has the opportunity to assess, support, and address their reported adherence directly. We have completed a study on how patients report their adherence and are beginning an analysis of how the clinicians respond.

We have used a longitudinal design, where we collected material from patients admitted to the hospital with heart failure through to their return to home. Specifically, we have 74 audio-recordings of consultations between 25 patients with heart failure and: (1) hospital doctors at first ward visit in hospital, (2) hospital doctors at discharge from the hospital and (3) general practitioners during the first follow-up visit after discharge. We are analysing recordings inductively using microanalysis of clinical interaction (MCI).

We have defined and characterized all medication adherence disclosures in clinical interactions (MADICI) in the recordings; i.e., when patients provide information to clinicians about their initiation, implementation, or discontinuation of medication at home. The two essential elements that we used to identify patient utterances as a MADICI are (a) a reference to a prescription medication that the patient is self-administering, and (b) it includes the patients' action, experience, or stance about taking the medication. We have characterized MADICIs along several lines, e.g., how the patient refers to the medication, what kind of information they share, their present adherence, and implications for future adherence. Current analysis is focused on how hospital doctors and general practitioners respond.

Questions:

1. **Should we analyse responses after each MADICI in the material? Or a selection? And what would be the criteria for a selection?**
2. **Should we keep this descriptive or aim for a normative approach?**
3. **How can we create an analysis to maximize its usefulness for training and guidance about best practice?**

7A: Early-stage research projects

Moments of Vitality - Music Therapy in paediatric palliative care in hospital-at-home

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Background

Where are the voices of children and adolescents participating in music therapy in palliative care? Based on a scoping review, which is the first article in the thesis, I suggest there is a missing part in the literature on paediatric palliative care in hospital-at-home. In recent decades, there has been a treatment shift in paediatric palliative care from hospitalisation to hospital-at-home. As a conceptual and practical expansion of treatment in the hospital, hospital-at-home means children receive the treatment they are obliged to at home. Children and their families report great satisfaction with the opportunity to receive treatment at home. It is expected that this practice shift will continue to grow in the future.

Methods

Video and audio recordings of the music therapy sessions in the patients home, questionnaires to the parents, field notes and observations.

Questions for discussion:

How can the chosen methods contribute to making the voices of children and adolescents come forward?

Analyzing interactions between doctors and patients with pediatric type 1 diabetes: Outline of a PhD project in Scandinavian languages

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It is estimated that 95% of the treatment of pediatric type 1 diabetes (T1D) is self-treatment; it is therefore of vital importance that the diabetes consultations promote the complexities of the illness, and instill self-efficacy in the adolescent patients to manage their own illness. Previous research establishes that the quality of interaction determines the patient's adherence to therapy; in diabetes, adherence could entail managing one's own glucose levels, knowing one's insulin pumps, and maintaining a healthy lifestyle/diet. In addition to this, diabetic consultations for adolescent (teenage) patients might be challenging; the teenage years are associated with physiological and psychosocial changes that could negatively affect glycemic levels or glycemic control. Also, extra effort is made during the teenage years to have the patient accept an autonomous responsibility of the T1D treatment instead of relying on possible care-takers. Using Conversation Analysis (CA) tools I would want to identify both best practice and how to overcome roadblocks in the interaction leading to patient self-efficacy. I am currently in the process of applying for ethics approval, and am hoping to have circa 20-25 video recordings as my material, as well as field notes, questionnaires and electronic medical records. At this stage, I would want to discuss the following three questions:

1. **Several recordings of a few patients' consultations versus one recording of many patients' consultations. Pros? Cons? Consequences?**
2. **When recruiting teenage research participants who are possibly wary of being filmed/documented, what needs to be communicated by me (as a researcher) to instill trust and confidence?**
3. **Adherence to diabetes treatment can be operationalized and measured by objective clinical measurements: the Hb1Ac measurement and the Time in Target measurement. Are there other ways of measuring patient adherence to treatment that would be relevant to use in this CA study? Is the patient's perceived adherence a form of adherence, even if it doesn't lead to actual effect?**

7B: Early-stage training projects

How to engage medical students in curriculum and attendance

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Background and aim

Presently we are enrolling a new generation of students at medical school which are known as generation Z. This is the group who are challenging the educational system as they are expecting another experience in the classroom than our previous students found inspiring their learning.

Lecturers experience that their previous didactic and pedagogic approaches are challenged, and students approach medical school with a very selective process of not attending lectures. A systematic review addresses the dilemma and they found that the generation Z students need settings and formats which are similar to their daily life and the modern digitalization. Education at medical school is designed to embrace both nature and human sciences, and a crucial part of professional development is to learn communication, reflection, clinical uncertainty, and decision-making. However, there is a tendency that students pick and choose which lectures to attend and thus miss vital information and learning which may not be obtained on published presentations or YouTube. This tendency has increased after the Covid-19 pandemic with digital solutions like streaming and recording of lectures. We question whether these students will lack essential skills as future clinicians.

Our aim with this study is to explore the experience of medical students and their attitude to learning to tailor lecturing at medical school in a Danish- Norwegian context.

Methods

We want to perform a mixed method study with both Danish and Norwegian participants among medical students. First, we plan to perform a qualitative study with semi-structured individual interviews with 6 students from each country to explore their attitudes and preferences of learning.

Based on the results of the interview study, we will then design a questionnaire to a representative group of medical students in both Denmark and Norway. We will compare the answers from the different universities and from students in different parts of the education. This study can be a project for a Ph.D. candidate or for students on research track.

Discussion

We want to discuss the possibilities and limitations of this preliminary study plan to improve the protocol and have ideas for the study logistics.

Stabilizing health services – Can doctors' job satisfaction be enhanced by fostering Shared Decision Making and clinical empathy?

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What can help keeping doctors at work? Understanding factors for job satisfaction can contribute to stabilizing health services. A planned study focuses on communication skills and attitudes (Shared Decision Making), patient-connectedness and the experience of meaning at work as drivers for job satisfaction.

In a project using a mixed-methods approach, the relation between the factors shall be analysed from three different perspectives:

1. Deepening the understanding of doctors' experience by analysing qualitative material obtained in interviews and reports.
2. Exploring intercorrelations between job satisfaction, Shared Decision Making attitudes, and clinical empathy by using a self-reported survey. Data collection in Norway and Germany shall allow for international comparison.
3. Measuring the effect of communication training on job satisfaction with a focused pre-post survey. The comparison of two different training concepts ("Four habits" in Norway/ "Share-to-Care" in Germany) can give implications to further develop the Norwegian concept that is used in the specialisation training of doctors at University Hospital of North Norway.

We would like to present a preliminary study design and discuss it in search for improvement.
Possible questions are:

- **How can causality be strengthened?**
- **How can we control for confounding factors?**
- **What are important questions to ask the participants?**

8A: Qualities for shared decision making

What underlying doctor ‘qualities’ affect shared decision making? A starting shot for further investigation

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Background

Shared decision making (SDM) is highly recommended when more than one possible management strategy could fit an individual patient best. The aim of this clinical decision-making model is to combine the best scientific, medical, and clinical evidence, and what is important in this patient’s life. Research shows that SDM is still uncommon in clinical practice, even after four decades of efforts.

Objective

SDM may ask for more from doctors than (doctor) skills training, (patient) decision aids, and time. We propose a need to explore what SDM asks from doctors in terms of necessary underlying professional ‘qualities’ and how these can be nurtured or suppressed, in medical training and on the job.

Discussion

Key SDM tasks call for doctors to understand communication and decision mechanisms to carry them out well, including reflecting on what they know and do not know, considering what to say and how, and listening unprejudiced to patients. Different doctor qualities could support accomplishing these tasks. Possible necessary qualities may include humility, flexibility, honesty, fairness, self-regulation, curiosity, compassion, judgment, creativity, and courage. Doctors have many or all of these to some level, we assume, yet the qualities may get overshadowed by high competing demands during training and in the work environment. How the qualities relate to accomplishing SDM, which of these are (most) relevant and when, and how they could be nurtured best, are all empirical questions.

Conclusions

We conceive that particular qualities foster, or even are essential to SDM. Based on theory, we are starting to understand what they are. We now need to investigate their role.

Questions for discussion:

1) What theory or theories would be most relevant to studying how to nurture doctor ‘qualities’ relevant to SDM?

2) What study design or designs would be most fit to study the possible role of qualities in the occurrence of SDM?

Shared decision-making in advanced lung cancer: conversation analytic study of how doctors present treatment decisions and options

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BACKGROUND

To facilitate shared decision-making (SDM) it is important that doctors clearly present the decision to be made and the available treatment options to the patient. This study explored how treatment decisions after first line therapy were presented by doctors in advanced lunger cancer consultations.

METHODS

Twelve audio recordings of lung cancer consultations between patients with advanced disease, their relatives, and doctors in three Norwegian hospitals were transcribed and analysed using Conversation Analysis. The consultations took place between November 2019 and March 2022.

RESULTS

Doctors employed different strategies when presenting treatment options to patients. These were (1) selective option presentation; (2) recommended option presentation; and (3) open option presentation. Strategy (1) involved the doctor presenting one treatment option to the patient and not articulating the possibility of refraining from further therapy. Strategy (2) included the doctor's clear preference for a certain treatment option. Strategy (3) was the doctor clearly presenting all the different options in a balanced manner.

CONCLUSIONS

Strategies that doctors employ to present treatment options can facilitate SDM to different degrees, where some of them can be found to challenge core principles of SDM such as creating choice awareness. Doctors must be aware of their strategies to ensure that treatment decisions are presented in a way that supports SDM.

QUESTIONS FOR DISCUSSION

(1) Is it possible, or even preferable, that doctors should be neutral in these situations?

(2) Are organizational issues the most challenging? While breaking bad news, they are also dealing with everyday symptoms and issues in addition to decision-making.

(3) The best "template" for such discussions – could it be "six steps to SDM" or another framework?

8B: Patient factors affecting care decisions

Contextual factors among old patients with heart failure in the Norwegian health care system: Presence and form.

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The influence of patient contextual factors on patient outcomes is a vital yet often overlooked aspect of medical practice. Patients often struggle with balancing adherence to their treatment plans and the myriad of factors from their daily life that may interplay with it. The examination of these contextual factors, what they are, how they influence patient outcomes, and if they are adequately addressed has received increasing attention in recent years. However, our understanding of how they emerge in different medical interactions is limited, specifically for some patient populations.

This PhD project is part of MAPINFOTRANS, a longitudinal observational study which follows old (65+ years) patients suffering from heart failure admitted to a cardiology unit at Akershus university Hospital in their hospital to home transition. Our main data consists of sequential audio-recordings of consultations between patients and clinicians at: (1) first ward visit in hospital, (2) discharge from hospital and (3) follow-up visit with general practitioner (GP-visit). Additionally, patient records and medication lists were collected, together with questionnaires covering health literacy, cognitive function, and patient engagement. In total we have a participant population of 43 patients, constituting 115 recorded interactions.

To detect and describe contextual factors displayed by this patient population, a top-down approach is utilized. First, we created a reference list of contextual factors from a systematic review of reviews examining patient factors affecting adherence among patients with cardiovascular diseases. This list, combined with the 4C contextualization of care scheme developed by Saul Weiner, will be used as entry point in the interactions to (1) identify relevant contextual factors and (2) explore how and when they occur throughout the patient trajectory.

In OCHER, I will present this “contextual factors’ list”, the analytical plan, and preliminary findings. Particularly welcomed points for discussion are:

- **Discussion of unclear/grey/doubtful cases collected during the analysis**
- **Relevant dimensions to consider in the analysis (e.g. when contextual factors occur in the interactions, eliciting behaviours, form of contextual factor revelations)**
- **Possibilities for structuring the findings in a paper.**

An adapted approach to shared decision-making

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Shared decision-making (SDM) has been promoted and supported by policies, yet SDM is not widely adopted in clinical practice. Most SDM approaches tend to focus on involvement of patients in single treatment decisions, where patients are encouraged to consider pros and cons of available options and to communicate their informed preferences. However, health care providers (HCP) do not often consider the current SDM focus relevant for the decisions they make with patients. In chronic care settings, it is common for patients to experience challenges, such as symptoms and needs, which affect their daily living. Care for patients with a chronic condition may require SDM in response to their experienced challenges.

Based on previous SDM approaches, we seek to adapt a SDM approach to suit the challenges of patients living with a chronic health condition over time, and their HCPs. To support the adapted SDM approach a digital tool was developed to provide patients with the opportunity to communicate symptoms, needs and preferences prior to out-patient consultations with their HCPs.

The adapted SDM approach focus upon the collaborative work between patients' and HCPs to identify patient challenge and develop a shared understanding about how the challenge affects the patient's daily life, recognize the patient's feelings about the challenge and resolve or change the patient's situation by suggest or make decisions regarding possible actions in line with the patient's preferences and relevant evidence. The developed digital tool has the potential to provide insight into patients' current situations and identify important topics for patient-provider conversations.

A SDM approach adapted to suit situations patients and HCPs commonly face may have the potential to facilitate SDM, as well as potentially increase its adoption. The extent to which the adapted SDM approach and the developed tool actually can facilitate SDM for patients experiencing challenges from living with a chronic condition needs further exploration. However, the adapted SDM approach and the developed tool is in line with other initiatives to explore and understand SDM, which highlight that SDM practice need to vary with patients' situations.

Suggested questions for discussion:
In what way may the adapted SDM approach be a suitable response in chronic health care settings?
How could such a tool facilitate SDM in chronic health care settings?