Program overview

Annual OCHER workshop on clinical communication

Fornebu, Norway

January 14-16, 2026

	Wednesday, January 14		
Time	**Activity**	**Plenary room / Room A**	**Room B**
1000	Plenary	Introduction, mutual presentation	
1045	Break		
1100	Plenary keynote	**Marij Hillen: Combining multiple research methods to illuminate complex phenomena in healthcare communication**	
1200	Lunch		
1300	Plenary keynote	**Rose McCabe: "Using CA methods to design and test communication-based interventions"**	
1400	Break		
1415	Groups	**Session 1A** (Chair: Anne Marie) **Uncertainty**	**Session 1B** (Chair: Lena) **Patient needs**
		Gabriele Leonie Schwarz	Patrick Cairns
		Arwen Pieterse	Kristen Thornton
1515	Break		
1530	Groups	**Session 2A** (Chair: Anne Marie) **Patient agency**	**Session 2B** (Chair: Lena) **Shared decision-making**
		Anna Lindström	Simone Kienlin
		Johanna Haraldsson	Elzana Odzakovic and/or Alexandra Säwen
1630	Break		
1645	Plenary presentation	Knut Eirik Eliassen	
1715	Break		
1845	Networking	Activity	
1930	Dinner at hotel		

Program overview

	Thursday, January 15		
0830	Plenary keynote	**Marij Hillen: How clinicians, patients and caregivers discuss uncertainty: from theory, through observed behavior, to education and training**	
0930	Break		
0945	Groups	**Session 3A** (Chair: Jennifer) **Patient agency**	**Session 3B** (Chair: Eirik) **Patient records & CST**
		Ana Carvajal de la Torre	Anna Smålander
		Daniel Skog	Christian Emil Brinck
1045	Break		
1100	Groups	**Session 4A** (Chair: Anne Marie) **Mental health**	**Session 4B** (Chair: Lena) **Clinicians´responses**
		Vaida Kazlauskaite	Anna-Lea van Ooijen
		André Løvgren (presents H Skirbekk)	Julia Menichetti
		Harrison Boyajian (Brooke Ripley and Traci Stephens present)	Sofia Östensson
1230	Lunch		
1330	Plenary workshop	Alberto Zamanillo	
1430	Break		
1445	Groups	**Session 5A** (Chair: Anne Marie) **Questions**	**Session 5B** (Chair: Hanne) **Decision-making in case discussions**
		Kristina Edman	Barbara Schellenberger
		Fiorella Huijgens (Arwen Pieterse presents)	Irja Alida Oppedal
1545	Break		
1600	Plenary method. workshop	Marij Hillen & Julia Menichetti	
1645	Networking	Thematic rooms	
1730	Break		
1900	Dinner at hotel		

Program overview

	Friday, January 16		
0830	Plenary keynote	**Rose McCabe: “Communication in Mental Health Assessments: Implying implausibility and undermining versus accepting peoples’ experiences”**	
0930	Break		
0945	Groups	**Session 6A** (Chair: Jennifer) **Critical/challenging conversations**	**Session 6B** (Chair: Hanne) **Theory/Model development**
		Aldona Katarzyna Jankowska	Marte-Marie Wallander Karlsen
		Elna Leth Pedersen	Pål Gulbrandsen
1045	Break/check out		
1115	Groups	**Session 7A** (Chair: Lena) **Empathy/Emotions**	**Session 7B** (Chair: Pål) **Medical education**
		Karin Bergman	Edvin Schei
		Malin Östman and Annelie Sundler	Karen Shlanka
1215	Lunch		
1315	Groups	**Session 8A** (Chair: Lena) **Empathy/Emotions**	**Session 8B** (Chair: Julia) **System balancing**
		Massimiliano Mameli	Luna Richardt
		Sara Jordan	Emma Källerö
		Arnstein Finset	Stig Nymo
1445	Break		
1500	Plenary presentation	Jennifer Gerwing, Kristina Edman, and Anne Marie Landmark	
1530	Plenary closing	Evaluation and round-up	
1600	End	Safe Travel!	

Session 1A: Uncertainty

Learning from older patients' and their next-of-kins' strategies to cope with medical uncertainty in the event of acute critical illness

*Gabriele Leonie Schwarz[1], *Britt Ågot Sjøbø[1], Elisabeth Skaar[1], *Margrethe Schaufel[1], Paul Han[2]

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Introduction:
In a recent survey, we found that the treatment preferences of older patients (? 80 years) regarding intensive care varied widely and were difficult to predict for their next of kin. Contrary to these findings, decisional confidence was high among both older and next-of-kin respondents [1].
In the same survey, we collected qualitative data on how older respondents and their next-of-kin envisioned their participation in shared decision-making.
From these free-text comments, we aim to explore sources of the respondents' confidence.

Methods:
We started analyzing the material by conducting systematic text condensation (STC) [2]. After the first two steps of STC and through our healthcare professional lens, we found it challenging to understand that the majority of our respondents seemingly did not take notice of the medical uncertainty, which was explicitly stated in the questionnaires.
After discussions in the research group, we decided to apply a framework for uncertainty in medicine [3], aiming at facilitating our understanding of our respondents' stance.

Preliminary findings:
We identified four main strategies by which older patients and their next-of-kin cope with medical uncertainty.

Strategies aiming to reduce uncertainty:
- Searching for more information
- Assessing robustness/frailty (Is life on the wane?)

Strategies aiming to palliate uncertainty:
- Improving the decisional process
- Strengthening the contribution of human relationships

Questions to discuss:
1. Where is medical uncertainty situated in the event of acute critical illness in advanced age? Who "owns" it?
2. Attempting to learn from patients' and their next-of-kins' ways of knowing – instead of relating their stance to a lack of medical knowledge – opened new avenues to understanding these data. Does it make sense for health care practitioners?
3. How could our findings inform clinical decision-making?

Talking About Uncertainty (TAU): A vignette study on how clinicians disclose uncertainty to patients

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[2]*Amsterdam University Medical Centers, the Netherlands*

Background
Uncertainty –a person's conscious awareness of ignorance– is widespread in healthcare. Fast-paced developments of new medical technologies and treatment options generate numerous unknowns, while developments like increased patient autonomy require clinicians to openly discuss these uncertainties with patients. Yet, research on uncertainty communication is limited, leaving clinicians with little guidance for adequately discussing it. Inadequate communication about uncertainty may negatively affect patients. We further have no insights if uncertainty communication may differ across clinical settings, characterized by different patient groups (e.g., younger/older patients) and types of uncertainty (e.g., diagnosis, prognosis, treatment options).

Aim
To map variation in clinicians' approaches to uncertainty communication in different medical contexts, taking into account clinicians' intentions and characteristics. Ultimately, this project seeks to generate practical guidance to clinicians for optimally discussing uncertainty.

Methods
A vignette-based experimental study (expected N=200 clinicians) and follow-up interviews (expected N=20) to identify clinicians' approaches to uncertainty communication in pediatrics, oncology, and neurology. Clinicians consecutively view three scenarios with different types of uncertainty (diagnosis, prognosis, treatment). After each scenario, we ask them to say out loud what they would tell the patient/parents portrayed. These statements and their reflections on their intention(s) with their statements will be audio-recorded. In follow-up interviews clinicians reflect on their communication, and their perception of their role and underlying values when communicating uncertainty. We will quantitatively test the effect of medical context, type of uncertainty, and clinician and context characteristics on clinicians' experienced uncertainty, intentions, and communication behavior. We will thematically analyze clinicians' statements and audio-recorded and transcribed interview data using both inductive and deductive coding.

Results
We will present the preliminary analysis of audio-recorded verbal communication (expected N=50 clinicians).

Points for discussion:
- how to analyze the audio-recorded verbal communication thematically;
- how we can meaningfully integrate the data on intentions from the vignette study and the data from the follow-up interviews, with the data on clinicians' verbal communication.

Session 1B: Patient needs

Hopes and Concerns of Adolescent Patients and their Caregivers in Genetic Testing for Childhood Cancer: A Two-Year Longitudinal Follow-Up

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Technological advancements over the past decades have improved our understanding of how germline genetics affect childhood cancer, with an estimated 8-16% of cases having a significant germline genetic component. Accordingly, genetic predisposition testing can inform treatment decisions and screening practices for patients and survivors. However, the practical benefits are uncertain due to variability in: how much the gene mutations effect the patients, and what physicians can do with the genetic knowledge from testing. Furthermore, introducing genetic predisposition testing raises psychosocial concerns that require inquiry to avoid potential harm. While previous research has explored these areas, limited longitudinal data exists, particularly concerning the hopes and concerns of patients and caregivers.

This study aims to investigate the hopes and concerns of adolescent cancer patients and their caregivers regarding genetic predisposition testing over a two-year period. By assessing changes at four different time points, we seek to discover the psychological consequences and support needs related to genetic predisposition testing.

Our research questions include: What hopes and concerns do adolescent cancer patients and their parents have regarding genetic predisposition testing over a two-year period? Do these hopes and concerns change over time? Are any sociodemographic factors associated with changes in hopes and concerns regarding genetic predisposition testing?

By addressing these research questions, our study aims to create knowledge in the field of pediatric oncology. This knowledge will be used to develop communication tools for healthcare workers. Ultimately, we hope this knowledge can inform clinical practice and support strategies. Understanding the psychosocial dimensions of genetic testing may improve patient and caregiver experiences, ensuring that their emotional and informational needs are effectively met throughout the testing process.

Questions for Discussion:

- Is genetic predisposition testing an important moment for pediatric cancer patients, or is it just another test?
- What role does clinical communication play in managing expectations related to genetic predisposition testing outcomes?
- How might sociodemographic factors influence the hopes and concerns surrounding genetic predisposition testing in diverse patient populations?

Using Co-Creation to Identify the Information Needs of Child, Adolescent, and Young Adult Cancer Survivors: A Discussion of Co-Creation Data Analysis

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Background:

With the number of child, adolescent, and young adult cancer survivors (CAYACSs) growing rapidly, there is a pressing need for accessible tools to support survivorship. Personal digital tools, such as phone applications, can help fill this needs gap and provide easily accessible information and resources for this group.

Aim:

First, to identify CAYACSs' information and support needs to guide development of resources that address them. Second, to co-create the framework for how CAYACSs will interact with a newly adapted digital tool, including prioritization of tailored resources based on CAYACSs' self-reported needs.

Methods:

Through co-creation workshops, the project's user panel, which consists of CAYACSs, their support network members, and healthcare professionals, met to generate and refine information topics most pertinent to include in the app, review the developed content and prototypes, and discuss mechanisms by which the app could tailor the information and resources provided.

Results:

From preliminary observation of workshop recordings, the user panel identified fatigue, relationships and social stigma, cognitive challenges, fertility and sexual health, and psychosocial health as the most important information topics to include in the app. Further, CAYACSs cited the need to access resources that not only explain what late effects are but also need advice on how to manage them and support for how to explain their experiences of late effects to others, such as romantic partners, employers, etc.

Conclusion:

Co-creation seems to be a feasible and valuable method for the development of digital tools for CAYACSs.

Questions:
1. Have you used methods to analyze co-creation data? If so, please describe them.
2. What are possible ways these types of data could be best explored?

Session 2A: Patient Agency

Manifesting patient agency: Patient-initiated descriptions of self-treatment

Anna Lindström*

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Development of antimicrobial resistance (AMR) is a global health challenge. Within primary care, respiratory tract infection (RTI) is an area where antibiotics are prescribed inappropriately. Conversation Analytic research can contribute to the solution of this global health problem by identifying communicative patterns and strategies that promote appropriate prescription (Stivers, 2007). Stivers (2002) examined problem presentations during the information gathering phase of pediatric consultations for RTI. She found that parents who presented their child's problem as "symptoms only" were hearable as adopting the stance of primarily seeking a medical evaluation of their children. Parents who presented a "candidate diagnosis" by contrast were hearable as adopting the stance that they were seeking confirmation of their lay diagnosis. The latter practice could be understood by doctors as pressure to prescribe antibiotics.

I will examine another patient practice during the information gathering phase of RTI-consultations, namely patient self-initiated descriptions of efforts to self-treat. The analysis will explore the sequential contexts and trajectories of these descriptions including how they may be heard to embody stances toward treatment outcomes. The data are drawn from 68 video-recorded clinical consultations with adult patients for common respiratory infections in Swedish primary care. Conversation analytic (CA) methods were applied to make case-by-case observations and to build a CA-grounded coding scheme.

Patients initiated descriptions of self-treatment in 24 visits (n=68). Nineteen of these (79%) were initiated during the information gathering phase of the encounter. Treatments mentioned included over the counter cold medicines, pain killers, prescription medicines and different home remedies. Patients often described the treatment as ineffective and doctors sometimes aligned with these descriptions of treatment inefficacy.

Points for discussion and improvement
I will present extracts from pseudonymized video-recordings and welcome comments on the contextualization of the study and preliminary analysis.

Adolescent Males' Directive Involvement in Consultations with General Practitioners – A research plan

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Background

Many adolescents report difficulties talking to 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.

To address health concerns, adolescent males must raise them with the GP, for instance by initiating a topic, asking a question, or adding information not explicitly requested by the GP. Such interactional practices may be described as the patients' directive involvement. Previous research has shown that children's directive involvement in child and family therapy sessions may be enhanced by the clinicians' communication styles, indicating that directive involvement may be interactionally facilitated in GP consultations as well. However, this is sparsely studied. The aim of this study is therefore to explore adolescent males' directive involvement in consultations with GPs.

Research Questions

1. What characterises adolescent males' directive involvement in consultations with GPs?

2a: How do adolescent males exercise directive involvement in consultations with GPs? What occurs in the consultation when an adolescent male exercises directive involvement?

2b: What characterises the conversations or conversational sequences in which adolescent males exercise directive involvement? What may have contributed to their directive involvement?

Method

Following the inductive and qualitative method Microanalysis of Clinical Interactions (MCI) we will analyse eight video-recorded GP consultations with males aged 15 to 19 years, obtained from earlier research. A previous operationalisation of children's involvement in child and family therapy sessions will be adapted and applied to these video recordings. Sequences containing the phenomenon (directive involvement) will be identified in the recordings. Each instance of directive involvement will be traced and followed to determine what occurs in the consultations after an adolescent male exercises directive involvement and what may the GP have done to contributed to their involvement.

Questions:

- We are curious on your take on the study design and the aim of the study. We would also like your input on some of the tricker sequences in our data. What do you observe?

Session 2B: Shared Decision-Making

Patient-Perceived SDM in Specialist Healthcare: A Cross-Sectional study in Norway

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Background:
Although legislation and policy state that patient involvement in decisions about their health is a clear goal, this kind of involvement has not yet been routinely implemented in clinical practice. Patients can be supported to be involved in decisions using shared decision making (SDM). This is a collaborative patient-centred communication process for arriving at informed and value-based decisions in the context of treating, screening, or preventing a health condition. The South-Eastern Norway Regional Health Authority has launched a multifaceted SDM implementation strategy that explicitly calls for defining and tracking indicators, including patient-perceived SDM. Comparable region-wide data on patient-perceived involvement across specialties are scarce; existing audits are sporadic and methodologically heterogeneous. Establishing a baseline and evaluating future implementation efforts therefore requires measuring patient-perceived SDM.

Aim:
To measure the degree of patient-perceived SDM across selected specialties in the South-Eastern Norway Regional Health Authority.
Methods: Cross-sectional study using a patient questionnaire administered immediately after consultations. The literature offers several SDM instruments differing in purpose, data sources, and psychometrics; among these, the Multifocal Approach to Sharing in SDM (MAPPIN'SDM) is notable for its comprehensive, multi-perspective coverage and theoretical completeness. MAPPIN'SDM consists of 11 indicators of patient involvement, the same quality indicators used in regional SDM trainings. Participants will indicate whether a decision was made and what it concerned; role preferences will be assessed with the Control Preference Scale (CPS; 5-point). MAPPIN'SDM scores will be rescaled to 0–100; reported decisions will be independently screened and classified for SDM relevance; CPS values will be analysed nominally. We plan to include ?200 adult patients (18–95 years) referred to specialist care and facing decisions about treatment, follow-up, or diagnostics across services with multiple reasonable options.

Results:
We expect to present the first baseline estimates of patient-perceived SDM across multiple specialties in this region to inform subsequent implementation and evaluation.

Questions for discussion:
1. What thresholds should define "acceptable" patient-perceived SDM?
2. How do we close the feedback loop from measurement to improvement?

Communication, shared decision-making, and patient involvement between patients with Restless legs syndrome (RLS) and clinicians during visits to specialized neurological clinics and primary healthcare

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BACKGROUND

Restless Legs Syndrome (RLS) is a neurological disorder affecting 3% of the global population. It is characterized by an irresistible urge to move the limbs and discomfort in the evening which significantly disrupts sleep. Diagnosis depends largely on patient-reported symptoms and clinician interpretation. While there are treatments available, their effectiveness varies, making communication crucial. To overcome the limited understanding of how patients with RLS communicate their experiences or engage in decisions, a project including five sub-studies is planned.

AIMS

Study I: To explore and describe how patients with RLS communicate their symptoms and engage in shared decision-making during appointments at specialized neurological clinics.

Study II: To describe how patients with RLS perceive communication and shared decision-making during initial visits at specialized neurological clinics.

Study III: To evaluate the psychometric properties of the Four Habits Patient Questionnaire (4HPQ) and the Observing Patient Involvement (OPTION) scale on communication regarding treatment strategies for patients with RLS during initial visits at primary healthcare clinics.

Study IV: To explore and compare sociodemographic characteristics and clinical factors associated with the 4HPQ and OPTION scale among working and retired patients with RLS.

Study V: To examine the mediating roles of communication (4HPQ) and attitudes towards treatment in the association between RLS symptoms and involvement (OPTION) among patients with RLS.

METHODS

A mixed-method design will be employed.

Study I and II use an abductive approach that combines multimodal conversation analysis of 20 video-recorded consultations between patients with RLS and neurologists taking place in specialized neurological clinics. Study II includes 20 follow-up interviews with patients two weeks later to explore communication and shared decision-making.

Study III-V uses a cross-sectional design including 200 primary healthcare patients diagnosed with RLS. Inclusion criteria: >18 years, having a diagnosis and treatment for RLS, being able to speak and understand Swedish, and providing written informed consent. Planned instrumentation: RLS symptoms, sleep quality, shared decision-making, patient involvement, communication.

DISCUSSION AT OCHER

We want to discuss aims, design, instrumentation and analysis of the five studies in relation to communication and patient involvement theories.

Plenary presentation Day 1

Improving alignment of consultation teaching practices across pre- and postgraduate levels of family medicine doctor training

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A well-developed primary health care sector is recognized for being the most effective way to take care of an increasing and aging population with complex health issues. The backbone of such primary care is well-functioning general practitioners (GPs). Compared to secondary care, family medicine is characterized by lower prevalence of well-defined diseases, and higher prevalence of multimorbidity and complex health issues. To make family medicine work it is therefore required to use a different approach than practicing a light version of hospital medicine. These methods can be condensed into the concept of consultations and encompasses doctor-patient communication, medical history taking, and decision making, all approached in a patient-centred ethos.
Medical students and resident doctors meet a wide variety of teachers and supervisors, most of whom will have had a different training than their trainees, leading to a varied understanding and practice of consultation methods across contexts. By ensuring alignment between consultation models taught in universities, practiced in real-world settings, and implemented by practicing physicians, often functioning as supervisor themselves, a self-reinforcing learning experience across educational levels can be achieved.

We seek to answer "To what degree are consultation teaching practices aligned across the educational levels today?" and "How can alignment of consultation teaching practices across the educational levels be improved?"

In Part 1, we seek to map to what degree the concept of consultation practices already aligns across the educational levels. A multi-method approach investigating study plans as well as interviewing educators and supervisors at the different levels, may be applied.

In Part 2, we will investigate the perceived alignment of consultation models among students and resident doctors, using qualitative interviews supplemented with geographical and demographic data.

In Part 3, we seek to develop and pilot a shared educational module on consultation models, aiming for integration into both undergraduate education and supervisor training for both undergraduate and postgraduate training.

Questions to discuss:
- How can several countries (Nordic, the Netherlands, UK and Canada?) be involved?
- How can strengthened learning outcomes resulting from better alignment be measured?
- To what extent is it true that alignment as described is a goal in itself?

Session 3A: Patient Agency

Reading Patient Initiated Utterances as a Narrative

Ana Carvajal de la Torre

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Patient-initiated utterances (PIU) are patients' verbal initiatives that do not respond to a direct doctor inquiry / are not expected during the conversation. Through PIU, patients provide their perspectives on what matters 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 from the consultations, we developed a coding system with categories that describe PIUs (moments during the consultation, opening strategies, content, decisional stage, and form of expression) and the doctor's response: present / not present, and different levels of complexity.

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

Through reading these narratives, we discovered that some patients' 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 initial results suggest that it may be a promising approach to understanding specific 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

Exploring Responsibility and Identity in Pediatric type 1 Diabetes Consultations

Daniel Skog

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Clinical consultations for chronic pediatric conditions are sites where biomedical knowledge intersects with the lived experience of families (Silverman 1987; Montenegro & Dori-Hacohen 2020). These consultations involve negotiations of identities, responsibilities. Furthermore, they give insight into participants' perspectives on what a good life with a chronic illness may entail.

This presentation offers a preliminary analysis from my dissertation project, which explores how the macro-level challenges of chronic illness are managed at the micro-level of interaction. The data consists of video-recordings of Type 1 Diabetes (T1D) consultations from a Swedish pediatric clinic. Using Conversation Analysis (CA), I will present extracts that highlight how responsibility for complex 'illness work' (e.g., monitoring, decision-making) is allocated and negotiated turn-by-turn between clinicians, parents, and young patients. The analysis focuses on the interactional practices through which participants manage accountability and co-construct the identity of the 'good' patient.

Building on a rich tradition of Conversation Analysis in medical settings (see Maynard & Heritage 2005), where the interactional structures that underpin clinical encounters have been documented (e.g., Heritage & Raymond 2005; Pilnick 2022), this study extends prior CA research on type 1 Diabetes interaction (e.g., Silverman 1987; Montenegro & Dori-Hacohen 2020). While previous studies have often focused on specific aspects of diabetic care, this project provides a more holistic view. It examines how the 'illness work' of T1D is managed throughout the consultation – as a situated and co-operative achievement.

Discussion points:
How do clinicians' strategies work to balance the dual tasks of medical instruction and empathetic alignment with the family?

What interactional resources (e.g., gaze, gesture, turn-taking) do young patients use to claim agency and participate in decision-making?

Session 3B: Patient records and CST

Writing for multiple addressees: the language of clinical notes

Anna Smålander

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Background

Since 2017, medical records are accessible online for all Swedish citizens. According to Swedish law, medical records should be "as easy as possible to understand by the patient" (Patient Data Law, ch. 3 art. 13, SFS 2008:355), but these records are also seen as a work tool for health-care professionals (Grünloh, Cajander & Myreteg 2016). The medical records thus have multiple addressees. While there is a fair amount of research on Swedish medical language and discourse in general, medical records have only been researched to a small extent, mainly by clinical text mining (see e.g. Dalianis 2018).

Methods

In my PhD project (work-in-progress), I approach the genre of medical records (more specifically, clinical notes) by using Critical genre analysis (Bhatia 2004, 2017). I analyze linguistic and textual features in Swedish clinical notes and conduct focus group discussions with health-care professionals about clinical note writing, to create a better understanding of the genre and how the multiples addressees are dealt with. The text material for linguistic analysis consists of a corpus of 20 medical record excerpts, half from 2008 and half from 2019–2020. The focus group data consists of 6 focus group discussions with doctors, nurses, and medical secretaries.

Preliminary results

The linguistic analysis shows that clinical notes are written in a very genre-specific manner. Complete sentences are fairly rare, often leaving the patient implicit. Health care personnel are almost never explicitly mentioned. Furthermore, connections between sentences are also left implicit. The reader must rely on inferences to make the notes coherent. The focus groups stated that the compact language is due to time constraints during reading, rather than during writing. In order to be as informative as possible, given knowledge is left implicit, which foregrounds the new information.

Points for discussion

1. How can I contextualize the study and the data in a relevant way for health care personnel? What contextual factors would be relevant?
2. How and where can I present my study and my results for health care personnel in ways that are relevant to them? I.e., I would welcome any thought on practical impact.

Cross-cultural adaptation of the Four Habits Coding Scheme into Danish: A study of inter- and intra-rater reliability in face-to-face and video consultations

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Background

Effective physician–patient communication is essential for high-quality care in general practice and can be systematically assessed using structured instruments such as the Four Habits Coding Scheme (4HCS). Although the 4HCS has been validated in English, no Danish version exists, limiting research, evaluation, and training opportunities in Denmark. This study aimed to translate and culturally adapt the 4HCS into Danish and evaluate its inter- and intra-rater reliability in both face-to-face (FTF) and video consultations (VCs).

Methods

Following internationally accepted guidelines, the original 4HCS was translated into Danish using forward–backward translation with minor cultural adaptations. The instrument contains 23 items rated on a 1–5 scale, grouped into Four Habits with a total possible score range of 23–115. Ten general practitioners recorded 150 consultations (78 FTF, 72 VCs), of which 138 were eligible for assessment. Three trained physician raters independently evaluated the consultations using the Danish 4HCS. Inter- and intra-rater reliability were calculated using intra-class correlation coefficients (ICC).

Results

The mean overall 4HCS total score was 79.80 (SD 14.30), with minimal differences between FTF and VC consultations. Inter-rater reliability for the total score was excellent (ICC = 0.75), with similar reliability for FTF (ICC = 0.74) and VCs (ICC = 0.77). Intra-rater reliability was good to excellent across all habits and modalities (ICC range = 0.67–0.75). Item-level reliability showed some variability.

Conclusions

The Danish 4HCS demonstrated good to excellent inter- and intra-rater reliability for assessing physician–patient communication in both FTF and VC consultations. It shows promise as a reliable tool for evaluating communication in Danish general practice across consultation modalities. Future studies may focus on enhanced rater calibration to further improve scoring consistency.

Questions for discussion

1. To what extent can structured tools like the Danish 4HCS capture the complexity of real-world communication — and how should such tools be used responsibly in learning, evaluation, and research contexts?

2. What are the opportunities and challenges of applying validated communication frameworks such as the 4HCS in new contexts like out-of-hours tele-triage, where communication is brief, high-stakes, and voice-only?

Session 4A: Mental health

Crafting helpful formulations for working with patient suicidal ideation

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Our team has looked at formulations used by a provider in conversations where the patient has a different agenda than the provider. The data consisted of a publicly available video where a provider talked with a patient seeking antibiotics for a sore throat. During the conversation, the provider introduced a “new” problem of the patient’s smoking habits and turned the conversation into strategies for smoking cessation. In this dialogue, seventy two percent of the words within the formulations of the provider in the dialogue were “words added”, thus only twenty eight of words within the provider’s formulations continued a variation of the patient’s words.

Our team is looking to expand this pilot project to examine specific medical dialogues where the patient is bring forth a medical concern and the provider introduces addressing the patient’s report of suicidal ideation SI (on their paperwork). Our team would like to develop real life scenarios/role plays of provider/patient interactions to examine the use of formulations in these conversations.

Discussion questions:

- What are the group’s thoughts on developing role plays to analyze these types of dialogues?
- Obtaining permissions to record “real life” conversations on these topics will be tricky since the prior knowledge of the patient’s SI is not often known until the provider reads their paperwork as they enter the room.
- How does/should the provider bring up SI listed on their paperwork if the patient doesn’t mention it in the session?
- What specific hypotheses or research questions can be generated and tested from the proposed study?
- Any suggestions for variations of the proposed project

Dropout dialogues:

A narrative analysis of how patients and therapists co-construct meanings when therapy ends

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Background: Psychotherapy dropout is common and variably defined, with consequences for patients, therapists and services. Research often focuses on patient traits; less is known about in-session interactions that produce dropout. We examined how patients and therapists co-construct narratives when termination is raised — "dropout dialogues" — emphasising implications for trust and clinical practice.

Methods: From an RCT for major depressive disorder (the MOP study), we purposively sampled videorecorded therapies in which patients raised ending treatment (n=6). Two cases (one short-term psychodynamic psychotherapy (STPP), one cognitive behavioural therapy (CBT)) were transcribed verbatim and analysed using narrative analysis, focusing on co-construction of stories, temporal orientations, speech acts, and implicit normative frames.

Results: In the detailed STPP case (Ann) three phases emerged: 1 setting the scene — Ann framed the decision as agreed with the research project, marginalising the therapist; 2 negotiation — competing narratives appeared with minimal responses, hesitation tokens and frequent "I don't know" as interactional resistance and relational protection; 3 resolution — Ann adopted a future-oriented "blank slate" narrative (new therapist), while the therapist offered a past/process-oriented summative account emphasising exploration and listening. Stories rarely converged; therapist normalising and generalising moves sometimes positioned Ann as responsible for limited progress.

Discussion: These interactional patterns reflect dynamics of trust and mistrust. An open mandate — the patient's willingness to disclose and rely on the therapist — increases vulnerability and sensitivity to perceived breaches. Minimal responses, hesitations and "I don't know" serve as boundary management within a strained mandate, protecting identity while signalling ambivalence about extending trust. Therapist moves that normalise can stabilise trust but may also prompt mistrust if they reassign responsibility or obscure institutional influences. Merton's distinction between attention to content versus motive explains how reframing can shift encounters from collaborative meaning-making to interpretive distancing. Termination dialogues thus enact micro-negotiations about expanding, restricting or withdrawing the mandate of trust.

Discussion points:
-Examine patients' termination narratives?
-Consider organisational factors as modifiers of trust?

Day 2

Operationalizing the traits of Narcissism in Dialogue: Tools for healthcare providers

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A group of students at UNLV are working on a microanalysis project to help operationalize the traits of narcissism in conversations. The purpose of the project is to help identify communication patterns among those with narcissistic traits in order to provide communication tools for practitioners. To date, the group has identified key traits of narcissism (e.g. Self-Promotion -steering conversations toward personal successes or credentials) and their operational definitions (e.g. To interject a statement, solicited or not, about themselves to another/others in which the speaker states that they are better than others or "the best" at a task, role, etc.) with examples (e.g. "I am a very successful architect").

Next steps include continuing to look for traits of narcissism in medical dialogues, not just in general conversations. The group is running into challenges with finding videos of individuals with narcissistic traits, especially in medical settings. The research group would like feedback on several things moving forward (discussion questions).

Discussion questions:
1. Any ideas on where to find videos to analyze for the topic?
a. Thoughts of creating role plays to video record and analyze?
2. Are there other personality traits (or disorders) that might be helpful to study as well (e.g. Borderline traits)?
3. Are there specific medical settings or types of medical conversations that would be useful to analyze?

Session 4B: Clinicians’ responses

Microanalysing clinicians’ efforts to tailor treatment information to cancer patients

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Background:

No two patients have the same information needs or abilities to comprehend or process information. Clinicians are therefore called upon to tailor their information provision to individual patients. Information tailoring can be defined as a dialectic process in which clinicians adjust what information to provide, when and how, in order to match patients' emerging needs and abilities. Tailored information is suggested to reduce information mitsmatches, thereby improving patients’ wellbeing. While previous research has attempted to conceptualize information tailoring and explored clinicians’ perspectives and experiences with it; no direct observational research has examined how clinicians actually tailor information in clinical practice. Such knowledge is crucial for the development of information tailoring guidelines in clinical consultation.

Method:

This qualitative study used a microanalytic approach to identify clinicians information tailoring efforts in oncology consultations (what it is and what it is not). We analyzed 12 video-recordings of clinical consultations conducted in the Netherlands and Norway between 2021 and 2025. Based on this analysis, we developed a decision tree to code cases of information tailoring.

Results:

Preliminary findings suggest that information tailoring unfolded as a two-step, iterative, process. First, patients’ needs for information or their cognitive ability to understand or process it came to the fore (i.e., spontaneously expressed by the patient themselves or elicited by the clinician). Second, clinicians adjusted their responses to align with the patients’ needs or abilities. We found that this was an interactive process between clinicians and patients, highlighting the dialectical nature of information tailoring. Patients’ needs appeared in direct or indirect form, and were examined in terms of their instrumental or affective function. Clinicians employed diverse strategies in response, tailoring both the content of the information provided (e.g., providing full answers) and the format of the information provided (e.g., analogies or additional aids), which we further categorized in light of its instrumental or affective function.

Point of discussion:

Whereas some information tailoring episodes are quite obvious, others are more ambiguous. During the group discussion, we aim to discuss a decision tree developed for coding information tailoring, and present several complex cases from our study.

How do physicians create and take opportunities for building patient health literacy during future action discussions? A microanalysis

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Health literacy (HL) is increasingly understood as situated and shaped within clinical interactions. Physicians can play a key role in supporting and strengthening patients' HL. During clinical interactions, patients and physicians may make decisions and proposals for what the patient should do after the appointment. We have studied how HL becomes relevant when physicians and patient discuss such future actions, which constitute critical moments for building patient HL.

This study builds on a previous analysis aimed at identifying opportunities for building patient HL. Previously, we focused on what opportunities look like and whether physicians take them by repairing (when opportunities are about problems in understanding), expanding (when opportunities are about knowledge sought) or developing HL (when opportunities are about new or different ideas). Here we focus on what physicians do to create such opportunities in the first place and how they take the opportunities that arise.

We are analysing videos of medical consultations from US and Norway, using microanalysis of clinical interaction. The analysis follows the sequential steps: 1) identifying future action sequences, 2) flagging sequences that constitute opportunities for building HL, 3) extracting physicians' actions that played a part in creating such opportunities, 4) extracting physicians' actions that constituted taking the opportunities (e.g., if the physician developed the patient's new or different ideas, how did the physician do that). We will analyse all opportunities until concept saturation.

During OCHER, we plan to present the analytical approach and some preliminary findings with examples. We particularly would like to discuss:
1) How to deal with physicians' practices that are diverse by the nature of the task? E.g. The practices requested for repairing a misconception may be very different from those requested to develop new ideas. Shall we envision findings that provide 4 different boxes of practices?
2) Would you focus on achievements (evidence for some HL mobilized) or in general on attempts?
3) Since the final direction is to translate this knowledge into training, what do you think would make the work relevant and digestible for clinicians?

Shared Decisions or Missed Opportunities? A Qualitative Analysis of Nurse–Patient Communication

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This ongoing qualitative study explores how communication patterns in registered nurse (RN)-led primary care consultations influence patient involvement in decision making. In Sweden, RN-led consultations have emerged as a strategy to improve accessibility and availability of primary care services. However, there is no established framework guiding how RNs can support general practitioners (GPs) in delivering accessible, person-centred care. In a previous study, we found that patients generally have high expectations and report positive experiences with communication, and that RNs largely succeed in meeting these expectations (Östensson et al., 2025).

In the current study, we focus on understanding how RNs facilitate, or fail to facilitate patient involvement in decision making through their communication. The data consist of audio recordings from scheduled, routine RN-led consultations in primary care. A total of 147 consultations involving 30 RNs and 148 patients were analysed. To identify decision-making sequences, the OPTION scale was applied, with coded segments forming the units of analysis.

The preliminary aim is to explore patterns of communication related to patient involvement in decision making in RN-led primary care consultations.

Research questions guiding the analysis:

- What types of decisions (e.g., treatment, self-care, referrals) are communicated and negotiated in RN-led consultations?
- How do patients respond to RN communication in decision-making moments?
- What verbal and non-verbal strategies are used by RNs to support or hinder patient involvement in decisions?
- Does the structure or flow of the consultation influence opportunities for patient involvement?

We plan to discuss our research questions guiding the analysis of communication and decision making in clinical encounters.

Plenary workshop Day 2

Language-centered deliberate practice in systemic brief therapy training

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Psychotherapy is, above all, a practice grounded in language. Indeed, language remains, to date, the only therapist-related variable consistently correlated with treatment success (Anderson et al., 2016; Anderson & Hill, 2017; Kadur et al., 2020; Pereira et al., 2023). Training should therefore emphasize communicative skills that enable the flexible and effective use of techniques.

Deliberate practice (DP) is the most effective route to expertise in complex domains, including psychotherapy (Brand et al., 2025; Chow et al., 2015; Rousmaniere, 2017; Vaz et al., 2025). At the Center for Brief Psychotherapy (Málaga, Spain), we have designed a DP-based protocol tailored to systemic brief models, organized in five stages: (1) theoretical explanation, (2) modeling, (3) pre-training assessment, (4) DP training, and (5) post-training assessment. The workshop will detail each stage and provide a template for analogous procedures across health disciplines.

Moreover, the pre-training assessment functions as a compass for deliberate practice. While some exercises are conducted collectively, assessment results direct each participant toward targeted objectives. To operationalize this personalization, we employ a repertoire of group, individual, and take-home activities, together with analytic rubrics that appraise the performance of therapeutic techniques and orient subsequent practice tasks.

The training emphasizes understanding and refining the language that underpins interventions in brief models (Solution-Focused Therapy and the Mental Research Institute's Strategic Therapy) as well as common therapeutic factors (Wampold, 2010). This focus cultivates responsiveness, flexibility, and precision—qualities identified as central to clinical effectiveness (Stiles, 2009; Wampold, 2015) and aligned with the theoretical foundations of psychotherapeutic models (De Shazer et al., 2007; Jordan et al., 2013; Korman et al., 2013).

Questions for discussion:

- What additional aspects of therapeutic language should be systematically evaluated and trained?
- Is role-play an adequate method to assess language proficiency, or should complementary procedures be developed?

Session 5A: Questions

Do you get the answer you ask for?
Callers' responses to polar questions in medical emergency calls

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Medical emergency calls are critical components in pre-hospital care, requiring rapid and effective communication between callers and emergency dispatch operators. These calls must be time-efficient and provide the operators with sufficient information to assess the situation, triage appropriately, and offer relevant care and guidance.

Language use is central in medical emergency calls, shaping how the calls unfold and ultimately whether the callers get the help they need. A key practice in these calls is the operator requesting information from the caller. Understanding how callers respond to operator's requests for information in these high-stakes, time-sensitive calls can inform professional practice and contribute to improving call quality and outcomes for those seeking emergency assistance.

This presentation reports our analysis of polar questions (i.e., ones that project a "yes" or a "no" answer). We aim to discern whether there is a match between projected responses and how callers actually respond. Is the saying true – do you really get the answer you ask for?

We will use microanalysis of clinical interaction (Gerwing, Healing, Menichetti, 2023) to analyze 32 audio-recorded calls to 113. Analysis will involve creating a collection of all forms of operators' requests for information, characterizing requests as polar questions or not, then analyzing caller responses to polar questions in terms of whether they stay within or go beyond the projected yes/no response. All operationalizations with examples and procedures for analysis will be documented in a detailed coding manual.

This analysis is a substudy in the Rescuevoice Pro project, an 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. The project is funded by the Norwegian Research Council and Somsagt AS. The aim of this substudy is to inform question-answer sequences in AI simulations intended to train emergency call operators.

We welcome your thoughts in general; we are also seeking the following specific feedback:

- How our operationalizations fit within other conceptualizations of questions (e.g., as open or closed)
- How could this inform practice, both in telephone triage and other health care settings?
- Your thoughts about our analytical approach, particularly if you come from a different analytic tradition.

Shared decision making and clinicians' response to the question 'What would you do, doctor?

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Background
Shared decision-making (SDM) is often appropriate yet not common in routine oncology practice. Ae potential barrier may be that clinicians perceive they are largely or ultimately responsible for making the best decision, leaving little room for an active patient role in decision-making. Clinicians' perceptions about their own and patients' role in decision making may manifest in their actions and speech, particularly in high-stakes decisions. When patients ask 'What would you do, doctor?', they make a straightforward appeal to clinicians, and clinicians may particularly struggle in how to respond to such appeals when SDM is at stake.

Research aim
To determine how clinicians respond when patients ask 'What would you do, doctor?' in SDM consultations.

Methods
We identified patients'/companions' expressions of the question 'What would you do, doctor?' in a set of N=87 real-life recorded treatment decision-making consultations of patients diagnosed with breast or prostate cancer. We qualitatively analyzed patients' expressions, clinicians' initial responses, and patients' subsequent reactions, using methods derived from microanalysis of clinical interaction. The present analysis focuses on clinician responses.

Results
We identified 28 expressions of the question in 20 videotaped and 1 audiotaped consultation with unique patients (range, 1-2 per consultation). The preliminary analysis suggests that clinicians' responses range from avoiding to answer - for example by repeating the decision-making procedure, acknowledging the burden of deciding, or repeating medical information - to stating what the physician would do themselves or in the patient's situation. These responses may be seen as more or less explicit demonstrations of the role physicians see for themselves and for patients in making this decision.

Questions for discussion
1. To what extent would you consider physicians' response to the question 'What would you do, doctor?' as signaling their role perception?
2. What (other) situations in the process of treatment decision making (during or outside consultations) could be most informative to observe, to provide insights into how physicians perceive their role in making the decision when SDM is at stake?

Session 5B: Decision-making in case discussions

Decision-making in case discussions in virtual interdisciplinary tumor boards on immune-mediated toxicity (iTox-Board)

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In multidisciplinary tumor boards (MTBs) treatment recommendations for cancer patients are discussed and decided upon. However, study results indicate that there is little interdisciplinary exchange during case discussions. An innovative cross-center, cross-location concept is the virtual interdisciplinary tumor board for immune-mediated toxicity (iTox Board) of the Center for Integrated Oncology Aachen Bonn Cologne Düsseldorf (CIO ABCD), in which experts from various disciplines discuss serious and rare side effects that can occur in the context of modern immunotherapies. Participants rate the board as highly beneficial. However, to date the iTox Board has not been evaluated. Aim of the study is to analyze communication processes and decision-making patterns in the iTox Board and compare them with existing communication data from MTB.

The Input-Process-Output Model of Team Performance serves as basis for data collection and analysis. 1) Case discussions in the iTox board will be observed and recorded on audio. The data on decision-making will be collected using the validated Metric for the Observation of Decision-Making in cancer multidisciplinary tumor boards (MDT-MODe). Structural characteristics of the board, e.g. present professions, will also be documented. Communication will be analyzed with a focus on patterns in the decision-making process. To identify differences, 2) existing data from complex case discussions in MTBs from our own PINTU study will be used for secondary data analysis. To obtain the perspective of healthcare providers, 3) providers who participate in the iTox Board will be interviewed and the transcripts will be analyzed with regard to the experience of decision-making in the iTox Board.

This study will evaluate the innovative concept of a cross-location, multidisciplinary iTox Board for the first time. The results will highlight existing differences in the decision-making process. They will also provide indications as to the extent to which available tools for MTB quality assurance need to be adapted or developed for the new board concept in order to ensure the planned long-term national implementation of the iTox Board.

Questions for OCHER:
1. General feedback on the project idea.
2. What other methods may help to examine and compare communication processes and decision-making patterns in the boards.

Decision-Making Challenges in Molecular Tumor Boards: A Qualitative Study

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Background
In Norway, patients with advanced malignancy who have exhausted standard treatment may be referred for molecular profiling of the tumor using the 500-gene NGS panel TruSight Oncology (TSO500, Illumina). Results are reviewed in weekly meetings of the molecular tumor board (MTB), which opens for inclusion to biomarker-defined clinical trials, including the nationwide trial, IMPRESS-Norway. We aimed to explore the challenges faced by members of the MTB when making treatment recommendations.

Methods
Four semi-structured focus group interviews were conducted in 2024/2025, involving a total of 23 members from the four MTB-sites. Participants included 10 physicians and 13 molecular biologists. Analysis was done by Systematic Text Condensation.

Results
MTB members reported four main dilemmas: 1) Inconclusiveness in diagnostic methods: Uncertain or ambiguous TSO500 results generated clinical uncertainty, complicating treatment decisions. 2) Sustainability of diagnostics: Expensive tests late in the course of the disease was seen as an unsolved challenge, given limited immediate clinical benefit, despite recognition of their value for knowledge development. 3) Unequal access: Access to molecular testing depends on the clinician’s knowledge and initiative, potentially leading to inequities in patient care. 4) Balancing hope with clinical uncertainty: Members faced ethical dilemmas offering experimental treatments of uncertain value and potential toxicity in a vulnerable patient group. Challenges were related to priority setting, non-maleficence and beneficence under uncertainty. Despite this, participants expressed enthusiasm for working in a novel, interdisciplinary field. Acting within the frame of a clinical study and knowing they had left no stone unturned was seen as ethically and professionally important.

Conclusions
MTB members are navigating in a novel field marked by significant uncertainty and complex ethical dilemmas. To support decision-making under these conditions, it is essential to ensure sufficient time and space for interdisciplinary discussions and address medical, ethical, and existential uncertainties. Increased education about precision oncology among clinicians is needed to promote equitable access and informed use.

Questions for discussion:
1) How should we further investigate the doctor-patient dialogues and experiences about the treatment suggestions from the MTB?
2) Which theoretical framework and methods do you suggest?

Session 6A: Critical/challenging conversations

EMPATHY in the Age of AI: A Modern Protocol for Clinician Readiness in Critical Conversations

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While artificial intelligence is transforming diagnostics and treatment planning, it cannot replace the human presence that defines healing—especially in emotionally charged conversations such as delivering bad news, discussing serious diagnoses, or initiating complex treatment decisions. In this context, clinical communication becomes not just a skill but a moral imperative. This abstract introduces the EMPATHY Protocol, a structured yet flexible guide designed to support clinicians in high-stakes, patient-centered interactions.

The protocol retains the acronym EMPATHY, where each letter corresponds to a key communication principle:

E – Emotions: Internal and clinical preparation, including emotional self-awareness and medical competence.
M – Meeting: Thoughtful arrangement of the conversation's time, setting, and participants.
P – Patient Perspective: Integrating the patient's values, experiences, and preferences into the discussion.
A – Appropriate Language: Clear, compassionate, and personalized communication, free from medical jargon.
TH – Truth and Hope: Honest, balanced messaging that respects both realism and resilience.
Y – Yes to Empowerment: Supporting the patient's autonomy, confidence, and decision-making capacity.

This workshop presentation will outline the protocol's development and theoretical foundations, and propose its implementation as a tool to bridge the growing gap between high-tech healthcare and human connection. Drawing from real-world clinical training experiences and interdisciplinary research, the protocol aims to help physicians move from task-based communication to presence-based dialogue.

Points for discussion:

- How can protocols like EMPATHY be integrated into existing communication training curricula across different health systems?
- What is the role of emotional self-regulation and clinician well-being in preparing for difficult conversations?
- How can we ensure that AI-supported clinical environments do not dehumanize but enhance the quality of clinician-patient communication?
- Can the EMPATHY model be adapted for interdisciplinary teams and non-physician healthcare workers?

By initiating this discussion, we invite participants to help refine a protocol that aims to prepare clinicians not only to communicate better, but to be present better—especially when it matters most.

Exploring ways to handle challenging clinical interactions with patients and their relatives. An action research project about strengthening patient involvement

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Background
Research in clinical communication shows that person-centered communication results in higher patient safety, improved treatment outcomes, and increased patient satisfaction. Over the past decade, this knowledge has motivated global efforts to train medical students and healthcare providers in person-centered communication. However, a gap still exists between teaching person-centered communication and the transfer of new skills into clinical settings. This is evident in research, which indicates that the biomedical agenda continues to dominate clinical interactions, and in patient complaints, where more than 35% involve communication failures and relationship issues.

Aim
This study aims to develop recommendations for strengthening the involvement of patients and their relatives in clinical interactions, providing healthcare providers with practices to implement directly in practice.

Methods
The study employs an action research approach to develop an understanding of clinical interaction while changing actions in practice. In four participatory workshops with patients, their relatives, and healthcare providers, we generated data and analyzed it iteratively and collaboratively through reflexive thematic analysis. We held two workshops as World Café workshops and two as Participatory Theatre workshops. Twenty-one patients with autoimmune rheumatic diseases affecting the lungs and their relatives participated, along with ten healthcare providers—half nurses and half physicians. Additionally, patient partners were involved in planning and conducting the workshops as well as analyzing the outcomes.

Results
The healthcare providers identified two generic situations where involving the patients and their relatives is challenging. The situations are clinical interactions with: 1) The quiet patient; 2) The disagreeing patient and relative.
The findings include specific tools and skills for supporting and sustaining person-centered communication and involving patients and their relatives in clinical interactions.

Discussion points
We have these discussion points for the workshop at OCHER:
1) What do you see as the strengths and weaknesses of this study?
2) How can the findings be used in communication training and be implemented in clinical practice?

Session 6B: Theory/Model Development

Communication with mechanically ventilated patients: Theory development in progress

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Introduction
Conscious and alert patients in the intensive care units (ICUs) on mechanical ventilation often experience challenges communicating their needs. Decades of research have revealed that this leads to reduced patient involvement, difficulties expressing symptoms, and negative emotions. Despite these challenges, there is still a lack of guidelines supporting best practice. The study aimed to obtain the perspectives of critical care nurses on a model for communication between mechanically ventilated patients and providers in the ICU as well as their perceptions of the communication.

Methods
Following a concept analysis of the existing literature, we developed a conceptual model for communication with mechanically ventilated patients. However, the clinical utility of this model was unclear. Situation-specific theories should be developed in close connection with the field of specialty where it is employed. We therefore presented the model for 29 critical care nurses conducting 6 focus groups in three different countries (Denmark, Norway, and the USA). The findings have been analyzed in accordance with Elo & Kyngäs´s qualitative content analysis with both inductive and deductive phases.

Preliminary findings
The findings reveal that the relationship between the patient and the caregiver is the foundation for communication. Nurses' competency and strategies for efficient communication are closely linked to the patients' abilities and challenges in communication while being mechanically ventilated. Tools and resources for supporting patient-provider communication can help build a bridge between the communications partners. Building a meaningful relationship with a patient who is non-vocal, critically ill, and fluctuates in consciousness, is a task that requires a lot of the nurses both time-wise and emotionally. Advanced communication skills were described by the nurses as essential to improve the quality of the interaction. A lack of both documentation and evaluation of the various communication methods was described by nurses across countries.

Focus for OCHER
This is an ongoing project, where the end-goal is to develop a situation-specific theory that can be used as a backdrop to get a deeper understanding of the communication between patients and nurses in ICUs. The goal for the OCHER session is to get feedback on the analytic method and findings.

Three Layers in the River of Conversation – a helpful metaphor?

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Heraclitus (540-480 BC) is known for the proverb “You cannot step into the same river twice. Because it is not the same river, and you are not the same man.” By this he described life and nature as a continuous flow. Building on that, I propose we think of every conversation as a river. The water in a river has interacting layers, different speeds, depending on the riverbed, river bends, and surface winds.

The deeper layer in a conversation is personal. It is what you as a clinician carry from your whole life, from conception till your last encounter, and it influences your now, in interaction with a patient or others. You carry your history, knowledge, emotions, relations, assumptions, and more.
The middle layer is the tasks. This is where the main stream flows, where you perform what you were taught to do, integrating the currently recommended encounter structure with biomedical exploration, shared decision making, and physical examination. The speed and whirls of this layer depend on the deeper layer, and what happens at the surface.

The surface layer is the connection layer. This is what is observable down to milliseconds, sighs, sounds, body language, words, tone, gaze, face, tempo, pauses, touch. What does the connection layer tell about the interaction, the performance of the tasks, the personal reactions that all people in the room have?

I suggest that this metaphor will help clinicians to understand better how they personally influence task performance and connection. By exploring self, they have a tool to reflect on why conversations flow smoothly and slowly with some persons and in rapids and waterfalls with others.

Questions:
- How do you think the flow of a river fits what happens in a conversation?
- Can the metaphor be useful for self-coaching?
- Will it be helpful also to understand the diversity of patients?
- How will it help students, junior or senior clinicians, if at all?

Session 7A: Empathy/ Emotions

Patient concerns - Coding Patients' Emotional Expressions in Primary Care Registered Nurse-Led Consultations with the VR-CoDES

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This study explores emotional communication in registered nurse (RN)-led consultations in Swedish primary care, as part of the PINPOINT project. In this setting, RNs often serve as the first point of contact, in parallel to general practitioners (GPs), for patients seeking help with new health problems, playing a key role in initial assessment, decision-making, and patient guidance.
Previous findings from the PINPOINT project indicate that patients generally hold high expectations for communication and report positive experiences with RNs who mostly meet their expectations (Östensson et al., 2025). Preliminary results also suggest that RNs tend to follow a natural consultation structure when exploring patients' health problems. However, essential components such as eliciting medical concerns, exploring social history, and confirming patient understanding are sometimes omitted (manuscript).
The current study investigates whether and how patients' emotional concerns, expressed through negative emotional cues or explicit concerns, are addressed during RN-led consultations in primary care.
Data were collected from 148 routine RN-led consultations across 10 primary care centers, involving 30 RNs and 148 patients. Emotional communication was analyzed using the Verona Coding Definitions of Emotional Sequences (VR-CoDES).

Research questions:
- What emotional cues and concerns do patients express during consultations, and what aspects of care do these relate to (e.g., current health problems, treatment, self-care, referrals)?
- How do RNs respond to or address these cues and concerns?
- Do RNs tailor their responses to patients' emotional cues and concerns or follow a standardized response pattern?

We aim to discuss both our research questions and the planned analysis for the study

How Language Matters: Exploring Emotional Communication in Registered Nurse-Patient Consultations with Linguistically Diverse Patients

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This ongoing qualitative study builds on findings from the PINPOINT project, focusing on communication and patient perspectives in registered nurse (RN)-led consultations in primary care. These consultations have emerged in Sweden to improve accessibility and availability of primary care services, yet there is no clear framework for how RNs can support general practitioners (GPs) in delivering accessible, person-centred care.

In one of our previous studies, we found that patients generally have high expectations and report positive experiences with communication, and that RNs largely succeed in meeting these expectations (Östensson et al., 2025). However, patients whose native language is not Swedish rated affect-oriented aspects of communication less positively. Preliminary findings also suggest that RNs often adopt a natural consultation structure to explore patient concerns, despite lacking formal training in clinical interviewing. Key components, such as eliciting medical concerns, exploring social history, and confirming patient understanding are sometimes omitted (manuscript).
It remains unclear how language influences these perceptions, and whether they are linked to language proficiency or deeper cultural differences. In this study, we aim to explore how language affects emotional communication and patient involvement in RN-led consultations with linguistically diverse patients. Drawing on audio recorded observations, we plan a qualitative exploration of communicative patterns and emotional attunement.

The preliminary aim is to explore how language influences communication and emotional attunement in primary care consultations between RNs and patients whose first language differs from the majority language. The study seeks to understand how linguistic and cultural factors shape communication in these encounters.

Research questions:
- Do language barriers influence RN–patient interaction in primary care consultations?
- What types of communication challenges arise, and how do RNs navigate them?
- What verbal and non-verbal strategies do RNs use to acknowledge emotional concerns and support patient involvement?
- How does language intersect with cultural dimensions in the RN–patient encounter?

We aim to discuss both our research questions and potential observational strategies for studying language use in these clinical encounters.

Session 7B: Medical education

Our need for attachment and our fear of losing face: Phatic communication in education and therapy

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Medical students in clinical practice can feel alienated and demotivated by seemingly trivial aspects of communication. When physicians and staff do not greet them, use their names, or show personal interest—such as small talk—students struggle to learn how to become doctors.
Studies of clinical communication reveal similar dynamics in patient-clinician interactions: first impressions form within seconds, and trust is gained or lost through gestures, words, and acts that may seem to lack factual content, yet constitute the “chemistry” that determines therapeutic success or failure.

These parallels between workplace learning and therapeutic relationships stem from humans’ use of phatic communication to navigate the complexities of face-to-face encounters. The term phatic communion, coined in 1923 by anthropologist Bronis?aw Malinowski, refers to speech that serves primarily to strengthen social bonds. Phatic communication is a linguistic concept encompassing a wide range of semantic phenomena that facilitate—or complicate—social interaction.

Drawing on theories that highlight humans’ need for recognition and the vulnerability this entails, we developed an intervention project at a small Norwegian hospital to support medical students’ clinical learning by enhancing workplace integration and affective support from physicians. The PROFMED study is a complex intervention with simple means. We created a win-win situation through a two-pronged approach: encouraging student agency and initiative, while helping junior doctors see how connecting with students eager to take on physician tasks can support learning and reduce their workload.

Results from interviews and observations show that both students and tutors thrive. Informants report that the learning climate in the department has improved. But:

- How can we understand what happened—and apply it elsewhere?

Phatic communication theory offers a powerful lens for analysing the subtle, largely unconscious mechanisms of interpretation and identification that foster attachment or estrangement, rapport or alienation. The work of applying this lens in health care and education has only just begun.

Bridging the Values–Practice Gap in Postgraduate Medical Education: Adapting the ORCA Video Review Coaching Process for International Medical Graduates

Karen Shklanka

UBC faculty of medicine

Communication skills are fundamental to high-quality, values-driven patient care, yet residents often experience a gap between their professional values and their observed clinical practice. To address this, I developed ORCA (Observation, Reflection, Communication, Awareness), a structured video review coaching process for family practice residents. ORCA integrates microanalysis of resident–patient conversations with a solution-focused coaching dialogue between educator and resident. Its goals are to help residents remain present, convey compassion, proceed with curiosity, choose boundaries, and take responsibility in their encounters.

In ORCA sessions, videotaped patient interactions serve as a starting point for reflective learning cycles. Residents are guided to explore what went well, how they were affected by the patient (and vice versa), and what alternative communication choices might have been possible. The educator models values-based communication, validates strengths, and supports the resident in identifying self-directed “homework” to take forward. This process creates a safe learning space, fosters awareness of self and patient, and links specific communication behaviors to core professional values.

Jennifer Gerwing, who observed video review sessions, contributed to describing and conceptualizing the ORCA process.

My current work explores adapting ORCA for International Medical Graduates (IMGs), who bring diverse strengths but may have had less structured communication training in their prior education. Many IMGs are also racialized physicians or speak English as an additional language, and may encounter unique challenges such as differing expectations of the medical interview or even unintentional microaggressions from patients. Early observations suggest that IMGs may benefit from additional scaffolding, such as explicit teaching of “missing” interview elements, validation of their cultural perspectives, and facilitated discussion of patient bias and resilience.

This presentation will describe the ORCA framework, highlight its grounding in linking values to practice, and share preliminary reflections on modifying video review coaching for IMGs in postgraduate medical education. The aim is to stimulate discussion on how we can create communication teaching that is both evidence-based and equity-informed, supporting all residents to deliver care that embodies their professional values.

Session 8A: Empathy/ Emotions

Shared Emoji Dictionary for Healthcare: Insights from Patients with Desmoid Tumor

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The growing digitalization of healthcare, accelerated by the expansion of telemedicine (Troiano & Nante, 2018; Seo et al., 2013), has profoundly transformed how doctors and patients interact. While digital tools facilitate access to care and continuity of follow-up, they also risk reducing empathy and increasing the risks of mono-modal communication, including misunderstanding at the illocutionary and inferential levels and miscommunication due to failure to properly convey the intended communicative functions (Derks et al., 2008; Fischer & Herbert, 2021). In this context, emojis have emerged as visual paralinguistic tools that enrich written messages with emotional and pragmatic nuances, facilitating expression, modulating tone, enhancing comprehension, and reducing communicative ambiguity (Bai et al., 2019; Yus, 2023; Riordan, 2017). However, their usage varies depending on individual preferences, cultural differences, and the communication platform employed (Bai et al. 2019; Miller et al., 2016; Rodrigues et al, 2018).

This study focuses on patients with desmoid tumors, a rare disease with significant psychological and social impact (Ingley et al., 2020). The aim of this study is to explore three main dimensions: (1) the general use of emojis in everyday communication, (2) patients' perceptions of their use in medical and telemedicine settings, and (3) the development of a shared dictionary of emojis associated with key concepts in the care experience. In particular, the shared dictionary aims to explore how emojis are used to express clinically and emotionally relevant dimensions such as pain, anxiety, fear, hope, trust, relief, and perceived support.

By combining exploratory and structured questionnaires, the study seeks to uncover both the practical habits and the meanings patients attribute to emojis. The main goal is to assess whether emojis can contribute to more empathic and clear healthcare communication, offering innovative tools to support the doctor–patient relationship in oncological contexts.

Empathetic medical dialogues: tips for healthcare workers

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Our group began the task of defining "empathy" in medical conversations. We watched medical interactions between physicians and patients and developed a list of behaviors that we believe display empathy. Then, we categorized these behaviors into the following categories: should or could. Those behaviors that SHOULD be present in empathetic medical conversations include: reassurance of care/prognosis and acknowledgement of emotional experience. (Note: emotional experiences are situations when a patient or their family member is having a physiological response and/or a behavioral reaction to a medically related situation/crisis such as receiving a diagnosis, injured, in pain, having a medical crisis). Those behaviors that COULD be present in empathetic medical conversations include: asking patient permission in medical care; inviting patient input; acknowledgement of challenges in medical systems; addressing/greeting patients by name; and giving details in medical information. We've only done a preliminary analysis (one conversation with 19 provider utterances) and the most interesting finding we discovered is that 47% of provider formulations acknowledged the emotional experience of the patient, a behavior in the "should" category.

We are ready to move into the next phase, looking for what is "not empathic". We've started to draft a list of behaviors but would like feedback on this next phase. We've tentatively used "indifference" to describe the opposite of empathy but would like more feedback on the term. Also, we would like to expand our data to other providers (nurses, etc).

Discussion Questions:
What feedback does the group have on the initial empathy and "indifference" definitions?
What differences might we want to consider if expanding the study to include other healthcare providers?
What considerations should we keep in mind if we want to create our own role play scenarios for this topic (for both empathy and indifference)?

Patterns of clinician responses to patient emotion as studied applying VR-CoDES: Impact on outcome

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Background: Many studies have applied Verona Coding Definitions of Emotional Sequences (VR-CoDES) to explore what variables influence how clinicians respond to patients' expression of emotion. One may ask: so what? The question may be even more clinically relevant the other way around: What are the effects of clinician responses to patient emotion on outcome? However, fewer studies have addressed that research question.

Objective: To examine the research literature based on VR-CoDES so far to summarize the findings on the question above. Based on such a summary, the objective is to discuss how future research may further elucidate the effects of clinician responses to patient emotion on outcome variables.

Methods: Five electronic databases were searched for articles applying VR-CoDES in empirical studies. One-hundred-and-seven papers were identified in which VR was applied. The papers were examined to find examples of the impact of clinician responses on outcome variables.

In VR-CoDES, responses are coded according to whether the responses to emotional cues and concerns are explicit or non-explicit and whether the responses provide or reduce space for further disclosure. Thus, four patterns emerge: explicitly providing space (EP), non-explicitly providing space (NP), explicitly reducing space (NR) and non-explicitly reducing space (NR).

Results: In several studies, response patterns were found to have impact on further patient expression of emotions. Most often, provide space responses were associated with more patient disclosure in the encounter. Provide space responses were also positively associated with more patient trust. On the other hand, in one study ER responses were associated with lower patient ratings of the quality of care. In another study, ER responses were associated with shorter consultation duration.

Discussion: Research so far has presented divergent findings on the impact on outcome of clinician responses to patients' expression of emotion. To better understand the relationship, a number of methodological issues should be discussed. For instance, clinician responses are coded on utterance level, whereas patient outcome variables are assessed on consultation level.

Questions for discussion:

1. What research questions would be interesting to explore to gain more knowledge on the impact of clinician responses to emotion on outcome variables?

2. How could such studies be designed and what methodological issues need to be solved?

Session 8B: System balancing

Beyond Blame: Neoliberalism, responsibility and hospital appointments

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Background

This study is part of a larger interdisciplinary research project examining failed and cancelled hospital appointments in the Region of Southern Denmark. The present study investigates how health policies and institutional discourses frame healthcare practices surrounding patient attendance and non-attendance, focusing on how notions of responsibility and structural vulnerability are articulated and enacted in everyday outpatient settings. Structural vulnerability refers to the ways in which social position and institutional arrangements systematically shape patients' exposure to barriers in accessing care.

In Danish policy and media, missed appointments are often portrayed as a matter of patient irresponsibility, reflecting neoliberal logics of self-management. In contrast, this study approaches non-attendance as an organizational problem. Our recent register-based studies show that while overall non-attendance rates are low (2%), they are unevenly distributed, with substantially higher rates among young adults, patients with mental health conditions, non-Danish nationals, and people living alone. This underscores the need to move beyond individualising explanations and address organizational, communicative, and systemic factors.

Methods

The study combines policy analysis with institutional ethnography. Data sources include policy documents, hospital and regional strategies, participatory observations in outpatient clinics, and interviews with healthcare professionals and patients. The analysis draws on theories of neoliberalism, structural vulnerability, and moral agency.

Findings and discussion

Early findings suggest that administrative and communicative infrastructures create new forms of structural vulnerability, particularly for patients with limited digital literacy, linguistic resources, or social support.

This raises following key questions for discussion:

- How do systemic designs, such as digital-by-default communication and limited language availability, produce structural vulnerability, and what kinds of interventions could mitigate these barriers?
- In what ways do dynamics of blame and shame, shape patterns of engagement and disengagement in outpatient care?
- What comparative lessons can be drawn from other healthcare systems that seek to reconcile efficiency demands with equity in appointment management, and how might these inform practice in the Danish context?

Exploring pet owners' and veterinarians' perspectives on communication in small animal veterinary practice

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Introduction/Background – Differences and similarities may exist in the communication requirements and barriers faced by veterinarians and pet owners in small animal practice. Understanding both challenges and successes in communication is crucial, as the veterinarian's communicative approach impacts treatment delivery as well as pet owner adherence.

Objective – To identify and compare veterinarians' and pet owners' perspectives on communication practices and challenges in small animal veterinary practice in Norway.

Methods – This exploratory qualitative study collected data through focus groups. Independent veterinarian and pet owner focus groups were conducted using semi-structured interview guides with open-ended questions and follow-up probes. Between December 2024 and June 2025, seven focus groups were held; three with pet owners (n=20) and four with veterinarians (n=17). All pet owner focus groups took place at the Norwegian University of Life Sciences (NMBU). One veterinarian group was held in Trondheim alongside a veterinary conference, and three at NMBU. Participants were recruited primarily through social media and prior to participation, they completed a demographic questionnaire and provided informed consent. Recordings were transcribed using Autotekst (Whisper Open Ai), coded in NVivo 15, and analyzed with reflective thematic analysis. Pet owner data was analyzed inductively and veterinarian data deductively with inductive elements.

Preliminary results – Three themes were developed from the pet owner data: (1) Every pet comes with a person – who feels, cares, and sometimes knows a lot, (2). Unequal relationship between laypeople and experts; (3). Who is responsible for which part of communication? Analysis of the veterinarians' perspectives is ongoing but suggests both similarities and differences. Pet owners emphasize inclusion, collaboration, and co-producing communication, whereas veterinarians focus predominantly on their own capacity to provide information. Pet owners reflect on veterinarians' perspectives more than the reverse. These findings may be discussed in light of current discussions in veterinary medicine regarding contextualized care or the spectrum of care.

Points for discussion and improvement
1)Any suggestions that might improve the study are welcome
2)What aspects are most interesting?
3)What additional considerations should be made?
4)What insights from human health care communication could inform the candidate themes?

Beyond Optimization: Understanding Goal Balancing in Emergency Room Decision-Making

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Improvement work on communication and decision-making in the emergency room (ER) has largely been framed in terms of optimization: improving communication in order to reach defined outcomes. Examples include enhancing shared decision-making, eliciting symptoms more effectively, giving clearer discharge instructions, or aligning care with patient-centered goals. Beyond communication, related work has sought to optimize clinical processes such as reducing diagnostic errors, shortening time-to-treatment for conditions like sepsis, limiting unnecessary tests, and minimizing cognitive biases.

Despite these efforts, evidence of sustained, system-wide improvement remains scarce. Many interventions show initial benefits but fade once the specific initiative ends. This pattern suggests that the prevailing optimization paradigm may overlook a fundamental feature of ER practice: its inherent complexity. Conversations and decisions in the ER rarely involve pursuing a single goal in isolation. Instead, clinicians and patients navigate competing, overlapping, and shifting priorities—what we conceptualize as a process of balancing rather than optimizing.

This project aims to investigate how clinicians and patients in the ER balance different, and sometimes conflicting, goals in everyday encounters. Rather than asking how communication can best achieve predefined outcomes, we ask: how are trade-offs negotiated in real time? How are priorities set often under conditions of urgency, uncertainty, and limited resources?

By reframing the question in terms of balancing, we hope to capture more accurately the lived experience of ER decision-making. Drawing on a dataset of filmed patient–clinician encounters, as well as audio recordings of interactions between both patients and clinicians and among clinicians themselves, we aim to examine how competing goals are negotiated in real time. This shift could open new avenues for understanding why many improvement efforts fail to produce lasting change, and a better way forwards.

Discussion:

- Is this a fair problem-description – does most improvement projects entail prioritization of some goals over others, and when attempting to improve communication practices, is this an implicit prioritization of some goals over others?
- Have you seen goal prioritization, and how has it been dealt with in your projects. Does framing ER communication as “balancing” rather than “optimizing” better reflect your observations of clinical work?

Plenary presentation Day 3

Inductive methods for studying video-recorded clinical interactions: Comparing conversation analysis and microanalysis of clinical interaction

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Communication between patients and providers shapes clinical outcomes. Studying videorecordings of clinic visits is an essential method for learning more about authentic communication practices in situ. Inductive exploration of these video recordings allows researchers to discover emergent, context-sensitive patterns and break new ground: An inductive approach complements established, deductive coding.

Both applied conversation analysis (CA) and m of clinical interaction (MCI) both adopt this inductive approach to understand and inform clinical practice. However, they diverge from one another regarding issues such as analytic unit and analytic procedure. To better understand how these approaches can complement one another, we are meeting to compare the traditions we follow. Three of us follow the conversation analytic (CA) tradition, three of us use microanalysis of clinical interaction (MCI). By comparing and contrasting our methods, we begin to appreciate our differences while seeing our own approach in a new light. We feel such openness will help to promote inductive work more broadly, increase curiosity about different approaches (including ones other than the two we use), and create more opportunities for cross-disciplinary collaboration. In addition, clearly articulating the affordances of each tradition could provide concrete guidance for others who are curious about doing bottom-up work with their video-recordings, assisting them in their choice of methods.

In this presentation, we will describe the process we are using to compare our traditions and present brief descriptions including some initial noticings about differences and commonalities.

We are open for all feedback and ideas from the OCHER community.

We also have some questions for discussion:

- In what ways could articulating the differences/commonalities of these methods (and others) be useful for the community?
- What are other inductive approaches that you are familiar with that could also be interesting to compare (e.g., discourse analysis, critical discourse analysis…)
- What sort of publication might be most useful: a discussion paper? An empirical paper employing both traditions in some detail? Other ideas?

Planning committee emails

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