Annual OCHER workshop on clinical communication
Thon Hotel Arena, Lillestrøm, Norway
January 8-10, 2025

		Wednesday, January 8	
Time	**Activity**	**Plenary room / Room A**	**Room B**
1000	Plenary	Introduction, mutual presentation	
1045	Break		
1100	Plenary keynote	**OCHER 2012-24: Learning, thinking, creating, and belonging (Pål Gulbrandsen)**	
1200	Lunch		
1300	Plenary keynote	**Different approaches to analyze communication in healthcare: methods and related outcomes (Lidia Del Piccolo)**	
1400	Break		
1415	Groups	**Session 1A** (Chair: Hanne) **Uncertainty**	**Session 1B** (Chair: Jennifer) **Perinatal care**
		Margrethe Schaufel	Anne Marie Landmark
		Jackelyn Payne	Marit Nygård
		Arwen Pieterse	Lene Lyngstad
1545	Break		
1600	Groups	**Session 2A** (Chair: Anne Marie) **Non-verbal communication and data gathering**	**Session 2B** (Chair: Jennifer) **Training	education**
		Annelie Sundler	Lotte Abildgren
		Daria Schwalbe	Trygve Skonnord & Christina Louise Lindhardt
		Hilde Eide	Eirik Ofstad
1730	Break		
1830	Networking	Clustering based on shared work aspects + curiosity questions	
1930	Dinner at hotel		

		Thursday, January 9	
0830	Plenary keynote	**Reconsidering patient-centered care (Alison Pilnick)**	
0930	Break		
0945	Groups	**Session 3A** (Chair: Lena) **Pediatric care**	**Session 3B** (Chair: Jennifer) **Primary care | Medical history**
		Lena Hedén	Malin Östman
		Sandra van Dulmen	Vibeke Sundling
1045	Break		
1100	Groups	**Session 4A** (Chair: Anne Marie) **Uncertainty**	**Session 4B** (Chair: Julia) **Asking patients (and clinicians)**
		Lizet Brenkman	Anna Lindström
		Chloe Shaw	Barbara Schellenberger
		Kristen Pecanac	Emma Källerö
1230	Lunch		
1330	Plenary keynote	**Now kitchen, next moment cathedral: Learning how to talk in medicine (Pål Gulbrandsen)**	
1430	break		
1445	Groups	**Session 5A** (Chair: Lena) **Making care fit**	**Session 5B** (Chair: Anne Marie) **Uncertainty**
		Anna-Lea van Ooijen	Sara Gilani
		Stig Nymo	Monique Heijmans
		Jennifer Gerwing and Kristina Edman	Willemijn Klein
1615	Break		
1630	Networking	Thematic rooms, based on program, suggestions, networking 2	
1730	Break		
1900	Dinner at hotel		

		Friday, January 10	
0830	Plenary keynote	**Communication in healthcare: some observations emerging from research and clinical practice (Lidia Del Piccolo)**	
0930	Break		
0945	Groups	**Session 6A** (Chair: Julia) **Heart failure patients and adherence**	**Session 6B** (Chair: Hanne) **Inequalities**
		Herman Bjørnstad	Karin Yde Waidtløw & Daria Schwalbe
		Christine Frigaard	Anniken Fleisje
1045	Break/check out		
1115	Groups	**Session 7A** (Chair: Lena) **Patient involvement**	**Session 7B** (Chair: Hanne) **Health literacy**
		Ana Carvajal de la Torre	Mette Haaland
		Elna Leth Pedersen	Julia Menichetti
1215	Lunch		
1315	Groups	**Session 8A** (Chair: Jennifer) **Primary care**	**Session 8B** (Chair: Julia) **Health literacy**
		Johanna Haraldsson	Weiwei Lu
		Trygve Skonnord	Helge Skirbekk
1415	Break		
1430	Plenary keynote	**Interdisciplinary research matters: reflections on working at the interface between sociology and medicine (Alison Pilnick)**	
1530	Plenary closing	Evaluation and round-up	
1600	End	Safe Travel!	

Session 1A: Uncertainty

"Now it's more uncertain than ever" – a qualitative study of doctors' experiences, coping and communication about medical uncertainty

Margrethe Aase Schaufel[1], Ingrid Milijeteig[2,3], Helge Solheim[3], Frode Lindemark[1], Paul K. J. Han[5]

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Background
From 2017, 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—known as "Powerlessness Rounds." The aim of this study was to explore how participating physicians experience, cope with, and communicate about medical uncertainty in order to improve teaching on this subject.

Methods
We are conducting a qualitative interview study among doctors attending the teaching sessions. A purposive sample comprising four consultants and four pulmonology fellows (LIS3) has so far been recruited and interviewed. Systematic Text Condensation is being used to conduct a thematic cross-case analysis.

Results
Preliminary findings show that doctors struggle with several key tensions in dealing with medical uncertainty:
1. Increasing medical knowledge vs. accepting and tolerating medical uncertainty
2. Simplifying vs. complexifying clinical decision making
3. Promoting individual vs. population priorities
4. Sharing vs. withholding uncertainty from others

Discussion at OCHER
How might these tensions be understood and investigated further? What theories could sharpen the analytical focus? We plan to supplement the sample with junior doctors (LIS1 and LIS2); are there other suggestions for future studies and analyses?"

Uncertainty 'warning shots': A persuasive device in end-of-life conversations?

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Background
During treatment decision making in the hospital, surrogates (family members or friends) are often asked to make life-or-death decisions for patients unable to make their own decisions. However, the patient's prognosis and possibility for recovery, even if continuing treatment, is often uncertain. This analysis examines how clinicians navigate this uncertainty in communicating the patient's potential for recovery.

Methods
We audio-recorded 27 clinician-surrogate conversations about life-or-death decision-making of an adult patient in 2 hospitals in the Midwest, USA. The data were collected 2020-2024. We used conversation analysis to analyze sequences in which clinicians used uncertainty in their descriptions of the patient's recovery.

Preliminary Observations
When discussing a seriously ill patient's potential for recovery, clinicians used uncertainty warning shots (e.g., "I don't have a crystal ball", "Everyone is different", etc.). The clinician would then pivot from the warning shot to a statement expressing more certainty, although often softening the certainty with "I worry" statements about projected outcomes (e.g., "But I worry he won't recover from this."). This pattern served a persuasive function, allowing clinicians to convey certainty that the patient wouldn't recover - thereby justifying the discontinuation of life-sustaining treatment. Surrogates' responses tended to be minimal, usually consisting of an acknowledgement or a continuer. However, in instances when clinicians sandwiched their certainty statements with another uncertainty acknowledgement (e.g., "… but anything is possible."), surrogates latched on to the expressed uncertainty about the patient's recovery, reiterating or affirming the possibility for patient recovery.

Questions for Discussion:
1) What are the effects and functions of using uncertainty as a "warning shot"?
    a. For example, does acknowledging the reality of medical uncertainty with a warning shot encourage alignment between clinicians and surrogates?
    b. Do uncertainty warning shots serve as a way for clinicians to "cover their bases" or couch their true certainty to placate surrogates' prognostic uncertainties?
2) What are the ethical implications of using uncertainty "warning shots" in end-of-life care discussions?
    a. How does the amount of uncertainty v. certainty conveyed in these discussions, as well as its placement/sequencing, affect surrogates' judgments and decisions?

The inevitable link between uncertainty and shared decision making – a conceptual analysis and empirical illustration

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Marij A. Hillen[3]

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Objective
In shared decision making (SDM), clinicians need to convey uncertainty, e.g., about which option suits a patient best, and patients need to confront uncertainty. This study aims to conceptually describe the interplay between SDM and uncertainty based on published literature, and empirically illustrate how uncertainty is expressed and responded to in practice.

Methods
We conducted a limited-scope literature search in PubMed/Medline for papers describing the role of uncertainty in SDM. Relevant papers were identified independently and in duplicate based on title/abstract and full-text. Themes were identified in consensus.
We further conducted secondary explorative analyses of two purposefully-selected videotaped consultations of breast or prostate cancer patient seeing a physician to discuss adjuvant or primary treatment. Based on an initial assessment of consultations, we chose to focus the analysis on mismatches in perceived uncertainty, where the physician makes uncertainty about the most appropriate treatment option explicit early in the SDM process and the patient shows disagreement to the uncertainty. We analyzed to what extent common ground with regard to (un)certainty was achieved.

Results
Our conceptual analysis of 15 papers yielded three overarching themes: uncertainty 1) as a reason and 2) inherent element of SDM, and 3) as a factor affecting patient and clinicians. Our explorative analysis showed patients to express disagreement with the uncertainty by repeating their conviction (one option is best) or pre-existing preference (for that option). Both clinicians explained the uncertainty in various ways, e.g. by providing evidence that benefit of treatment is uncertain and may entail harms, or that the alternative option is often chosen. Both clinicians and patients reiterated their position in weaker terms over the course of the interaction. Common ground was not fully achieved.

Discussion:
Various sorts of uncertainty exist in relation to SDM. Learning about how these manifest in interactions between patients and clinicians help provide guidance on how best to deal with uncertainty.

Questions for discussion:
• **Does the success of SDM depend on how much uncertainty is shared? If so, how to assess extent to which uncertainty is shared?**
• **What other methods than MCI may help study the interplay between SDM and uncertainty?**

Session 1B: Perinatal care

Video-based training in midwifery education: Experiences from the pilot CARM-workshop "How to ask about violence in antenatal care?"

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Background
In 2014, the Norwegian Directorate of Health introduced new guidelines recommending midwives in antenatal care to ask pregnant women about exposure to violence. However, asking about violence is not a straightforward matter, and even less so, is how to prepare students in midwifery education for this future task (Henriksen et al., 2017). The current project aims to develop and pilot a video-based training workshop in midwifery education focusing on this topic. The project is connected to a PhD project and is part of the HK-DIR-funded project 'Video-based training in professional education" (VIP).

Data and methods
Data consists of 35 video-recorded naturally occurring encounters in antenatal care with 8 midwives and 35 pregnant women. Conversation analysis (CA) is used to examine in detail the 21 encounters in which midwives ask about previous and/or ongoing violence. The video-based workshop builds on the Conversation Analytic role-play Method (CARM) (Stokoe, 2014). The workshop was developed through conversation analytic research and data sessions combining CA and midwifery perspectives. A pilot of the workshop was tried out on experienced midwives before the workshop will be tested in midwifery education in Spring 2025.

Results
The workshop is built around four communicative dilemmas the midwives oriented to when asking about violence, and constitutes the four trainables in the workshop: Dilemma 1: How to build up to asking about violence? Dilemma 2: How to pose the question? Dilemma 3: How to deal with a "no"? Dilemma 4: How to deal with a "yes"? Through anonymized, authentic video clips played together with line-by-line transcripts, participants are encouraged to view and reflect together on the various approaches used by experienced practitioners.

Discussion and questions
Evaluation from the pilot workshop indicates the usefulness of viewing and discussing extracts from real encounters. The way forward is to develop the workshop further, in line with feedback from the pilot and targeted toward inexperienced midwifery students. We would appreciate **input on the further development of the workshop, as well as ideas for further possibilities for implementation (e.g., how, when, to whom) in the field of midwifery and beyond.**

Beyond the Question: Midwives' Approaches in Thematizing Violence in Antenatal Care

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Background
Sensitive communication is crucial in healthcare, especially when discussing topics like violence. In Norway, national guidelines recommend midwives ask all pregnant women about violence during antenatal visits. However, these conversations are often more complex than guidelines suggest. This study looks at how midwives bring up the topic of violence in real-life consultations. The study is part of the HK-DIR-funded project "Video-based training in professional education" (VIP) and forms the basis of a PhD project.

Methods
We used Conversation Analysis (CA) to study 35 video-recorded antenatal consultations, focusing on 21 instances where violence was discussed. The data includes consultations from 35 pregnant women and 8 midwives, mainly from the first or second antenatal visits, where midwives are expected to ask about violence.

Results
Our analysis identified two main strategies midwives use to introduce the topic of violence. In topical organization, midwives raise the subject in response to cues from the woman's contributions. In sequential organization, midwives give warnings or "heads-ups" before asking the sensitive question. These approaches highlight how midwives adapt their talk, showing how recommendations are accomplished in real-life practice.

Conclusions
Midwives prepare for and ask about violence by drawing on both topical and sequential organizational resources, demonstrating that asking about violence is more than simply asking a question. This highlights the need for more flexible training that reflects real-life interactions. Training programs should go beyond the guidelines to better prepare healthcare providers for handling sensitive conversations effectively.

Questions for Discussion
1. Should national guidelines be adjusted to give midwives more flexibility when discussing sensitive topics like violence?
2. What are the potential risks or benefits when midwives don't strictly follow the guidelines during these conversations?

Nurse-parents communication and interaction in Singel-Family Room NICUs in Norway. Results from sub-study I

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Objectives

The growing trend toward single family room (SFR) Neonatal Intensive Care Unit (NICU) design and continuous parental presence are 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 causes frustration and is perceived by parents as an obstacle for involvement in care (Guttmann et al, 2024). Interaction with parents in SFR is reported as challenging for the nurses (Larsen et al, 2024).

The project will provide new knowledge of the parent-nurse communication and interaction in SFR NICUs. I would like to present the tentative analysis of the video data (sub-study I) for feedback and discussion.

Materials and Methods

The project 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 guided nurse-parents' interventions (Heath et al, 2010)

Results: 3 native speaking parental pairs with preterm infants born from 25-29 weeks of gestational age and the nurses in charge of the family at the time of the interventions was included in two hospitals with SFR NICUs.

N = 8 + 8. One intervention is missing in each unit, due to heavy workload for nurses.

Analysis: Inductive, interaction analysis (Jordan & Henderson, 1995).

The first step will be to look at all the recordings several times and identify key events. Second step is to transcribe the interaction and organize the patterns for a more detailed interpretation. Finally, the patterns will be formulated as themes.

Question to the workshop:

1) I am in an early phase of the analysis, and I would really like feedback on the presented results.

Session 2A: Non-verbal communication and data gathering

Strategies for successful data gathering with audio- and video-recordings

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Background

Data gathered on communication between healthcare providers and patients in clinical settings offers valuable insights with high ecological validity. However, doing observations with recordings in these environments presents challenges, such as ethical concerns and logistical complexities. Drawing from our experiences with audio and video recordings in both past and ongoing studies, we will explore strategies for effective data collection and the associated considerations for ensuring data quality and reliability.

Aim

This paper aims to discuss strategies for successful data gathering using audio and video recordings in healthcare communication research, focusing on how these strategies impact data quality and reliability.

Expected Findings

We will explore the utility, ethical considerations, and limitations of using audio and video recordings, with a focus on the following key areas:

• Planning: The importance of thorough preparation, setting realistic goals and sample sizes, and identifying key stakeholders to gain access to clinical settings.

• Enhancing Motivation and Acceptability: To minimizing response bias and developing positive perceptions among healthcare providers and patients and enhance the motivation of those being recorded

• Practical Considerations and Recruitment: Strategies for effectively informing and recruiting participants, providing support, technical issues and integration of recordings in clinical workflows. Ensuring that recording processes are straightforward and easy to manage.

• Audio vs. Video Data: A comparison of the pros and cons of using audio vs. video recordings in healthcare communication research.

• Quality: The importance of factors such as audio clarity, camera positioning, and equipment reliability for ensuring the accuracy and usability of collected data.

• Ethical Considerations: Addressing issues related to informed consent, privacy, confidentiality, and the comfort of both healthcare providers and patients during the recording process.

• Ecological validity and generalizability: Getting data mirroring communication practices in its natural contexts and environments where communication behaviors naturally occur. Balancing both requires capturing authentic data while ensuring the findings apply to broader settings and getting a representative sample of participants.

Request for Feedback

We welcome your **thoughts on the suggested areas of focus**: anything important missing? Would these topics be valuable to develop further in a methodological discussion paper?

'Busy Bodies'. On sensibility of time and busy body language in healthcare: Proxemics and skilled embodiment in person-centred communication

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Background:
Good and effective communication with patients is among the primary tasks of Danish healthcare providers. Yet, a concern for meeting schedules and increasing pressure on the clinicians to accomplish more tasks in less time places a contradictory demand on both the clinicians and the organization. It may prevent clinicians from being attentively present and sensitive to individual differences and patients' needs. Consequently, more patients feel they are being overlooked or mistreated in hospitals. This paper addresses business and a 'lack of time' from a situated perspective. It shows how skilled coordination of body, physical space, and objects (i.e., skilled embodiment) can help medical teams to solve clinical tasks successfully – i.e. in an efficient and timely way and accordance with good medical practice.

Methods:
Cognitive ethnography and multimodal interaction analysis of video-recorded patient consultations recorded at a dermatological ward at a Danish University Hospital during the implementation of a twelve-week Blended Learning communication training course are used to show how clinical dilemma emerges and is managed in interaction and how coordination and embodiment affects the overall performance of medical teams.

Preliminary results:
There are significant differences in how individuals utilize their body language, relevant objects and space with respect to others. Coordinated performance and enaction of skilled embodiment saves time, making room for a more inclusive and person-centred agenda, and projects a higher level of professionalism, copresence, and trust between clinicians and the patient.

Discussion:
While the analysis highlights the importance of coordinated agency for team performance, the disembodied action, on the contrary, may lead to interpersonal tension and dysfunctional team performance. Representation of disembodiment, however, raises a series of ethical questions. We therefore want to discuss:

1. How can we present and explain the function and value of applying different embodied strategies in an ethically appropriate way?
2. How can we shift focusing from individual performances towards the more systemic view of team performance, to help health professionals establish more efficient medical practices that show responsiveness to individual differences and needs necessary for supporting person-centred communication?

Learning social communication with «Robbie». Coding Interaction between autistic pupils and a humanoid robot using the "Social communication, Emotional Regulation and Transactional Support (SCERTS)" coding method.

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Background:
The prevalence of autistic children is increasing. In the Norwegian project "Robot-supported language development for children with Autism Spectrum Disorder (ROSA) the robot NAO (called "Robbie" by the pupils) is used to stimulate social interaction and language development.

In October-24 pilot 2 in the study will be performed. 8-12 autistic pupils in different language development stages will participate. For each child four robot-child-interactions will be video-recorded. Two teachers will participate in the learning interactions, one being the child's primary teacher, the other serving as a learning assistant, steering the robot responses with a remote control and providing learning tasks and learning games.

The aim of the pilot is to test the feasibility of the robot interactions, establish interrater-agreement of the SCERTS-coding, and determine meaningful outcome measures for a larger study.

The SCERTS-method will be used to code the videos
SCERTS provides a structured framework and systematic method for selecting educational objectives that are meaningful to the child, family and setting. The original SCERTS Assessment Protocol (SAP) is a curriculum-based assessment tool for gauging individual children's capacity to use certain skills and to engage in tasks across meaningful, everyday contexts. The emphasis is on understanding the functional role of an individual child's behaviors and communicative acts. Assessment of a child's level of social and communicative competence is based on detailed behavioral criteria derived from the SAP.

The method focuses on capacity for joint attention and capacity for symbol use. The early language development stage the child has, is identified as a) social partner, b) language partner or c) conversational partner. The different stages require different responses to support learning (transactional support) as well as specific and individual goals. On beforehand the teachers have evaluated the pupils with SCERTS as a baseline.

Analyses:
The plan is to describe the children´s scores on specifically chosen SCERTS-dimensions as individual cases (social communication; joint attention and symbol use and emotional regulation; mutual regulation and self-regulation). Further the teachers and the robot will be scored on transactional support.

Questions to discuss at OCHER:
Do these measures reveal meaningful outcomes?
Discuss possible issues we ran into establishing interrater-agreement.

Session 2B: Training/ Education

The Individual in the Healthcare System - developing and testing a training program and knowledge transfer process

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The healthcare system is currently facing urgent challenges such as staff shortages, high work pressure, and emotional demands. These issues are creating a strained work environment that is negatively impacting staff well-being and care quality. Research has shown that communication and relational skills training can play a crucial role in addressing these pressing issues. Furthermore, tackling these challenges in the healthcare system necessitates innovative solutions and interdisciplinary collaboration across scientific traditions and methods.

Accordingly, a new training program focusing on meeting the human in the healthcare system is being developed. It is being pilot-tested in close collaboration with researchers from the humanistic faculty (Human Health, University of Southern Denmark) and a research unit managing patient and staff data (Open Patient data Explorative Network, Odense University Hospital).

This training program is designed to make a significant impact on the healthcare system. It aims to enhance staff well-being and patient care quality by developing, testing, and evaluating comprehensive, context-sensitive, interdisciplinary, and tailored training programs for healthcare professionals.

The pilot-tested two-day course consists of theoretical and training sessions on compassion and curiosity, responsiveness and understanding, stigmatisation, and ethical decision-making to strengthen social and cognitive skills and foster relationships and collaboration among colleagues and patients. Between the two days of face-to-face interactions, the course has planned different transfer activities, e.g., peer-to-peer feedback, online supervision, and training, to support the participants' transition from knowledge and skills to competency in clinical practice.

Using a Realistic Evaluation approach, the project will examine which mechanisms work in specific contexts and why. The training programs will be developed, tested, and evaluated in various clinical departments using qualitative and quantitative data on work environment, well-being, and patient experiences. The focus will be on blended learning and transfer processes.

We want to discuss the following questions to explore further the potential of transfer activities in improving healthcare professionals' competency:
- **How can individuals, colleagues, and the organisation (from daily leaders to organisational leaders) be activated in transfer activities that coexist with daily performance?**
- **Idea development of types of transfer activities for the three different groups?**
- **How to observe actions, signs, and behaviour as predictors of competency in social and cognitive skills.**

How to engage medical students in curriculum and attendance; a mixed method study

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Objective

We are currently enrolling Generation Z students in medical school, a group challenging the traditional educational system with different classroom expectations compared to past students. Lecturers find their established methods are being tested as students selectively skip lectures. A systematic review reveals that Generation Z prefers educational settings and formats akin to their digitally oriented daily lives.

Medical school education, which combines nature and human sciences while emphasising communication, reflection, clinical uncertainty, and decision-making, is at risk. With the rise of digital solutions like streaming and recording, selective lecture attendance has increased post-COVID-19, raising concerns about future clinicians needing more essential skills.

Our study aims to explore medical students' experiences and attitudes toward learning to tailor lecturing methods in a Danish-Norwegian context.

Methods

This is a mixed-method study with medical students in Denmark and Norway participating in qualitative and quantitative aspects. First, we will perform a focus group interview study with 4-6 groups with up to 4-7 participants in each group, using a semi-structured interview guide. The discussion will be recorded digitally and transcribed using Autotext, an artificial intelligence tool that translates the texts from Danish and Norwegian to English, the standard language for the analysis. The interviews will be analysed using thematic analysis.

In the second part of the study, we will design a questionnaire based on the focus group study's results. This will be distributed to a representative group of medical students in Denmark and Norway. We will compare responses from various universities and students at different stages of their education.

Results

We conducted four or five focus group interviews in autumn 2024, and we will present the preliminary results of the thematic analysis at the workshop.

Discussion

We want to discuss the preliminary themes discovered through the first part of the analysis to receive input for the further analysis process. Furthermore, we want to discuss how these findings can best be used to develop a questionnaire that will be distributed to more medical students.

Coaching first year residents on medical uncertainty - a "qualitative intervention study"(?)

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[1]Nordland Hospital, Norway; [2]National Cancer Institute, USA

Background

The paradox between natural science, like medicine - which in a black and white-fashion crusades for right or wrong answers - and the clinical challenges pertaining to individual patients in different contexts - where a myriad of solutions might be just as good as the others - seem to be especially challenging for inexperienced physicians. In this study we aimed to coach 1st year residents (FY1) on medical uncertainty and to measure self-reported effects of a coaching intervention.

Methods

Questionnaire on uncertainty tolerance (UT) and "imposter syndrome" (IS) to all (n=21) FY1 doctors who started in Bodø, March 2024. Follow-up audio-recorded conversation 3-4 months later (n=20). The conversations aimed to: get to know the FY1, map motivation, understand choices, discuss medical uncertainty, discuss how the survey was answered - all of this, with the goal of the FY1 formulating their own focus area dealing with medical uncertainty for rest of the FY1 service. Data was analyzed using simple descriptive statistics and systematic text condensation.

Results

16 of 20 FY1 were women, on average FY1s had 10 months' experience with a medical license, 8 studied in Norway, 12 abroad. 16 FY1s found coaching very useful, the remaining 4 somewhat useful. 14 FY1s strongly agreed that all FY1s should get this conversation, 6 slightly agreed. 12 FY1s felt medical school had not sufficiently prepared them for clinical practice, while 5 felt well prepared and 3 adequately prepared. All FY1s were willing to have a follow-up conversation towards the end of their FY1 service. Preliminary results indicated that the focus areas articulated by the FY1s could be sorted into categories or virtues like courage, epistemic maturity, humility and flexibility.

Discussion/questions:

- **How could a survey on UT and IS be used to coach FY1s on their development as clinicians?**
- **Is it possible/feasible to analyze coaching conversations using qualitative methods?**
- **Can FY1s self-determined focus areas be sorted into categories, virtues or professional qualities?**
- **How should I/we follow up our cohort? Survey? Additional qualitative interviews? Direct observation?**

Session 3A: Pediatric care

How to measure shared decision-making during medical procedures in pediatric care?

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[2]Section for Nursing, University West, Sweden*

Background
To offer a communication style that acknowledges child preferences and shared decision-making (SDM) in medical procedures may help children to better cope with medical procedures. Previous research shows that children like to be involved in decisions related to care involving minor risks, which a needle procedure is considered to be. To support children, SDM should become common practice during medical procedure consultations. The 'Observing Patient Involvement in Decision-Making' (Option5) instrument is designed to measure SDM in adult and pediatric healthcare consultations. However, to the best of our knowledge, no studies specifically address the use of the Option5 instrument to identify levels of SDM during medical procedure communication in children. We therefore plan to evaluate Option5 regarding the feasibility criteria, completion rates, missing data, and observer agreement.

Aim
The aim is to evaluate the feasibility of using the Option5 instrument on clinical communication during medical procedures in pediatric care.

Methods
Data from children (7-16 yr) is gathered through video recordings during a regular insertion of a peripheral catheter in a medical setting. The video recordings will be analyzed to assess the feasibility of the Option5 instrument regarding completion rates, missing data, and observer agreement.

Request for feedback
- **Could Option5 be feasible and valid to explore to what extent health care providers involve patients during medical procedure communication?**
- **Are there alternatives to Option 5, suitable for this context?**

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

Sandra van Dulmen

Nivel, the Netherlands

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.

14 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?
- What other medical conditions influence HCP-patient communication?

Session 3B: Primary care | Medical history

Exploring registered nurse-patient communication in primary care: A structured analysis guided by the Calgary-Cambridge model

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Overall information:
This study is a part of the project 'The patient's first point of contact in primary care – registered nurses' communication and initial assessment' (PINPOINT).

Background:
In Swedish primary care, registered nurses (RNs) are usually the patient's first point of contact to assess patients' needs and concerns. For a proper exploration and understanding of patient's health concerns and the need for follow-up care, the interaction and communication between RNs and patients is crucial. However, RNs are not specifically trained in techniques to structure a consultation in practice. While communication and interaction between RNs and patients are central to care, these aspects are rarely studied authentically, particularly in primary care. Gaining such insights is essential for developing educational models that enhance RNs' competence and skills in primary care, which could in the long term, be beneficial for quality of care.

Aim:
The aim of this study is to explore the communication structure, content, and mode of delivery in RN-patient consultations in primary care.

Methods:
This is a descriptive qualitative study, based on audio-recordings of RN-patient consultations (n=27) in primary care when patients seeking care for a newly arisen health concern. Data was collected between September 2023 and March 2024 from four primary care units in Sweden. This study involves nine RNs and includes the first three audio-recordings from each RNs. The audio-recordings were transcribed verbatim and will be analysed in relation to the Calgary-Cambridge model according to a structured content analysis. We will also examine the proportion of time spent speaking during the consultation, with the duration of speech by RNs and patients quantified by measuring the seconds.

Expected findings:
This research will provide knowledge about the approaches and structures RNs use in consultations with patients presenting new health concerns in primary care. To analyze communication structures, strategies that support communication during consultations could be identified.

Request for feedback:
Methodological discussion of alternative for data analysis.

Digital medical history in optometry

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The health service faces significant challenges due to an ageing population, resource constraints, and increasing demands, including the uneven distribution of healthcare personnel and the rising need for integrated and patient-oriented services. Innovations such as skill-mix and task shifting can enhance the efficiency of healthcare delivery. Task shifting involves reallocating tasks from healthcare professionals to patients, carers, machines, or other healthcare workers. Moreover, technological advancements and digitization offer novel healthcare service delivery and shared care solutions. These changes impact both patients' daily lives and the work of healthcare personnel.

The study in planning will explore the use of digital systems designed to facilitate patient communication and engagement in eye care. Specifically, the focus will be digital systems for collecting patient-reported medical history before eye examinations. This approach allows optometrists to have comprehensive knowledge of the patient's vision and eye health before the appointment, enabling them to tailor the clinical assessment to patient-specific needs. This may enhance the efficiency of the examination and improve patient satisfaction and outcomes. Furthermore, better-informed optometrists can make more precise clinical decisions, ultimately improving patient health outcomes.

The study will be part of the CoTecH project (Co-created Health Technology). A post-doc will be recruited and is expected to start by January 2025. The postdoc and the author will develop the project protocol in collaboration with our partners during spring 2025.

Discussion at OCHER:
We want to discuss the methodological approaches for the study and explore areas of communication research that can inform the research and implementation of these digital systems.

Session 4A: Uncertainty

Talking About Uncertainty: a qualitative investigation into how uncertainty is communicated in patient-provider interactions, exploring the reasons behind providers' expressions of uncertainty and the impact on patients

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Uncertainty – defined as the conscious awareness of not knowing – is pervasive in healthcare. Healthcare providers are expected to discuss uncertainties with their patients, at least to some extent. This makes uncertainty an inevitable element of the patient-provider interaction. Empirical work regarding the communication of uncertainty in healthcare is scarce and scattered over medical contexts and across scientific disciplines. Future efforts should focus on reducing the burden it poses on both patients and healthcare providers. Potentially, this can be achieved through improved provider communication. To advance this, it is first necessary to examine the way uncertainty is communicated in real-world medical interactions, the intentions behind these communications, and the associated effects.

To this end, a mixed-methods qualitative observational study will be conducted. The study will involve the video recording of 75 real-world medical interactions across three medical contexts: pediatric general complaints, multiple sclerosis and rare cancers. These contexts are selected to capture the communication of a wide range of types of uncertainty, for instance regarding prognosis, diagnosis, or therapeutic options. Following the consultation, both patients and healthcare providers will participate in separate interviews, during which they will reflect on the interaction using video-stimulated reflection to facilitate their memory. As analytic frameworks, we are considering a combination of microanalysis of clinical interaction (MCI) and thematic content analysis. In conclusion, we will gather evidence on how uncertainty communication differs based on clinicians' intentions and medical contexts, along with the variable impact of uncertainty communication on patients.

Questions for discussion
- How can one identify uncertainty expressions, when the same expression can be used to display something else? (For example, the phrase "maybe" can be an expression of uncertainty, but it can also be used to soften a negative opinion and then serve to be polite)
- How can the findings of this mixed-methods design be meaningfully combined? Given that microanalysis of clinical interaction (MCI) relies on the video-recorded consultation, how can the interviews complement this? To what extent does each component inform the other, and can it also be the other way around?

Communicating uncertainty about prognosis to patients and their families facing serious illness: A conversation analytic study

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The communication of uncertainty is ubiquitous in life-threatening conditions and advanced disease (1). How clinicians communicate uncertainty regarding quality and length of life is fundamental to shared decision-making (2). However, there are almost no empirical data on clinicians' real-life communication of uncertainty (3). Such an evidence base is needed to inform best-practice.

We are developing a project that draws on existing data where uncertainty is communicated about prognosis related to both quantity and quality of life in serious illness. These include conversations from two datasets:
1) Video-recorded outpatient consultations (n=110) with older patients with advanced kidney disease from four renal units, from the OSCAR study (Optimising Staff-Patient Communication in Advanced Renal Disease); 2) Video- and audio-recorded neonatal intensive care consultations with parents of new-born babies with serious complex conditions: the Parents and Neonatal Decisions (PND) study (n=113). We also aim to extend our analysis to a third dataset - conversations between clinicians and patients in oncology consultations - which has yet to be collected.

The aim of our proposed session is to examine two extracts of conversations from each dataset. Using the method of Conversation Analysis, we will identify key conversational practices clinicians use to communicate uncertainty and consider their implications for patient understanding. In doing so we aim to build on a taxonomy of uncertainty and research in this area, led by those in the OCHER group (1).

Points for discussion
• **What is the feasibility of comparing these data sets to identify common conversational practices?**
• **What is the feasibility of developing training for clinicians that transcends medical specialty?**
• **Are there other important clinical sites/data that we should consider?**

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An uncertain recovery versus certain hospice bliss: How uncertainty and certainty are used to persuade surrogates to discontinue treatment

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Background
When seriously ill patients in the hospital are unable to make their own decisions, surrogates (family members or friends) are called to make decisions. Sometimes, these are life-or-death decisions involving whether to continue life-sustaining treatment (leading to patient survival but potentially an unwanted quality of life) or discontinue treatment (leading to patient death). Given the inherent uncertainty in presenting and selecting these different medical paths, our overall aim was to see how surrogates and healthcare practitioners attend to this uncertainty in decision-making conversations. This analysis examines how both uncertainty and certainty are used by healthcare practitioners to persuade surrogates to discontinue treatment.

Methods
We audio-recorded 27 healthcare practitioner-surrogate conversations about life-or-death decision-making of an adult patient in 2 hospitals in the Midwest, USA. We used conversation analysis to analyze sequences in which healthcare practitioners described the options of continuing treatment and discontinuing treatment.

Preliminary Observations
Overall, healthcare practitioners would first describe an uncertain recovery associated with electing to continue treatment followed by the certainty of comfort associated with discontinuing treatment. Regardless of the treatment (ventilator, feeding tube), healthcare practitioners conveyed uncertainty in whether the treatment would be needed only temporarily (and the patient would recover) or permanently (with minimal or no recovery). Along with conveying the uncertainty of whether treatment could lead to recovery, the recovery process itself was usually described as being "long," difficult," and potentially associated with patient suffering. Conversely, discontinuing treatment with hospice care was described with blissful language of making "absolute certain that they're not suffering." Healthcare practitioners conveyed certainty about what hospice would do: get rid of "burdensome" devices, give medications to "maximize people's comfort", and allow a "natural death." Even when healthcare practitioners conveyed uncertainty about a poor prognosis, their discourse—contrasting an uncertain, difficult recovery with the certain achievement of comfort with hospice care—manifested the persuasive nature of these descriptions.

Questions:
1) **What are the reasons that this communication pattern exists?**
2) **Is using uncertainty to describe continuing treatment and certainty to describe hospice "bad?"**
3) **How do we analyze surrogate responses when these descriptions were often part of multiple turns-at-talk?**

Session 4B: Asking patients (and clinicians)

Fight fire with fire: Asking patients about self-treatment in primary care consultations for respiratory tract infection

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Background
Development of antimicrobial resistance (AMR) is a global health challenge. Within primary care, respiratory tract infection is an area where antibiotics are prescribed inappropriately. Encouraging patients to self-treat (e.g. resting, drinking lots of fluids, and using over-counter medication) can help remedy inappropriate prescription. This study examines how doctors ask patients about their efforts to self-treat.

Barnes & van der Scheer (2021) examined doctors' questions about self-treatment during information gathering in a corpus of 134 recorded primary care consultations. Questions about self-treatment were rare (20%). The questions were often grammatically designed to allow for the possibility of a no-type response but could nonetheless be understood as casting doubt on the legitimacy of the patient's decision to seek medical care. Barnes & van der Scheer's data included a broad set of cases (pain, respiratory and skin) but the analysis they presented focused primarily on consultations concerning management of pain. They did not showcase examples from consultations for respiratory tract infection. The present study explores how questions about self-treatment are raised over the entire course of the medical consultation in one specific care context namely respiratory tract infection.

Methods
The data are drawn from 67 video-recorded clinical consultations with adult patients for common respiratory infections in Swedish primary care. The data were collected between 2018 and 2020. Conversation analytic (CA) methods were applied to make case-by-case observations and to build a CA-grounded coding scheme.

Preliminary observations
Questions about self-treatment were rare (22%) and they were most likely to be asked as part of information gathering. Analysis of grammatical format is not easily transferred between languages but there was some evidence that patients used the answer slot to bolster the legitimacy of the visit.

Points for discussion and improvement
1. How can we develop the contextualization of the study?
2. How can we apply previous findings on the polarity of questioning to non-English language data?

Reference
Barnes, R. K. and I. Z. van der Scheer (2021). Conversation Analysis: Questioning Patients About Prior Self-Treatment. Analysing Health Communication: Discourse Approaches. G. Brookes and D. Hunt. Cham, Springer International Publishing: 19-48.

Patient-provider-communication in post-prostatectomy care from the perspective of patients and providers

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With over 65,000 new cases, prostate cancer is the most common cancer in men in Germany. One of the curative treatment options for localised prostate cancer is radical prostatectomy, after which, however, a relevant proportion of men suffer from urinary incontinence and sexual dysfunction. These are associated with reduced health-related quality of life and psychological stress.

In the PRO-P study, a randomized controlled trial with formative process evaluation, the influence of intensified electronic symptom monitoring using electronic Patient Reported Outcomes (ePROMs), which are linked to measures such as patient-provider-conversations, is to be investigated in men who are urinary incontinent after prostatectomy.

In contrast to previous standard care, the faster detection, counselling and treatment of post-operative complaints could lead to a reduced symptom burden as well as improved patient empowerment and quality of life. Intensive, standardised interaction in follow-up care could also strengthen patient empowerment and improve patient-provider-communication.

The qualitative evaluation aims to describe the effective elements of the intervention. Characteristics at patient, provider and organisational level as well as the interactions between the levels (e.g. patient-provider-relationship) are explored.

So far, 30 semi-structured interviews have been conducted with patients, half from the control and half from the intervention group, and 9 interviews with providers. The patients are to be interviewed again towards the end of the intervention. The interview guidelines and deductive categorisation are based in particular on models of patient-provider-communication, patient-provider-relationship and patient empowerment.

A contrasting thematic coding of the data is planned. In addition to possible differences between intervention and control group, intra-individual changes will be analysed by contrasting coding of the data material at two measurement points. Part of the second interviews will probably have been conducted by the time of the workshop.

For OCHER, we would present some preliminary findings and want to discuss questions as:

How can we investigate the extent to which monitoring changes the patient-provider-relationship?

Can the perspective of patients be analysed with regard to the perspective of the providers? Or should the perspectives be presented separately and differences be discussed?

Exploring clients' and veterinarians' perspectives on communication in aquaculture, small, and farm animal veterinary practice

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Introduction/Background: Differences or similarities might exist in the communication requirements and barriers faced by veterinarians and clients within and across different veterinary sectors. Insights regarding both the challenges and successes of communication are of great importance since the veterinarian's communicative approach impacts both treatment delivery and client adherence.

Objective: To identify and compare veterinarians' and clients' perspectives on communication practices and challenges in three veterinary disciplines in Norway: aquaculture, small, and farm animal veterinary practice.

Methods: This is an exploratory study and a qualitative design with individual interviews and focus groups as the main form of data collection methods will be used. Semi-structured interview guides with open-ended questions and follow-up probes will be developed and used. Recordings from interview sessions will be transcribed using NVivo 14 software and analyzed with reflexive thematic analysis. All data collection and analysis for this study will be carried out and managed by the first author. Independent veterinarian, and client focus groups within small animal and farm animal veterinary practice will be conducted. Veterinary focus groups will be held at two distinct veterinary conventions, for veterinarians working with small animals and farm animals, respectively. Sector specific client focus groups are planned to occur at fairs (dairy farming) and by recruiting pet owners through clinics. Individual interviews will be conducted with aquaculture veterinarians and clients. Aquaculture veterinary practitioners attending veterinary conventions will be invited for individual interviews later and asked to suggest clients as potential interviewees.

Implication of findings: It is important for veterinarians to discern communicative challenges and understand clients' perspectives on communication in order to deliver treatment and recommendations that harmonizes evidence – based medicine with the values and situations of clients. The findings may also inform future research and serve as a foundation for how education in clinical communication can be adapted to suit what veterinarians and clients need within different contexts.

Points for discussion and improvement
1) **Purposive sampling – homogeneity vs variation?**
2) **Data collection methods – complementary methods?**
3) **Implementation of findings to improve the outcome of veterinary care – sharing of results? Informing education and professional development? Developing best practice guidelines?**

Session 5A: Making care fit

Micro-analyzing clinicians' efforts to tailor treatment information to cancer patients

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Background:
Cancer patients' information needs and abilities to understand and process information vary. This calls on clinicians' efforts to provide adequate and fitting information that matches individual patients' needs and abilities. Information thus ought to be tailored. Such tailoring of information is considered to positively affect patient outcomes, like satisfaction, information processing and recall, as well as patient emotional wellbeing. Studies however indicate that clinicians struggle to properly tailor information to individual patients, and often end up providing patients with information based on their assumptions about what a patient wants to hear or can understand. As a result, information mismatches occur that may harm the patient. Despite the relevance of information tailoring, much remains unknown about how information tailoring works and what it looks like in clinical practice.

Research aim:
The InfoMap project wishes to uncover the process of, and mechanisms that underpin clinicians' efforts to tailor treatment information to individual patients with cancer during consultations, as well as the subsequent impact of information tailoring on patient outcomes. Eventually, we want to translate our findings into practical recommendations for clinicians. The next phase of this study concerns making video-recordings of consultations. In doing so, we aim to assess how clinicians tailor treatment information to individual cancer patients during the clinical interaction.

Method:
160 Video-recordings of consultations will be made, starting December 2024. We include 16 clinicians and respectively 10 patients per clinician from two Dutch academic hospitals. The analytical process will be guided by previous findings from the InfoMap project (i.e. a scoping review and focus groups) and by use of the microanalysis of clinical interaction method.

Point of discussion:
Information tailoring remains a broad and largely undefined concept, therewith various elements of the communication during consultations could be coded as part of the tailoring process. Therefore, our question to you is: **what would you analyze in video-recordings of consultations to assess information tailoring efforts by clinicians?**

Decision-making as a balancing act: how goals are prioritized and talked about in the emergency room

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As emergency physicians, a large part of our job is making decisions. Implicitly, in making decision we are striving towards achieving some goals. Some goals are obvious such as excluding life-threatening conditions requiring immediate interventions, finding the right diagnosis, and alleviating unbearable symptoms such as pain or nausea. These goals might guide decisions such as what investigations or treatment one initiates. Recently, the way these decisions are complicated by uncertainty has gained much needed attention. Both the information used to make decisions and the full consequence of the decisions are ridden with uncertainty. However, a further complicating factor is that in most decisions we make, there are multiple, sometimes contradicting goals and how these are balanced and prioritized have mostly been neglected in empirical studies.

Studies examining goals so far have focused on overarching goal conflicts with drastically different management strategies, such as palliative vs curative care. In this study, we are more interested in how less drastic, but much more common goal priorities are made. For instance, how do clinicians balance the needs of multiple patients, their own needs such as food and bathroom breaks, the resources available and how does this balancing act shift as the conditions in the emergency room change? How does patient factors affect choices, such as health literacy, comorbidities, support network and distance to hospital? To what extent are goals talked about, negotiated and prioritized between patients and clinicians, and how much is implicit in the choices made?

This is a multi-part project still in the planning phase, where the first part aims to develop an operational definition of goals, such that talk about goals, explicit or implicit, can be identified in videotaped and audio-recordings of real clinical encounters. Our first challenge is developing a definition which is both operationalizable as well as relevant for the working clinicians . Our first iteration of such a definition will be presented.

Questions
1) To what extent does goal-priorities occur in clinical encounters, and are these mainly implicit or explicit?
2) Are there existing concepts that might be useful in order to approach a definition of goals?

Assessing possible outcomes after training operator practices in medical emergency calls: Early investigations for Rescuevoice Pro

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Scaling up training interventions is a universal conundrum in clinical communication work. One potential solution is to use avatars in a simulated environment. Using artificial intelligence, these avatars learn how to act and respond to health care providers as patients would and to give them feedback.

Rescuevoice Pro is an NFR funded innovation project that involves collaboration among several key players, including Akershus University Hospital, the University of Oslo, OsloMet, Crayon AS, NAKOS, the Norwegian Cardiac Arrest Registry, and Vestfold Hospital. It is aimed at creating a scalable and cost-effective training program using avatars in a simulation to train emergency call operators. If such training works, we should see it reflected in how operators handle authentic calls: both an increase in the cluster of trained behaviours and improvements in outcomes we are targeting. The purpose of the presentation for OCHER is to present ideas for microanalysis of authentic medical emergency telephone calls aimed at evaluating whether the avatar training is working.

The proposed analysis builds on a previous research project undertaken by personnel at Somsagt AS, AMK Vestfold Telemark, and Akershus University hospital; that project tested a communication training intervention for operators (Gerwing, et al. 2021) that aimed to teach behaviours that might increase cooperation between caller and operator. To test the intervention, we operationalized the following operator practices: acknowledging the caller's cooperation, displaying empathy, judicious use of open-ended questions, and avoiding disagreements when the caller's actions moved into the operator's epistemic domain (e.g., making a triage decision). For the current project, outcomes of interest are a shorter time to the operator's first logged decision and to the operator identifying cardiac arrest and initiating CPR. In addition, we propose that the cluster of trained behaviours *may help to build the trust necessary to assist the callers to accept operator's resource decision, particularly when the caller had requested an ambulance, but the operator decides the situation is less urgent and suggests an alternative*.

We will use microanalysis of clinical interaction (Gerwing, Healing, Menichetti, 2023) to analyze resource-decision sequences in audio-recorded calls.

The feedback that we seek from the OCHER community is the following:

• **How might we operationalize callers' acceptance of operators' resource decisions**
• **What challenges we should expect and what are possible solutions**

Session 5B: Uncertainty

What we learned from observing residents handle uncertainty in the emergency department

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Background
Uncertainty is pervasive in medicine, but few have studied how it is handled by 1st year residents.

Methods
Twenty 1st year residents were recruited at commencement of their residency in March 2022 at Akershus University Hospital and Nordland Hospital Trust. They worked at five different sites, in Oslo/Lørenskog, Bodø, Kongsvinger, Lofoten and Vesterålen. The sites represented diverse work environments, from the largest emergency department in Norway to small rural hospitals on islands in northern Norway.
We conducted participatory observations (PO) during two emergency shifts with each resident spanning over their first year of residency. PO was followed by reflective interviews focusing on situations of uncertainty that occurred during the shift. All interactions between the resident and patients and between resident and senior doctors were audio recorded if participants provided informed consent. The audio recordings were transcribed verbatim by an external transcriber. We are currently analyzing the data using Systematic Text Condensation (STC) focusing on the interactions with patients and senior physicians.

Findings
We do not have the results of the analysis at the moment as it is ongoing, but preliminary findings suggest a pattern where residents use repetitive questioning, paraphrasing and rephrasing of questions, extended examination, consulting literature and senior physicians as common actions to handle their uncertainties.

Discussion
We believe the findings can help hospitals tailor supervision and coaching of 1st year residents to local working conditions so that they can tolerate the inherent medical uncertainty better.

We'd like feedback on the following:
• **thoughts about the analytical approach**
• **thoughts on the preliminary findings**
• **thoughts on additional data, variables or dimensions that could be considered**
• **potential practical impact (both in the medical/communication field, but also in regard to teaching and transferability)**

Uncertainty management during COVID-19: experiences of scientists, policy makers and communication professionals

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Policy decisions during COVID-19 had to be made under overwhelming time pressure and under high scientific uncertainty, with suboptimal and fast changing evidence and potential disagreements among experts and models. We conducted a study on how uncertainty in scientific evidence was communicated, received and used for decision making and communication to the general public. We found that scientists, policy makers and communication professionals – as main stakeholders in the decision making process - viewed scientific uncertainty differently, each from their own role and perspective. For scientists, scientific uncertainty and fast changing knowledge was an integral part of their work and as such not problematic as long as the reasons behind the uncertainty were communicated transparently. By policymakers, scientific uncertainty was recognised but not always transparently communicated to the general public (e.g. in case of contamination routes, effectiveness of facemask and vaccination) or communication was even too certain. They also encountered problems in understanding scientific advise. For communication professionals, scientific uncertainty actually played little or no role at all; their main aims were to give understandable information about policy decisions on personal preventive measures and to make sure that people behave accordingly. For this, their strategy was consistent messaging, thereby excluding uncertainty (e.g. face masks). Citizens, especially as the pandemic lasted longer and the various measures took their toll, had less and less appreciation for the government's overconfident communication or omission of uncertainty in public communication and trust in both policy and public communication declined.

In my presentation, <u>I would like to discuss the communication of scientific uncertainty during crisis along the following questions:</u>
- **What is the best way to communicate scientific knowledge to policymakers so they can understand and use it? Any experiences regarding layout, level of detail?**
- **To what extent, when and how should scientific uncertainty be communicated to the general public?**
- **What can be the effect of not communicating uncertainty around (the effectiveness of) measures to the general public?**

Talking about uncertainty: a quantitative systematic investigation of how physicians disclose uncertainty to patients and the effects on physicians and patients

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Uncertainty – the conscious awareness of ignorance – has a great impact on both physicians and patients in healthcare interaction. The rise of new medical technologies and treatment options generate a multitude of unknowns, while simultaneously developments like the growing importance of shared decision making heighten the need for physicians to openly discuss such unknowns with patients. The way these uncertainties are communicated may have varying effects on patients. Moreover, variation in clinical setting and patient characteristics may require different communicative approaches, due to differing types of uncertainty (related to diagnosis, prognosis or treatment), life stages (end vs. beginning of life) and perspective (concerning one's own vs. one's child's health). Yet, comprehensive research on uncertainty communication is limited, leaving physicians with little guidelines for adequately discussing uncertainty with patients. This is problematic as inadequate communication about uncertainty may negatively impact patients' comprehension of information, the treatment relationship and psychological well-being. This project aims to identify how physicians can meaningfully discuss uncertainty with patients in a way that enhances patients' well-being, trust, autonomy and participation in decision making.

For this purpose, multiple vignette-based experimental studies will be conducted to systematically identify variation in physicians' approaches to uncertainty communication, depending on medical setting, the physicians' intentions, and patient/caregiver characteristics. Subsequently, the effects of different communication approaches on individual patients will be measured to detect beneficial communicative approaches. With these insights, this project seeks to advance the limited scientific knowledge and generate practical guidance to physicians about optimally discussing uncertainty.

Questions for discussion:
- What improvements and/or additions can we make to the theoretical framework underlying the design of the studies? A preliminary theoretical framework will be presented during the workshop, on which input is highly valued. For instance regarding:
- **Potential effects of uncertainty communication on patients.**
- **Relevant provider and patient characteristics (e.g., uncertainty intolerance) that might moderate providers' approaches to communicating uncertainty as well as possible effects of uncertainty communications on patients.**

- What are important considerations (benefits and potential downsides) when choosing between written vs. video vignettes?

Session 6A: Heart failure patients and adherence

Association between patient-related factors and clinical outcomes among old patients with heart failure

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Old patients with heart failure are a particularly vulnerable patient group characterized by high mortality and re-admittance rates, low treatment adherence, and with overall poor patient outcome. During the hospital to home trajectory, multiple patient-related factors, such as cognitive function, comorbidities, social support, and factors related to patient adherence, can significantly influence patient outcomes, yet are often overlooked. Understanding these factors may be crucial for practitioners to optimize treatment plans, reducing readmissions, and improving overall care in this vulnerable population.

This PhD project is part of MAPINFOTRANS, a longitudinal study tracking heart failure patients (65+) during their transition from hospital to home. Data includes audio recordings of 105 patient-clinician consultations across three stages: hospital admission, discharge, and a follow-up GP visit. The study involves 43 patients, with additional data from patient records, medication lists, and questionnaires on health literacy, cognitive function, self-efficacy and patient engagement. Patient outcomes, i.e. hospital readmissions and death, were recorded 6 months after patient recruitment. In the first PhD study, doctor-patient interactions were analysed with a novel coding scheme to identify non-biomedical patient-related adherence factors disclosed during medical interactions.

We have just started discussing this last study, which we consider a summary paper and where we want to explore the association between patient-related factors and clinical outcomes. In particular, we aim to integrate diverse interaction-based and self-report data assessing patient-related factors and explore associations with two types of patient outcomes: (a) clinical outcomes: readmissions and mortality; (b) non-clinical outcomes: patient-reported adherence, cardiac self-efficacy, and health engagement.

Questions for OCHER:
1. Given our small sample (n=42 patients), what is the most appropriate and feasible statistical analysis?
2. Given the multiple data, should we focus on some variables and how to select them?
3. How to categorize clinical outcomes? We have patients with no-readmissions, a single readmission, several readmissions, and patients who have died.

What kind of written information about prescription changes do doctors provide to self-managing patients with heart failure?

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In the MAPINFOTRANS project, we seek to understand why older patients with heart failure might struggle to use their medications as prescribed. To meet this aim, one of the PhD projects has focused on how doctors and patients talk about medication adherence in authentic consultations. In the first study, we operationalised how patients talk about their medication adherence, and identified how much, and what kind of information patients disclose to their doctors about their use of medications at home. In the second study, we described how doctors addressed patients' signals of adherence problems. Now, we wish to study the quality of written information doctors provide when they change patients' prescriptions and assess patients' adherence to these changes.

We have collected information from patients admitted to the hospital through to their return home. For this third study, we plan to use materials from medical records to identify prescription changes from (1) hospital admission, (2) hospital discharge, and (3) first consultation with a general practitioner (GP-visit) after hospital discharge and characterise the content of written information given to patients about these changes. In addition, we plan to assess patient adherence to identified prescription changes at the time of the home visit, using materials collected by the research team a few weeks after the GP-visit.

Current research questions:
RQ1: How many prescription changes do doctors make as patients with heart failure transition from hospital to home and do patients appear to adhere to these changes?
RQ2: How often, how much, and what kind of written information do doctors provide to their patients to support implementation of prescription changes?

Questions:
(1) This is an inductive, exploratory observational study, where we plan present our findings descriptively. We would like to maximize usefulness for training and guidance about best practice. Which analytical methods fitting this intent would you suggest?
(2) During the home visit we collected three potential sources of information to assess patient medication adherence: (i) semi-structured interview about current medication use, (ii) standardised self-report questionnaire (MOS) and (iii) photographs of available medications. How could we integrate these to create one adherence measure?

Session 6B: Inequalities

Everyone wants to be treated by Claus: relational factors and the meaning of quality of patient-clinician conversations for patient attendance.

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Background
Danish practitioners, policy-makers, and the media often describe nonattendance as one of the major problems in Danish health care. Attempts have been made to reduce nonattendances (fines, SMS and E-Box reminders, etc.). Although some of these approaches have been effective in reducing no-shows, they also reinforce social biases and health inequalities, particularly regarding a growing number of vulnerable patients, facing social, economic, linguistic and psychological challenges. The present study is a part of a larger interdisciplinary project aiming to provide a more holistic picture of problems and intervention possibilities related to no-shows in the Region of Southern Denmark.

Method
The study draws on the statistical analysis of no-shows based on a regional patient population, participatory action research (PAR) framework, and cognitive ethnography (CE). It integrates multiple data sources, combining national registries and EPR with a longitudinal ethnographic study to explore a broad range of no-show management, patient-specific experiences, and relational dynamics that cause patient appointments to fail, or succeed.

Preliminary results
Accommodating vulnerable patients represents a major challenge for the Danish health care. Vulnerability itself may arise in the encounter between the clinician and the patient (e.g., as a result of misunderstanding or dissimilar points of departure or beliefs for the patient and the clinician or health system, e.g., owing to sociocultural or linguistic distance between the patient and the clinician), eliciting no-shows. The organizational and relational factors and communicative interventions that contribute to a more efficient management of patient appointments include solicitation of positive conversational strategies (thanking instead of scolding the patient), appropriation of physical space of waiting rooms, possibility for mentoring arrangements, reduction of long waiting times, cross-sector collaboration, awareness of 'vulnerability' and social stigmas in decision-making.

Discussion
1. How can PAR and stakeholder integration be used to explore causes of no-shows in situ and to design communicative and organizational intervention targeting no-shows?
2. How can we better accommodate vulnerable patients to better predict and prevent no-shows, and which communicative and interpersonal skills are required?

Social inequality for immigrant cancer patients?

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The number of immigrant patients in Norwegian health care is expected to increase as the proportion of immigrants in the population rises. National and international studies conclude that the perceived quality of care is lower for immigrants compared to the native majority. Although there are some studies of immigrant patients' experiences in other parts of health care, little is known about their experiences in cancer care. Studies of health personnel's experiences with these patient groups are also scarce, as is insight into how current guidelines address the specific barriers to quality cancer care for immigrant patients.

What is considered good cancer care may vary depending on cultural background, and many patients have spiritual and religious perspectives that may influence how they perceive their disease. While people of Catholic faith have been shown to endorse cancer screening and treatment, patients from a Muslim background may cope differently with cancer and the prospect of treatment. In Islam, cancer can be seen as a sign from God, rather than something negative.

In collaboration with the Institute for Studies of the Medical Profession (LEFO), I am planning a research project that seeks to determine the cultural, spiritual, socioeconomic, and language barriers faced by immigrant patients, their next of kin, and health personnel. The project will have a qualitative component (interviews and video-recordings of hospital encounters); a quantitative component (data from the Cancer Registry of Norway, Statistics Norway, and the Norwegian Patient Registry); and a normative component (suggesting guidelines for improved practice based on the findings and medical-ethical principles). The patient groups included in our study will be patients from the Middle East and North Africa, patients of Pakistani and Turkish descent, and patients with a Polish background. We will include patients diagnosed with breast cancer, prostate cancer, and/or colon colon cancer.

Question for discussion
What practical, theoretical, and ethical challenges does this project pose, and how can we, as researchers, approach them?

Session 7A: Patient involvement

The Narrative of Patient Initiated Actions

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Patient Initiated Actions (PIA) are patients' verbal initiatives that do not respond to a direct doctor inquiry / are not expected during the conversation. Through PIA, patients provide their perspectives on what they value when making decisions. We developed a study to understand how and when patients take verbal initiative during decision-making consultations and how doctors respond to these verbal initiatives.

Methods
Mixed-methods observational study; videotaped real consultations (N=206) Primary Care settings in Spain. Participants were pairs of doctors and patients. Through iterative observation and transcription of excerpts of the consultations, we developed a coding system with categories describing PIAs (moments during the consultation, opening strategies, content, decisional stage, form of expression) and doctor's response: present / not present; different levels of complexity.

"The narrative of PIAs"
An unexpected finding of this study was that the transcription of PIA from each consultation could be read as a narrative, as a piece apart from other interventions of the patient or the doctor. This narrative followed the schemes of any storytelling.

Through reading these narratives, we discovered that some patient`s intentions, motivations, fears, preferences, or even values were revealed. All these are known as "attributes" of the decision-making processes. To make a systematic approach, we defined a series of questions to be applied after reading the transcription of PIA in each case:

By reading every "patient's narrative"
1_ Can the patient's purpose be identified and specified?
2_ Can any patient preferences -concerning problem management options- be identified and specified?
3_ Can fears, barriers, or precautions be identified and specified?
4_ Can values be identified and specified?
5_ Can role preferences in decision-making be identified and specified?

This methodology is still tentative, but the first results suggest that it could be a good method to help understand some of the attributes of shared decision-making.

Questions that arise for discussion:
- the method and its "definition"; how it can be further developed and refined
- how can categories (questions) be defined
- applicability in other scenarios

Understanding patients' and their relatives' perspective: Expectations and experiences of involvement in clinical encounters

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Background

Research establishes that patients' participation in clinical encounters can be improved through effective communication skills, and global efforts are being made to provide communication training for healthcare professionals (HCPs). However, communication occurs in a dynamic interaction between HCP, patients and their relatives. Studies show that HCP tend to adopt a more patient-centred communication style and provide more information to patients who ask questions and express preferences and concerns. Furthermore, factors such as trust, time and patients' capability and motivation affect patients' involvement in clinical encounters. There is, however, a lack of understanding regarding how patients and their relatives experience and expect to be involved in clinical encounters, especially in long-term studies, as most studies with patients are conducted through interviews or questionnaires. Therefore, it is important to understand the expectations and experiences of patients who meet a specialised clinician for the first time and how their expectations and experiences evolve over time as they become more familiar with interacting with HCPs.

Aim

This study aims to explore, over time, the expectations and experiences of patients newly referred to a specialised outpatient clinic and their relatives regarding their involvement in clinical encounters.

Methods

Qualitative data was generated with ethnographic and co-creative methods over 8-14 months. During this period, 27 patients and their relatives participated in the project. Initially, all participants were newly referred to one of the two outpatient clinics of Rheumatology or Respiratory Medicine at a University Hospital in Denmark. Participants engaged in informal reflective dialogues with the researcher before and after clinical encounters and all clinical encounters were observed and recorded. We analyze data with dialogical narrative analysis. Thereby, we can ensure equal representation of all participants, despite differences in trajectories and experiences. Additionally, the study is part of a comprehensive action research project, where participants take part in analyzing data. Dialogical narrative analysis allows participants to co-author their narratives of expectations and experiences.

<u>**Discussion points:**</u>
In the discussion at OCHER, we would like to engage the OCHER attendees in exploring the pros and cons of applying narrative analysis and sharing experiences with involving participants in co-authorship.

Session 7B: Health literacy

Exploring health literacy from the perspective of people with rare diseases – a qualitative study

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Background
Health literacy, deemed a vital prerequisite for developing self-management skills and coping with long-term illness, is of particular concern for patients with rare diseases. These patients often report inadequate access to expert care and difficulties in sourcing reliable information. On this background, our study aims to explore health literacy experiences of adults living with rare diseases.

Methods
Participants for this study were sourced from a self-management course that included health education and social support activities at a national resource center for rare disorders. Five focus group interviews were conducted between December 2022 and January 2023, involving 31 adults (68% female, aged between 24 and 64 years) who live with rare diseases. These interviews were transcribed verbatim, and a thematic analysis is being conducted to extract key insights.

Findings
Participants elucidated their experiences navigating the healthcare system, often describing it as daunting and demanding. They identified several areas and types of knowledge that were critical to them, and their interactions with healthcare professionals. Participants also expressed their desires for specific types of support in their follow-up care and in their daily life as they strive to lead meaningful lives.

Discussion
The findings shed light on the nuances of health literacy in the context of complex life situations, providing insight into the health promotion needs of adults with rare diseases. The study raises several pertinent questions:
• **Participants portrayed health literacy as an essential resource in daily life. What implications do these findings hold for health literacy development?**
• **Given the context of participants' everyday lives and their dependency on healthcare interactions, how can we minimize the barriers they face from a healthcare development perspective?**
• **Viewing health literacy as a concept inherently linked to environmental complexity and situational demands, how effectively does this study capture the multifaceted nature of health literacy in the participants' daily lives?**
• **Is a personalized approach to enhancing health literacy, often seen in diagnosis-specific health education in clinical settings, adequate, or do we need alternative strategies? In which areas of healthcare, or even in which sector, are health-promoting efforts most effectively applied?**

Detecting signs of patient health literacy in medical interactions: First study of the HeaLin project

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Despite wide acknowledgment that communication plays a central role in improving patients' health literacy (HL), we lack practice-based knowledge about how physicians can detect relevant aspects of patient's HL during clinical interactions, and building on it.

With the HeaLin project, we will first provide knowledge about how HL can be recognized based on what patients say and do in interactions, and then identify physicians' supportive actions to patients' HL. As a final phase, we will co-design a course for current and future physicians to recognize patients' HL in interactions and build on it. The project makes use of already-collected 150+ recordings of clinical interactions with connected patient HL self-reports.

The first phase of the project has begun: We are analysing videorecordings of medical interactions, using microanalysis of clinical interactions, in search for patients' HL signs. Our "extreme cases" sampling strategy is making active use of the patient educational level as a close explanatory variable for HL. We have started with four interactions with patients with high education, and will then contrast them with other four matched interactions with patients with low education.

Some of the domains of patients' HL the analysis is capturing:
1. Patient epistemic displays about health information: questions, statements of knowledge, use of technical terms or terminology, how patients connect and explain symptoms, numeracy and memory of health information, orientation to complexity and uncertainty of health information
2. Displays about healthcare system use: stated goals and expectations for the consultation, demonstrated knowledge about the system, understanding of roles and responsibilities, preparation to the consultation
3. Network and support domain, both including the network outside and inside the visit room
4. Responsiveness and engagement: being corrected and correcting, taking initiative during the consultation, and openness to change their mind about health-related information and actions

For OCHER, we would present some preliminary findings.

The specific questions we are asking are:

   (i) which observable behaviors would you use to recognize patients' HL?

   (ii) what are your thoughts about our sampling strategy?

   (iii)   how would you use the information that we have from the patients' self-reports on HL?

Session 8A: Primary care

Adolescent males' consultations with GPs: Exploring GP's consultation techniques. A study plan

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Background
Many adolescents report difficulties talking to a general practitioners (GPs), especially when discussing sensitive issues. This challenge is particularly pronounced among adolescent males, who, compared to their female counterparts, face greater health risks and struggle more in revealing themselves as vulnerable. There are also indications that physicians may communicate less effectively with adolescent males than with females.

GPs, in turn, may find consultations with adolescent males challenging, feeling that essential details are left out of the patient's narrative. Medical organisations and consultation guidelines provide advice of how to communicate with adolescents, but this guidance is, as far as we know, largely based on physicians' clinical experience and adolescents' preferences as reported in interviews. Few studies have used observational methods to examine these interactions. The aim of the study is to explore and describe GP's consultation techniques during encounters with adolescent males using video-recorded observations.

Methods
A qualitative approach was adopted with data collected in spring 2022. All males aged 15 to 19 who visited a GP, regardless of the reason for their visit, were invited to participate. Nine adolescent males and six GPs took part in the study. The consultations were video-recorded and semi-structured interviews were conducted with the adolescent males and the GPs individually. We aim to analyse the video recordings in two phases to explore what consultation strategies are used in the encounters and how they affect the interactions. First, an inductive approach will be taken to explore the phenomenon with sensitive openness. Second, a deductive approach will be applied using a categorisation matrix, based on results from the interviews with the GPs (separate, unpublished study) and advice from the World Health Organization, medical organisations for adolescent health, and Larsen's consultation model. The analysis will follow the content analysis approach as outlined by Elo and Kyngäs or reflexive thematic analysis as outlined by Braun & Clarke.

Questions:
• **Will this set-up be appropriate and sufficient to answer the research questions?**
• **Are there better methods for this aim?**
• **Should deductive analysis come before inductive?**
• **Is nine observations enough?**
• **Other suggestions or improvements?**

The experience of meeting a medical student at the GP's office

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Background

Practical experience with patients is essential for medical students, to integrate theoretical knowledge and develop crucial professional skills for their professional formation. Increased practice teaching is important according to national health education regulations. As the number of medical students increases, more patients will encounter students in the role of physicians, making it vital to understand patients' experiences.

At the University of Oslo, fifth-year students in general practice must conduct three evaluated consultations triangulating feedback from patients, supervisors, and themselves. Research shows that patients and teachers typically score students higher than the students score themselves.

Shared decision-making is essential, but skills vary among students. Although strong in factual knowledge, students struggle with clinical reflection and decision-making, which may result in uncertainty. Students in their final clinical exam often miss the management phase in consultations, lacking a summary of findings and a plan for the patient.

This study aims to explore patients' experiences with medical student consultations, focusing on satisfaction, outcomes of the consultation, and shared decision-making.

Methods

This cross-sectional study used anonymous questionnaires from patients who had consultations with medical students in general practice. Distributed after each consultation, the questionnaires were available both digitally and on paper, collected by a secretary and sent to the project leader.

The questionnaire included demographics and reasons for the visit. It also covered frequency of visits with their regular doctor. Patients rate satisfaction, acceptance of the student, and whether they received the needed help. Further questions address actions taken, follow-up plans, and shared decision-making. The study involves 220 students with potential for 4,400 participants, running March-June and September-December 2024.

In addition to descriptive analyses, we plan to examine differences in patient characteristics using binary logistic regression analysis. Correlations will be explored using Pearson's correlation coefficient.

Results

Inclusion of participants will run until December 2024. We will present preliminary results from the study at the workshop.

Discussion

We would like to discuss the preliminary results to get input on **which findings are most interesting and what additional analyses we should perform to uncover valuable insights about the management phase and shared decision-making in student-led consultations**.

Session 8B: Health literacy

What do they know when patients say "I don't know"? Unlocking the gateways to person-centered care

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Background

In the communication between physicians and cancer patients, one repetitive phrase from patients is, "I don't know." This speech is usually concluded as the representation of low health literacy. The negative consequences of low health literacy include difficult communication, low patient autonomy, physicians bearing more responsibilities and power, and higher medical risks.

However, "I don't know" may refer to different interpretations. From speech act theory, the act of saying "I don't know" may demonstrate resistance, asking for help, or trust. It may also imply an invitation for physicians' further curiosity to continue the conversation. It may also mean that the patient is stuck in a confusion of reality, needing people to co-construct a knowledge of reality. Therefore, "I don't know" does not mean patients know nothing. This speech can be a gateway for physicians to understand patients' interpretations of the illness situations.

Objective

This study aims to understand the knowledge behind "I don't know" to inform physicians and patient communication.

Research methods

The research analyzed 38 patient interviews and applied thematic analysis to generate findings.

Preliminary findings

The implicit knowledge behind "I don't know": 1) Patients' responses to the disease, including their emotional, cognitive, and behavioral responses. 2) What kind of persons they are, including the knowledge about patients' values, preferences, needs, and abilities. 3) The persons they can trust, which can indicate a supporting social-ecological system in the patients' environment.

Discussion at OCHER
1. What are the relationships between the three findings? What are your observations of patients' speech of "I don't know"? What is the common speech of patients in your culture that indicates a "literacy gap"?
2. What is the most proper theoretical framework for this study? Health literacy, patient autonomy, epistemic injustice, power and resistance, or patient-provider communication?
3. How can this research contribute to the practice of person-centered care?

Sense & sensibility: A qualitative study on trust and mistrust among parents seeking infant healthcare

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Proposed research project

Primary objective: To examine the goals and driving forces (sense and sensibility) of parents seeking nutritional aid for newborn babies at healthcare centres.

Secondary objective: To examine their trust relationship with family, healthcare nurses and influencers

First-time parents of newborn babies are "bombarded" with information on how to care for their infants. Grandparents, friends and public health nurses show care and give well-meant advice to the parents. In recent years, nutritional influencers have also entered this "advisory board" for the parents, sometimes giving corrections to outdated information, but often creating uncertainty with advice conflicting with the old sources.

First-time parents face massive challenges to their daily routines, and they need to make important decisions for their newborn babies constantly. They seek, and receive, information on how to care for infants from several sources. Grandparents and other family members, friends and colleagues, traditionally all want to help the new family. Healthcare authorities also want to help the parents in the upbringing of new taxpayers; providing care, research and information. Public health nurses receive the parents for controls and healthcare for the infants at given intervals. In addition, influencers give advice on caring and nutrition in social media. This could lead to an overload of conflicting advice and information for the parents, often causing uncertainty instead of solving challenges.

An example of such conflicting advice was the public debate in 2023 over baby food. Nutritional influencers and public health nurses were in aggressive mainstream and social media debates over the recommended nutritional values of food given to babies.

We will examine this conflict from the viewpoints of parents, public health nurses and nutritional influencers. The problems will be examined through qualitative interviews and focus groups with the three above mentioned groups. A pilot study with two master students in public health nursing will provide important background information for the proposed study, asking parents and public health nurses about their meetings at the healthcare centres.

NIPH has already expressed an interest in creating health literacy programs based on the proposed study.

Any suggestions?