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The impact of a stories based educational DVD on patients’ intentions to change hypertension management behaviors: A randomized control trial

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Introduction/Objectives: African-Americans have higher rates of hypertension and uncontrolled hypertension compared to whites. Many educational behavioral interventions have had limited success in controlling blood pressure (BP). Real life stories of patients who are successful in managing their BP may have important lessons for helping patients with hypertension control their BP. We developed and tested an educational DVD consisting of African-American patients’ success stories of controlling their hypertension.

Methods: 620 African-American patients with uncontrolled hypertension at three US Department of Veterans Affairs Medical Centers were randomized to receive either a DVD with only didactic healthy behavior information (control) or a DVD adding videos of African-American Veterans telling stories about successful daily hypertension management (intervention). Immediately post-DVD viewing, participants completed measures of 1.) intellectual and emotional engagement with the DVD and 2.) influence of the DVD on intention to change behavior. We computed the mean scores for the two groups and compared them with two-sided t-tests.

Results: Patients in the intervention group reported significantly higher emotional engagement (means: 4.3 vs. 3.2; p < 0.0001) than those in the control group. They were more likely to report intentions to become more physically active (4.6 vs. 4.4; p = 0.018); use salt substitutes (3.9 vs. 3.4; p = 0.0006) and talk openly with their doctor about HTN (4.6 vs. 4.5; p = 0.049). The stories DVD did not significantly affect intellectual engagement or changes in intentions for other behaviors.

Discussion: Patients were more emotionally engaged and reported intentions to change behavior when watching DVDs with patient stories of successful hypertension management. Behavioral intentions have been associated with clinical outcomes in prior research. Further analyses to explore the impact of patient stories on long-term behavioral changes and clinical outcomes are in progress. Videotaped patient stories may be more influential than purely informational educational materials to effect patient behavior change.
Participatory design of an e-health communication intervention to support young people with long-term illnesses transitioning to adult healthcare

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Introduction/objectives: Results from a three-year study on young people, parents’ and healthcare professionals’ experiences of transition from child to adult health services, revealed inadequate information and preparation for young people. In consultations with young people, we co-developed information materials (n=32) and a website to help prepare and support young people for the transition to adult services. This intervention www.Steppingup.ie is an innovative way of providing relevant information.

Methods: We used participatory design methodology and conducted a survey (n=207) and interviews with young people (n=15) to identify preferences for e-health and information provision and to develop an appropriate intervention. Ethical approval was obtained from the relevant ethics committees. Young people were involved in participatory workshops, video recordings and the co-design group. In this way, their voices were heard and their information preferences were integral to the design of the materials and website.

Results: Almost 6 in 10 young people (57.1%) believed that a website would be quite or very useful in receiving information about their illness. They expressed a preference for information that was trustworthy, reliable, easily downloaded, colourful format and written using non-patronizing language. They desired video testimonials and stories from other young people who had moved to adult services. They wanted to hear from other young people about: tips and information on managing the transition, becoming more independent, knowing about medications and the differences between child and adult services. They also wanted information about key hospital personnel, differences between child and adult services, location and configuration of services, transition stories, FAQs and illness management.

Discussion/Implications: Close working between young people and web designer and project team led to the development of a successful innovative online resource that is tailored to young people’s information needs. Preliminary feedback indicates that it is a valued resource.

Talking about the hard stuff: Short-term outcomes of a multi-center RCT of oncologist, patient, and caregiver interventions to improve communication in advanced cancer

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Introduction/objectives: In advanced cancer, open discussions between oncologists and patients (and family caregivers) about emotions, prognosis and treatment choices are associated with improved quality of life and decreased utilization of burdensome health care interventions at the end of life. Promoting such discussions has been challenging. This is the largest clinical trial to date using communication-based interventions, directed at oncologists, patients and caregivers, in the context of advanced cancer designed to address patient and clinician reluctance to talk about prognosis, promote meaningful patient/family involvement in decision-making and provide emotional support to help patients and families participate in care.

Methods: Multi-site cluster RCT (usual care control) involving 280 patients with stage III/IV solid malignancies, >70% of whom had participating family caregivers, and 38 oncologists. Oncologists randomized to intervention received two individual in-person communication training sessions focusing on patient activation, responding to emotions, and informing and framing disease-specific information including prognosis. Patients/caregivers of intervention physicians each received individual communication coaching with similar objectives, with three follow-up telephone calls. Outcome measures from audio-recordings/transcripts of an oncologist visit included active patient participation, responding to emotions, and informing and framing disease-specific information including prognosis. Patients/caregivers of intervention physicians each received individual communication coaching with similar objectives, with three follow-up telephone calls. Outcome measures from audio-recordings/transcripts of an oncologist visit included active patient participation, responding to emotions, and informing and framing disease-specific information including prognosis. Patients/caregivers of intervention physicians each received individual communication coaching with similar objectives, with three follow-up telephone calls. Outcome measures from audio-recordings/transcripts of an oncologist visit included active patient participation, responding to emotions, and informing and framing disease-specific information including prognosis.

Results: Complete recruitment, >95% follow up, excellent intervention fidelity and acceptability have been achieved. Although final data analyses are not yet available, preliminary results based on 80% of the coded audio recordings suggests an increase in the composite communication outcome of 0.26 SD (95% CI -.067/+0.59). The composite outcome was affected by race (nonwhite > white, 0.36 SD, 95% CI 0.11/0.61). Final results will be available for presentation at the conference.

Discussion: Combined communication interventions are feasible in busy oncology practices. Results of this trial will help address critical barriers to patient-centered care at the end of life.
Do Knowledge Gains Translate into Behavior Change? Pairing Physician-Directed and Point-of-Care Patient Education Strategies to Increase Colorectal Cancer Knowledge and Screening Completion

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Introduction/Objective: Colorectal cancer (CRC) screening rates remain suboptimal. We implemented physician-only (MD) and combined physician-patient (MD+Video) strategies to assess effectiveness on patient knowledge, physician recommendation, and CRC screening completion.

Methods: We conducted a three-arm quasi-experimental design: the MD strategy involved multiple physician training sessions and continuous quality improvement feedback; patients in MD+Video arm also were shown an educational video. Participants were English- or Spanish-speaking, age 50 – 75, and not up-to-date with screening. Eight clinics were allocated to receipt of physician intervention; patients at intervention clinics were randomized to video. Knowledge was measured immediately prior to and immediately following MD visit using 8 items. Physician screening recommendation and patient CRC screening were calculated using risk ratio; screening recommendation and screening completion comparison between control and intervention groups were adjusted for clustering by clinic; analyses among the two intervention (MD, MD+Video) arms for screening completion were adjusted for stratification by clinic and age.

Results: Participants’ (n=538) mean age was 57.8 (SD= 6.2); 73.8% female; 42.9% Hispanic/Latino and 53.2% Non-Hispanic Black. We observed a significant increase in knowledge in the MD and MD+Video groups (results presented at ICCH 2014). No significant difference was seen in physician recommendation of screening in control (42.9%) versus combined intervention groups (57.6%; Risk ratio (RR) = 1.43, p=0.42, 95% CI: 0.60-3.43); due in large part to the large interclass correlation coefficient (ICC) = 0.295. Results indicated no significant difference between control and intervention for CRC screening completion (RR=1.65, p=0.32, 95%CI: 0.62-4.38, ICC=0.081), nor between MD and MD+Video (RR=0.80, p=0.28, 95%CI: 0.53-1.20).

Discussion/Implications: Providing patients a point-of-care educational video on CRC and CRC screening resulted in significant knowledge change, yet no comparable difference was seen in CRC screening completion. Comprehensive health system involvement, including patient and physician interventions and system redesign may be necessary to increase CRC screening rates.

Eloquent silence: a musical analysis when words fail

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Background and Objective: Silence in doctor-patient communication may represent a moment of compassionate connection or merely a trivial distraction by a competing non-communicative task (e.g. computer use). This study presents an empirical description of poignantly compassionate silences arising in medical encounters between oncologists and patients with advanced cancer.

Methods: Using 124 audio recordings of outpatient oncology consultations, two medical students and an opera professor screened all 1208 silences for evidence of communication versus distraction across the silent moment. Within these, all coders described 20 particularly eloquent silences that immediately struck them as compassionate. We chose 4 to analyze in-depth by constructing a digital graphic representation using PRAAT. We examined these silences in context for linguistic and paralinguistic features including word choice, silences, pitch, volume, and tempo.

Results: Linguistic analyses revealed no consistent evidence of compassion. Paralinguistic analyses however, revealed an increase in pitch, speaking rate, and volume in the seconds following compassionate silences relative to the seconds preceding each silence. Unlike a majority of pauses in music and most silent moments associated with computer use in clinical settings, compassionate silences did not mark the transition from one phrase to the next; instead they maintained some tension across the pause by avoiding closure and leaving any possible resolution in the future.

Implications: These data suggest that types of compassionate silences are empirically identifiable, and that such measurement should attend closely to paralinguistic features, including the musicality of silence. Future research should explore whether these musical “fingerprints” can be measured reliably in larger studies and whether they identify compassionate versus distracted silences.
It’s Not Monopoly Money Anymore

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Introduction/context: Patient financial liability has climbed steadily since the advent of the Affordable Care Act, with patient responsibility projected to be 50% of healthcare costs by 2020. Nevertheless patients are choosing insurance based on low-cost premiums without comprehending the financial impact until they require emergent or unintended care. Non-profit healthcare organizations must assume the role of financial educator to engage patients early and often in financial conversations, integrate patient clinical and financial plans and ensure organizational success.

Description of policy or practice innovation: The University of Pittsburgh Medical Center (UPMC) implemented a Patient Financial Advocacy Program (PFAP) to engage patients in proactive and continuous financial communications throughout the care continuum. The PFAP performs pro-active outreach to score patients according to charity and time to payment. Uninsured or underinsured patients are assigned a Patient Financial Advocate to provide financial guidance to patients throughout their care plans and determine eligibility for Medical Assistance or Financial Assistance programs. Price estimates are available for any service, with on-demand estimates for a variety of high cost services. A pilot patient outreach program provides pre-service estimates for all high tech radiology patients. After service completion, patients receive a single simplified statement - available both electronically and on paper.

Evaluation/impact: The PFAP financial communication pathways have converted 38% of patients scored as “low propensity to pay” to Medicaid plans, and secured payment on 37% of patients scored as “high propensity to pay.” Additionally, uncompensated care has reduced by an average of $1.6 million weekly, and patient payments have increased by $1.58 million monthly. The program estimates a 19% decrease in patients transferred to bad debt, and a 5% increase in charity care.

Discussion/implications: With shifting market dynamics, financial communications are as imperative as communications regarding disease management. Healthcare organizations must develop strong and accurate financial communication pathways to meet patient demands across the socio-economic spectrum.

Patient and Oncologist Discussions of Cancer Treatment Costs During Clinic Visits

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Very little is understood about clinical communication regarding patient cost of cancer treatment. Patients want to discuss cost with oncologists and their concerns and communication related to costs influence treatment decisions, but oncologists are hesitant to bring up cost. Prior research is limited and based on self-reports. We conducted an observational study of patient and oncologist clinic visits to objectively determine the presence and content of patient-oncologist discussions of cancer treatment costs.

Participants included oncologists (N = 18) and their patients (N = 115) who were meeting to discuss cancer treatment. Visits were video-recorded. Cost discussions were defined as any mention of a direct (e.g. paying for a scan) or indirect (e.g. time off from work) expense for the patient for cancer treatment. Trained coders observed and coded visits for presence and duration of cost discussions, who initiated initiation form, the cost issue and how the oncologist managed the discussion.

Cost discussions occurred in 43.5% (n=50) of the visits with a range of one to six per visit for a total of 93 coded discussions. Discussions lasted an average of 35 seconds (SD = 34.5). Patients (60.2%) initiated most discussions (oncologists: 38.7%; family: 1.1%). Initiation most often took the form of a statement (60.2%; question: 38.7%). Time off from work was the most frequently discussed issue (47.3%), followed by insurance (25.8%), transportation/parking (11.8%), and paying for treatment (7.5%). Oncologists’ responses were often imprecise and did not offer concrete information (57%). Oncologists provided a full response 26.9% of the time and referred the patients to another person (e.g. social worker) 8.6% of the time.

Discussions of cost are indeed occurring during cancer treatment discussions. They are often patient initiated, are dealing with a variety of concerns, but interventions are needed to better prepare oncologists to respond effectively to patients’ concerns.
The devil is in the details: Interpreting “I don’t know” in Mini Mental Status Exams

Authors:
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Introduction: This work investigates dementia patients’ use of I DON’T KNOW (IDK) in Mini Mental Status Exams (MMSEs) and assesses the value of objective linguistic IDK interpretation for MMSE scoring. IDK is used by patients to disavow knowledge, affect exam progression and/or hedge answers. Uncritical interpretation of IDK as a device that exclusively signals insufficient knowledge risks over-diagnosis of dementia and its more severe sub-types.

Objectives: The objective of this analysis is to provide a rigorous, practically applicable, position- and intonation-based schema for differentiating IDKs that signal lack of knowledge (LOK) from those that serve textual (e.g., turn-holding) or social (e.g., hedging) functions within MMSEs. Additionally, this work compares an objective sociolinguistic analysis of IDK to clinicians’ subjective assessment of disease severity in a sample of dementia patients.

Methods: 189 IDK tokens were extracted from 72 interactions drawn from a large database of audio-recorded/transcribed doctor-patient consultations (Kozloff & Barnett 2006). Patients were selected based on having a dementia diagnosis (any type) and at least one IDK token in their MMSEs. Tokens were coded for linguistic/social characteristics and subjected to multiple logistic regressions.

Results: Use of LOK IDK as opposed to social/textual IDK was significantly correlated (p=0.03) with physicians’ subjective ratings of dementia as “severe” vs. “mild”/“moderate”, indicating that objective sociolinguistic criteria approximated physician judgments of cognitive impairment. The majority of IDK tokens in the data performed a knowledge disavowing function (83%, N=156). However, if clinicians were to interpret every occurrence of IDK as LOK, 17% (N=33 in this sample) of IDK responses to MMSE questions (N ranging from 1-12/patient) would be mis-scored.

Conclusion: Positional and intonational criteria can suggest whether or not a given IDK is being used to signal genuine LOK. Thus inattention to these linguistic details has the potential to produce meaningful variance in MMSE scoring.


The Power of Patient Questions: A Secret Shopper Study

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Objective: To examine how much new information community pharmacists provide “secret shoppers” after the shopper asks one generic question regarding their nonprescription medication (emergency contraception (EC) or Ibuprofen).

Methods: Twenty-five pharmacists from 7 independent community pharmacies consented to audiotaped visits following IRB approved procedures. Secret shoppers audiotaped 73 encounters which followed standardized scenarios. Recordings were coded for topic content and sequence. At the end of 36 encounters, the patient asked, “What else should I know before taking this product?” Building on the Elaboration likelihood model, one question was hypothesized to increase topics addressed by pharmacist.

Results: The interrater reliability for coders was found to be Kappa=0.95. Consultations on OTC medication were brief except for one instance (EC mean = 1 min 58 seconds and ibuprofen mean = 1 min 57 seconds). Overall, significantly more number of topics were discussed for ibuprofen than EC (p<0.01). Additionally, total number of topics discussed in encounters with and without patient questions differed (p<0.01). In 25 of 36 encounters where patients asked a question, the pharmacist provided new information after the question. An average of 1.22 new topics were discussed in encounters with patient questions. Topics included key information (medical conditions, current medications, side effects, managing side effects and method of administration).

Implications: Pharmacy students and practitioners need more training to encourage patient questions which trigger more complete consultations and to offer appropriate consultation for sensitive OTC products.

Chronic Conditions

Addressing Food Insecurity and Dietary Modification Challenges in Underserved Populations Diagnosed with Type 2 Diabetes

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Background: Underserved individuals with Type 2 Diabetes (T2D) are more likely to struggle with food insecurity, access fewer health resources and report less consistent engagement in self-care activities. Underserved individuals have largely been excluded from diabetes education and behavior change interventions.

Objectives: 1) To systematically review the literature addressing dietary modification interventions among low income populations to understand how interventions have specifically defined and targeted low income communities and, 2) To explore the role of food...
insecurity for dietary modification among community members in Richmond, VA who are living with T2D.

**Methods:** 1) Systematic literature review was conducted following the Cochrane Collaboration methodology. Articles were evaluated using the CONSORT (assessed intervention rigor) and CALO-RE (assessed the use of behavioral change techniques) taxonomies. Inclusion criteria were: English language papers describing interventions with concurrent control, specifically targeting dietary change among low income, adult populations.

2) Three focus groups with low income Richmond, VA community members diagnosed with T2D. Interviews assessed access to diabetes education programs, food insecurity and availability of social support through friends/family. Interviews were transcribed verbatim and coded thematically.

**Results:** Systematic review identified 43 relevant articles. Definitions of low income populations varied greatly. Few interventions were multilevel and primarily focused on individual factors. Three focus groups (total n=23) identified primary themes of: a) confusion about dietary recommendations, b) conflicting advice, c) food cost barriers and d) negative and positives family/friend influences.

**Conclusions:** Our review identified interventions that primarily target individual level influences on dietary modifications. While individual influences (i.e., T2D knowledge, food preferences, and understanding dietary recommendations) were echoed in our focus groups, influences at the household (social support of friends/family) and community (food cost/availability) levels were less well represented.

**Practice Implications:** Improving access to resources that will support dietary modification among underserved communities need to be multilevel to address issues of food insecurity and social support.

**Beyond experienced anamnesis - Review dialogues as a chance to extend perspectives in long-term-care of patients with chronic conditions**

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**Introduction/objectives:** In long-term care family doctors are successively generating implicit knowledge driving his or her professional practice and determining density and effectivity of the doctor-patient-relationship. Because this previous knowledge is mostly not addressed, there can be mistakes or systematic lacks. It is worthwhile to question from time to time the anticipated knowledge about the patient. The tool of Reviewing Dialogues (RD) offers a chance to go beyond everyday routines and to develop a comprehensive understanding in the sense of an ‘overall diagnosis’ (M. Balint).

**Methods:** 52 family doctors carried out 2 to 4 RDs with a total of 286 patients. They agreed on health objectives and corresponding ways to reach them. They were asked to document treatment process, data being completed by socio-demographic ones, data concerning sense of coherence (SOC), quality of life, health care utilization, and doctor-patient-relationship. 125 of these consultations were videotaped by a sub-group of doctors. These encounters were coded by a partly standardized evaluation tool. Additionally, 5 cases were analysed sequence by sequence with regard to the process.

**Results:** RDs show, that slight hints often can be sufficient to assure mutual understanding because of key information being present. On the other hand, RDs help to recognize that some lack of knowledge can result from tacit consent to not address some issues. Thus, patients’ resources often remain underestimated, respective hints neglected. RDs allow insights in patients’ specific formation of relationship (with former and actual significant others). This might be relevant to transform doctor patient relationship.

**Discussion:** RDs facilitate the process of diagnostics and therapy, which can be experienced as a co-construction of both. In this way, tacit knowledge can be re-affirmed but relativized as well, doctor-patient-relationship will be empowered, the therapeutic and diagnostic process fostered. Thus, routine care can be systematically completed to arrive at an ‘overall diagnosis’.

**Persistence of diabetes control is related to the interaction of gist understanding of risk and collaborative goal setting**

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**Introduction/objectives:** In long-term care family doctors are successively generating implicit knowledge driving his or her professional practice and determining density and effectivity of the doctor-patient-relationship. Because this previous knowledge is mostly not addressed, there can be mistakes or systematic lacks. It is worthwhile to question from time to time the anticipated knowledge about the patient. The tool of Reviewing Dialogues (RD) offers a chance to go beyond everyday routines and to develop a comprehensive understanding in the sense of an ‘overall diagnosis’ (M. Balint).

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the other hand, RDs help to recognize, that some lack of knowledge can result from tacit consent to not address some issues. Thus, patients’ resources often remain underestimated, respective hints neglected. RDs allow insights in patients’ specific formation of relationship (with former and actual significant others). This might be relevant to transform doctor-patient-relationship.

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Doing great! Discourse perspective of evaluative talk in chronic disease consultations

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Patients living with chronic illness, such as diabetes, can contribute to better health outcomes through self-management of behaviors and conditions. Clinicians play a role in monitoring patients’ self-management of behaviors such as physical activity, diet, medications, and emotional well-being. How the clinician and the patient report on these aspects and the role of evaluative talk in promoting and supporting patient adherence have not been the focus of sustained investigation. This paper aims to examine the language and function of evaluative language in chronic disease consultations. In particular, we investigate the evaluative language clinicians and patients use to show 1) what aspects they evaluate, 2) the degree of alignment with each other in the evaluations, and 3) whether the evaluations contribute toward shared clinical goal setting.

The study analyzes consultations in a US primary care setting with medical residents. Twenty-five interactions were transcribed and then analyzed using Appraisal Theory, a form of discourse analysis to examine how speakers express reactions such as attitudes and emotions. This approach views language resources speakers use to construe evaluations such as emotions and judgments of behaviours as a system. The sub-systems are AFFECT (expressing emotion), JUDGEMENT (assessing behaviour) and APPRECIATION (evaluating processes and objects). The findings show patients utilise all sub-systems of Appraisal yet residents mostly appraise aspects to do with the sub-system of JUDGEMENT. Findings for AFFECT show that patients express their fears and sadness; however, these psychosocial aspects tend not to be acknowledged and attended to by the residents. For JUDGEMENT, patients and residents positively and negatively appraised patient self-management including the provider input: Doing great; she [provider] should be proud of that and you should be proud. The implications of the findings will be discussed in terms of the role of evaluation in patient education and shared clinical goal setting.

AIDS and Intercourse: Using Language to Understand Sexual Culture in Malawi

Author: Yael Danovitch, Tel Aviv University

Introduction: HIV prevention messages in Malawi have largely focused on sexual behaviour change and the ABC approach (Abstain, Be Faithful, and use a Condom). However, there is a clear difference between the formal, stilted language for sex that is utilized in those messages and the colorful, inventive language that is used for sex in daily speech. This linguistic discrepancy could lead to confusion regarding the types of sexual behaviors that are considered at risk for HIV. This research examines Chichewa euphemisms for sex as a previously unexplored point of entry into an understanding of Malawian sexual culture.

Methods: The primary source for this research stems from an archive of narrative journals written by rural Malawians and collected by the Malawi Research Group (MRG) at the University of Pennsylvania. In-depth interviews and informal conversations were conducted with MRG supervisors to provide further explanation for the terms identified in the diaries. Finally, a questionnaire about sexual words and phrases was distributed among MRG interviewers to provide a sense of the frequency and scope of those terms.

Results: The findings from these three sources indicate that Malawians indeed use a broad range of euphemisms and metaphors to communicate ideas and stories about sex. The specific euphemisms vary based on the context of the speech act: who is speaking, where, and to whom. Furthermore, the metaphorical basis of those euphemisms sheds light upon local conceptualizations of sex.

Implications: Such insights can drastically improve HIV prevention messages that focus on behavior change by making sure those messages are compatible with Malawian linguistic culture. By making sure the language of prevention matches the language of daily speech, policy makers can improve the reception of sexual behavior change messages.

Innovative Program to Identify and Address Barriers to Self-Management Among Older Adults with Asthma

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Introduction: Chronic illness self-management (SM) support interventions typically target a small number of barriers to disease control, thereby skirtting the complex, multifactorial nature of management. This is particularly true of programs for older adults, who often experience multimorbidity, frailty, cognitive impairment, low health literacy, high healthcare costs, misunderstandings about illness, and others that diminish the impact of their SM behaviors.
Patients were interviewed longer and more complicated the disease was, the more stressful the waiting became and the stronger participants felt the need to know. Reaching a diagnosis, although causing an initial shock reaction was mostly experienced as a relief, a turning point that could enable families to start adjusting to their new normality. Yet, processes that facilitated disease management and normality reconstruction in celiac families, notably information seeking, social support and personal contact with comparison others were found to be important stressors for families living with Bartter syndrome.

Discussion: To the best of our knowledge, this is the first study attempting to provide an insight into the experiences of families living with Bartter syndrome, while heightening the peculiarities of caring for a child diagnosed with a rare disease.

Engaging Patients and Families in the Development of a Transitional Care Intervention to Facilitate Coping with Chronic Obstructive Pulmonary Disease

Authors: Thomas Lynch, Johns Hopkins Hospital (School of Medicine) Tina Brown, Armstrong Institute for Patient Safety and Quality Mohammad Naqibuddin, Armstrong Institute for Patient Safety and Quality Suna Chung, Armstrong Institute for Patient Safety and Quality Hanan Aboumatar, Johns Hopkins Medicine Edna Shattuck, Johns Hopkins Medical Institution

Introduction/objectives: Patient perspective of communication and teamwork within the medical encounter is vital but an often overlooked aspect of the health care experience. We thus devised a brief structured interview designed to obtain direct and immediate feedback from patients.

Description of practice innovation: Patients were interviewed immediately following an observed medical encounter with a pediatric subspecialist and were asked for their input on how well the provider and staff were: sensitive to their needs, worked together, answered questions and addressed their worries. They were also asked for suggestions for how the medical team could do a better job at meeting their needs.

Evaluation/impact: Patients (n = 186) and their families were forthcoming about their experience of communication and teamwork within the health care interaction. 100% (n = 186) of patients agreed to voluntarily participate in the interview. Cumulatively, the 186 patients provided 930 responses. 87% of responses (n = 809) were coded as reflecting positive aspects of the experience. 10% (n = 93) of responses were coded as neutral and 3% (n = 28) were coded as reflecting a negative experience within the health care encounter. 22% (n = 204) of responses were coded as “actionable”.

Discussion/implications: There are advantages and disadvantages to direct patient interviewing immediately following an encounter. Given the immediacy of the encounter, patients are more likely to remember and reflect specific details of the health care visit and to provide actionable suggestions. Having the interviewer/observer...
conflicting and conflicting responses were noted. Overall, this interview may provide a way to easily capture detailed reflections directly from families and may serve as a helpful adjunct to other standardized measures of patient experience.

Feeling Under-Informed: Parental Challenges when Communicating about Epilepsy

Authors: Stephanie O’Toole, Dublin City University
Amre Shahwan, Temple Street Children’s University Hospital, Dublin
Joan Austin, Indiana University School of Nursing, Indianapolis, IN, USA

Objective: Epilepsy is a complex neurological condition with extremely varied symptomatology. In the instance of childhood epilepsy, children with epilepsy (CWE) rely on their parents to support and guide them in learning about their condition. The primary source of epilepsy-related information for parents at the time point of diagnosis is healthcare professionals (HCPs). Often, discussions with HCPs can inform the level of knowledge parents have about their child’s epilepsy and consequently their ability to relay this information to their child. In this presentation, findings relating to parent need for information following a diagnosis of childhood epilepsy will be discussed.

Methods: Data in this presentation emerged from a larger programme of research, the “Talking about Epilepsy” study, comprising two mixed-method studies. For the qualitative phases, in total, 117 interviews were conducted with CWE and their parents. For the quantitative phases, cross-sectional surveys were conducted with 60 parents and 40 CWE, examining the relationship between parent need for epilepsy-related information and other variables (including family communication, impact on the family and social participation).

Results: Findings from this study revealed that parents were largely under-informed in relation to their child’s epilepsy diagnosis. Parents felt unsure of where to access reliable information and/or found epilepsy-related information complex and difficult to understand. This impacted upon parents’ ability to represent the condition to their child and presented difficulties when engaging in parent-child dialogue about epilepsy.

Conclusion: A lack of parental knowledge about epilepsy can present challenges for parents in supporting their child with epilepsy-related issues. HCPs should provide families with diagnosis-specific information to ensure that they are capable of adequately informing their child about his/her condition. This study provides HCPs with valuable insights into the challenges that a lack of epilepsy-related information presents within a family context, from both parent and child perspectives.

Using a Virtual Environment and Video Conferencing to Promote Inter-professional Practice for Care of Elders with Chronic Conditions

Authors: Deborah O’Rourke, University of Vermont
Mary Val Palumbo, University of Vermont

Introduction/Objectives: Elders with complex chronic health conditions require inter-professional care to address their health care needs. It is challenging to implement inter-professional learning experiences for students given curricular, scheduling and other constraints. A virtual environment and video conferencing were used to teach inter-professional practice (IPP) when caring for elders with chronic conditions with students from eight professions. This study evaluated the effectiveness of this approach.

Methods: Seventy-five students from communication sciences, exercise science, medicine, nursing, nutrition, pharmacy, physical therapy, and social work participated. In the virtual environment, students performed a chart review and interviewed an elderly Korean woman with multiple chronic health conditions. Students then participated in a team meeting via a video conference to develop a collaborative inter-professional plan of care. Each video conference was 90 minutes in length, attended by 8 students and facilitated by a nurse practitioner student. The Readytalk© platform was used for the video conferences and students connected by calling in and by using a webcam. The evaluation survey was comprised of fourteen questions related to health care teams and IPP in caring for elders with complex conditions. Participants also provided demographic information and answered 5 open-ended questions.

Results: Seventy-two students completed the survey. Participants rated the value of this activity highly in response to all survey questions. For example, 100% of participants Strongly Agreed or Agreed that it is necessary to utilize a health care team when providing care for elders with chronic conditions. Thematic analysis of open-ended questions indicated the educational value of the experience, the utility of the technology, and the feasibility of the experience in terms of time and scheduling.

Discussion/Implications: The combination of using a virtual environment and video conferencing in the context of IPP in caring for elders with chronic conditions was highly rated by students from eight professions.
Medical Resident Education

Graduate Medical Education: Most Common Feedback Themes in Internal Medicine Residency Training, Lessons from Resident Audio-recording Project

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Heeyoung Han, Southern Illinois University School of Medicine
Jacqueline Ferguson, Southern Illinois University School of Medicine
Timothy Koschmann, Southern Illinois University School of Medicine
Steve Sandstrom, Southern Illinois University School of Medicine

Introduction/Objective: Individualized structured feedback is an integral part of Internal Medicine Residency Training. However, we do not know the most commonly occurring themes related to communication skills that require feedback to our learners. Our objective is to identify the most common feedback areas given to residents during Internal Medicine training.

Methods: At Southern Illinois University School of Medicine, we developed the Resident Audio-recording Project to improve communication competency in resident education using audio recordings of the outpatient encounters. [1] We used the feedback report data from 2008 to 2013 to extract the most common themes through content analysis and grounded theory. Three panel members analyzed a total of 53 feedback reports and coded the feedback items. During the analysis, new codes were developed and added to the data collection sheet. The data were then compiled to extract the most recurring feedback items (both positive and negative), positive feedback items only and negative feedback items only.

Results: Based on the analysis of feedback reports (n=58), the most commonly occurring themes are: Utilization of patient educational opportunities: 35 (60.3%), Transition of topics: 35 (60.3%), Timely confrontation: 34 (58.6%), etc. (Table 1). Among the positive feedback themes, the top three are Non-judgmental conversation: 20 (50%), Empathy: 18 (45%) and Timely confrontation: 17 (42.5%). Among the negative feedback themes, the top three are: Medical jargon: 29 (52.7%), Thorough self-introduction: 28 (50.9%) and Holistic exploration of patient’s problems: 26 (47.3%).

Discussion: To our knowledge, this study is the first of its kind to identify the most common communication feedback themes that we provide to our learners in the Internal Medicine Outpatient clinics. Based on our retrospective observation of the feedback reports, we identified the common themes that are encountered during the feedback sessions. According to the joint initiative of ACGME and ABIM, The Internal Medicine Milestones Project, communication skills are primarily assessed in Milestone #20. However, communication is a part of most other skills mentioned in the report. Strictly following the milestones project might miss the opportunity to develop these subtle but most commonly encountered skills during residency. Our observation reiterates the importance of commonly encountered strengths and deficiencies. We hope to incorporate these feedback data into our orientation and training during residency to help the resident physician master these skills.

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<thead>
<tr>
<th>Most recurring feedback themes (combined positive and negative feedback items)</th>
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<tr>
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<td>2. Transition of topics 35 (60.3%)</td>
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<td>3. Timely confrontation 34 (58.6%)</td>
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<td>4. Medical jargon 31 (53.4%)</td>
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<td>5. Thorough self-introduction 29 (50%)</td>
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<td>6. Open-ended questions 29 (50%)</td>
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<td>7. Holistic exploration of patient’s problem 29 (50%)</td>
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<td>8. Empathy 28 (48.3%)</td>
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<td>9. Summarizes all identified concerns 27 (46.6%)</td>
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<td>10. Appropriate responses [cueing/non-meaningful responses] 25 (43.1%)</td>
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Teaching Effective Communication in Family Meetings

Authors:
Jaya Raj, St. Joseph’s Hospital and Medical Center
Jeanette Boohene, St. Joseph’s Hospital and Medical Center

Introduction: Leading a family meeting requires a complex set of communication skills and is one of the key entrustable professional activities that Internal medicine residents must learn during training. Research has shown that physicians feel inadequately trained to do this effectively, particularly in the Intensive Care Unit (ICU) when discussions often include decisions about end-of-life care. There is sparse literature on teaching residents the communication skills required to facilitate a family meeting.

Instructional and assessment methods: Our residency program implemented a curriculum to teach and assess residents’ skills in facilitating a family meeting. In July, 2014, Internal Medicine residents participated in an interactive workshop led by Palliative Care faculty. Throughout the year, the residents were required to facilitate at least two family meetings in the ICU under direct observation by a supervising physician, ICU nurse, or other member of the Palliative Care team. The observer completed an assessment rating the resident’s performance in ten communication skills and provided the resident with feedback. The resident was required to complete a self-assessment and reflection exercise, in which he/she reported what was learned, what went well, what could be improved upon, and what role other team members played in the meeting.

Program evaluation results: Residents’ self-assessments indicated a high level of learning from facilitating the family meetings. Residents learned the importance of involving the family early, eliciting the family’s understanding, using direct language, avoiding jargon, minimizing interruptions, and acknowledging the impact of the patient’s illness on the family. They also learned to appreciate the essential roles of interprofessional team members.

Discussion: Although our residents reported comfort with family meetings at baseline, their self-assessments showed that they learned valuable lessons and skills in communication, professionalism, and interprofessional teamwork, highlighting the impact of direct observation, immediate feedback, and self-reflection on their learning.

Someone needs to call the family... why (or why not) the resident?

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Introduction/Objectives: The death notification process can have lasting effects on family grief and bereavement. It can also have lasting effects on the well-being of involved physicians. As part of the Be Safe initiative at the University of Virginia (UVA) Hospital, we investigated current death notification practices in order to develop an evidence-based template for standardizing this process.

Methods: With IRB approval, we invited all UVA internal medicine (IM) residents at our institution to respond anonymously to a 29 item emailed survey. We asked them about their training in death notification and their experiences with talking to families about expected and unexpected hospital deaths.

Results: The response rate to the survey was 72% (67 of 93 IM residents). 87% of responders reported involvement in a death that required notification by telephone. 80% of these residents felt inadequately trained to perform this task and 27% reported that calls went poorly. Attendings were involved in the notification process in only 17% of cases. PCPs were not involved prospectively. Respondents never delayed notification of death until family arrived at the hospital. 12% of responders made condolence phone calls or sent condolence cards. There was no consistent approach to rehearsing the call, making the call, advising families about a safe journey to the hospital, greeting families at the hospital, notifying the deceased’s PCP, or following up with the family.

Discussion/Implications: Poor communication skills during death notification may contribute to complicated grief for surviving relatives. Inadequate training in communication may also contribute to stress and burnout among physicians. This study is the first to describe current practices of death notification by internal medicine residents. More training on this type of communication is needed, and it could be combined with training in disclosure of medical error.

Training Housestaff to Open Interviews with Patient-Centered Strategies: Housestaff Perception and Effects on Patient Experiences in Clinic

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Introduction/Objectives: Few studies have explored the impact of communication skills training for housestaff on patient experiences in housestaff clinic. We examined how an educational program, in which housestaff practiced a 5-step strategy for opening patient-centered interviews using role-playing exercises, affected patient experiences in housestaff clinics and also assessed housestaff perceptions of the program.
Residents received training in CRC screening; those in the education video and simplified FIT instructions developed by the authors. All literacy and culturally appropriate pamphlet, YouTube instructional where residents additionally give brief education that includes a 2) a health literacy strategy developed by GI fellows and faculty, for CRC screening, FIT kit and education they usually provide; or

Methods: We conducted a pre-post study in the Departments of Neurology, Neurosurgery, and Urology at an academic medical center. Between February and April 2014, housestaff in the 3 departments were assigned to participate in a two-hour educational session led by trained departmental preceptors. Sessions centered on practicing a published 5-step strategy for opening patient-centered interviews (Smith, R. Patient-Centered Interviewing. Lippincott, 2002) using small group role-playing exercises. Housestaff completed post-training questionnaires. For one month prior to and one month following the training period, patients in the housestaff clinics of the 3 departments completed surveys adapted from the CG-CAHPS questions regarding physician communication, immediately following clinic visits. Pre- and post-intervention results for top-box scores were compared using the chi-square test.

Results: Forty-four of a possible 45 housestaff (97.8%) participated in a session, with 31 (70.5%) indicating that the role-playing exercise increased their perception of the 5-step strategy. There were no significant differences on patient responses to survey items between the pre- and post-intervention period, including questions about whether the resident listened carefully (pre-intervention “Yes” responses = 93.7%, 50th national percentile; post = 90.9%, 25th percentile; p = 0.27) and whether the resident showed respect (pre = 92.1%, < 25th percentile; post = 96.0%, 60th percentile; p = 0.16).

Implications: While an educational program in which housestaff practiced a 5-step strategy for opening patient-centered interviews was well-received, demonstrating an improvement in patient experiences in response to such a program remains challenging. Ongoing coaching may be needed to cement practice changes.

Patient Education and Medicine Residents - is it a “FIT”?

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Terry Davis, LSU Health Sciences Center

Introduction: Colorectal cancer (CRC) is the third leading cause of cancer death in the U.S. Screening has reduced mortality yet significant disparities in CRC mortality and screening persist among adults with lower SES, limited health literacy, and members of racial/ethnic minority groups. Practical strategies are needed to promote the use of fecal occult blood tests (FOBT), the most feasible, cost-effective screening option for low-income patients.

Objective: Test the effectiveness of a physician-directed health literacy patient education intervention to improve CRC screening with fecal immunochemical test (FIT).

Methods: Patients will be enrolled into one of two arms April 2015 - March 2016. Four medicine residents were randomized to either: 1) enhanced usual care - residents give patients recommendation for CRC screening, FIT kit and education they usually provide; or 2) a health literacy strategy developed by GI fellows and faculty, where residents additionally give brief education that includes a literacy and culturally appropriate pamphlet, YouTube instructional video and simplified FIT instructions developed by the authors. All residents received training in CRC screening; those in the education arm were given additional training in health literacy appropriate communication techniques.

Eligible patients are given a structured interview by an RA that includes demographics, CRC knowledge and beliefs, and the REALM literacy test before their regularly scheduled clinic visit. The resident then gives the FIT and education. 200 patients will be enrolled.

Results: To date 8 patients have been enrolled, 5 have returned FIT tests. Residents enter FIT results into EHR and mail a letter to inform patients of negative results. Residents call patients with a positive result and schedule a colonoscopy. We anticipate enrolling 100 patients by October.

Implications: An effective resident-initiated health literacy patient education strategy has the potential to improve CRC screening understanding and completion in vulnerable patients.

Colorectal Cancer

Development of Colorectal Cancer Screening Patient Education Materials and Methods in Rural Community Clinics

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James Morris, Louisiana State University Health Sciences Center Shreveport
Connie Arnold, Louisiana State University Health Sciences Center Shreveport

Background: Patient education strategies are needed to promote the use of fecal immunochemical test (FIT), the most feasible, cost-effective and sensitive colorectal cancer (CRC) screening option for low-income and rural patients. Health literacy guidelines call for patient educational materials to be understandable and actionable. Evidence suggests that eliciting patient input enhances patient comprehension and improves utility of materials.

Purpose: to elicit patient feedback on CRC screening educational materials developed by the authors, use of FIT and telephone reminder calls.

Methods: The authors conducted 3 focus groups and 20 iterative individual interviews in three rural community clinics. Participants were given iterative drafts of CRC screening pamphlet (developed by the authors and written 4th grade reading level) and simplified FIT instructions (written on a 3rd grade reading level) and probed about wording and pictures, clarity, appeal and cultural appropriateness. Additionally, they were asked what was helpful, confusing, and what else was needed.

Results: Patients preferred simplified to standard FIT instructions. They liked simple drawings illustrating specific steps in test completion and suggested adding “Do not store stool sample in refrigerator” and spelling out what FIT stood for (some thought it was a fitness test). Some patients confused colon screening with prostate exams,
illustrating the need to explore perceptions and understanding in the accompanying verbal education. They suggested a motivating title for the instructions: “Do it Yourself, an easy colon cancer test you do at home.” For the educational pamphlet, patients liked the action-oriented title, “Get Screened for Colon Cancer” and suggested putting the benefit “It can save your life” as a subtitle. When shown a variety of covers they preferred multicultural photographs of men and women over 50 to illustrate who needed testing.

Conclusions: Patients preferred to-the-point, behavior focused motivating messages expressed in a conversational tone and pictures that conveyed key points.

Facilitators and Barriers to Colorectal Cancer Screening among a Racially and Ethnically Diverse Population

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M. Rosario Ferreira, Northwestern University, Feinberg School of Medicine; Jesse Brown Veterans Affairs Medical Center
Nancy C. Dolan, Northwestern University, Feinberg School of Medicine, Division of General Internal Medicine and Geriatrics
Jonathan Radosta, University of Illinois Hospital & Health Sciences System
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Kenzie A. Cameron, Northwestern University, Feinberg School of Medicine, Division of General Internal Medicine and Geriatrics

Introduction/Objectives: Facilitators to colorectal cancer (CRC) screening are less well-explored than barriers, particularly in a longitudinal setting. We sought to explore and identify both facilitators and barriers to CRC screening (via stool tests and colonoscopy) in a population of average risk, 50-75 year-old, racial/ethnic minority patients.

Methods: Data were extracted from a study designed to increase CRC screening recommendation and completion, conducted at 7 federally qualified health centers and one academic health center in an urban area. English and Spanish-speaking patients completed an interviewer-administered telephone survey six months following a non-acute general medicine visit. Three independent coders conducted content and constant comparative analysis; disagreements were resolved by discussion.

Results: Response rate was 44.4%: 239 patients completed the survey. Participants’ mean age was 58.2 years (SD=6.4); 77.8% were female; 43.7% self-identified as Hispanic/Latino, 54.0% as Non-Hispanic Black; 75.3% reported ≤12 years of education; and 29.3% were uninsured. Self-reported screening rates within the past six months were 14.6% for colonoscopy and 7.1% for stool tests. Among colonoscopy-screened patients, 59% reported at least one facilitator such as physician recommendation, desire for wellness or reassurance, and susceptibility due to age. Additional reasons identified by stool test-screened recipients (18.7% identified specific facilitators) included the lower cost compared to colonoscopy and perceiving stool tests as less invasive. Among unscreened patients, 68.0% intended to complete CRC screening in the next year. Embarrassment was an additional barrier identified among patients reporting no intention to complete CRC screening.

Discussion/Implication: Implementing and communicating the presence of identified facilitators (e.g., physician recommendation, identifying screening options), is crucial to increasing CRC screening in this population. Barriers identified among our sample are similar to those in the literature, suggesting the continued need to address patient-level issues such as fear, and stressing the importance of CRC screening, even with competing priorities and medical comorbidities.

Health Literacy Patient Education and Outreach to Overcome Disparities in CRC Screening

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Introduction: Colorectal cancer (CRC) is the second leading cause of cancer death in the United States. Fecal occult blood tests are a proven, cost-effective CRC screening tool if completed annually. Regular screening is challenging and disparities exist in vulnerable populations including those with low SES, inadequate health literacy, racial/ethnic minorities, and those living in rural communities.

Objectives: To compare the effectiveness of two distinct telephone follow-up strategies to improve initial and sustained CRC screening with Fecal Immunochemical Test (FIT) in rural community clinics.

Methods: A two-arm, randomized controlled trial is being implemented in four community clinics in underserved rural areas of Louisiana. Eligible patients, age 50-75, are recruited at the clinic prior to a scheduled appointment. A clinic-based RA conducts a baseline structured interview measuring patient knowledge, beliefs, and self-efficacy about screening. The RA then uses health literacy communication techniques to recommend screening, gives the FIT with pre-addressed envelope, and demonstrates how to use it with patient-friendly education materials which includes a pamphlet (4th grade level) and simplified FIT instructions (3rd grade level). Patients are then randomized to receive either 1) a personal follow-up call reminding them to complete and mail FIT kits, and discuss any barriers perceived by the patient; or 2) an automated follow-up call in which a voice recording using plain language and motivational messages encourages patients to complete and mail FIT. Outcomes include FIT completion at enrollment, 12 and 24 months. 800 patients will be enrolled.

Results: To date 46 patients enrolled; 67% African American, 50% women; 30 (65%) have completed FIT; 5 (17%) had positive results.
Discussion/Implications: Establishing feasible strategies in rural community clinics where patients are given a FIT kit with literacy appropriate education and phone outreach has the potential to increase CRC screening and address public health disparities.

Communication strategies associated with greater spousal influence in colorectal cancer risk prevention discussions

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Wendy Birmingham, Brigham Young University
Wendy Kohlmann, Huntsman Cancer Institute
Jordan Sgro, Brigham Young University
Emily Hartung, Brigham Young University

Introduction/Objectives: Colorectal cancer (CRC) is one of the most common cancer diagnoses. Detection and removal of precancerous polyps through CRC screening procedures (i.e., colonoscopy) can reduce mortality, yet screening rates remain less than optimal. Research suggests that spousal influence, through social support and social control, may increase CRC screening participation and risk-reducing behaviors, but less is known regarding the specific communication mechanisms spouses use to influence each other.

This study aim was to identify how perceived spousal influence relates to interpersonal communication framing, process, and content in spousal discussions of CRC risk prevention.

Methods: In this pilot study, 16 heterosexual married couples (n=32; M age=57) in which one spouse had a family history of CRC individually completed questionnaires, including assessment of spousal influence. Couples then engaged in a 5-minute semi-structured discussion task in which they discussed risk prevention strategies. Discussions were transcribed verbatim and analyzed using Linguistic Inquiry and Word Count (LIWC). Mixed effects modeling was used to analyze the role of spousal influence on types of personal pronouns used, cognitive/emotional processing words, and relevant content, including biological processes, time, and personal concerns. All analyses controlled for sex, CRC history, relationship length, and marital quality.

Results: Perceived spousal influence was significantly related to communication patterns in aspects of interpersonal framing, process, and content of communication. Influence predicted the use of first-person plural pronouns (e.g. “we,” p>.01), causation communication (e.g. “because,” p=.06) and topics of communication (biological processes, e.g. “pain,” p=.07; time, e.g. “until” p=.05).

Discussion/Implications: Spouses’ perceived influences were related to communication strategies used when discussing CRC risk prevention strategies. Communication from more influential spouses conveyed that spouses were a unit, employed more causal language, and were focused on specific relevant content. This preliminary work has implications for future interventions encouraging more effective couples’ discussions to improve CRC screening behavior.

Identifying Sociocultural Barriers to Colorectal Cancer Screening Adherence Among Appalachian Kentuckians

Authors:
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Richard Crosby, University of Kentucky
Maudella Jones, University of Kentucky
Cynthia Lambert, University of Kentucky

Introduction: Despite higher colorectal cancer incidence and mortality rates, Appalachians evidence lower frequency of screening colonoscopy and fecal immunochemical (FIT) testing compared to non-Appalachians in Kentucky, and in the United States, overall. Research has shown the importance of clinical recommendation of colorectal cancer (CRC) screening to patient uptake. Research also indicates that providing patients a choice of screening may increase CRC completion, particularly among racial and ethnic minorities. To date, no such research has assessed the nature and frequency of CRC screening discussion among Appalachian Kentucky patients and providers. We assessed patient and provider understanding of CRC guidelines, and communication about advancing in prevention practices to facilitate timely colonoscopy and FIT.

Methods: Utilizing data from 30 in-depth interviews from men and women in seven Appalachian Kentucky counties and 20 in-depth interviews with health care providers, this study examines how Appalachians explain sociocultural barriers and facilitators to timely colonoscopy and FIT, and explores their common narratives about colorectal cancer screening experiences.

Findings: The patients describe how embarrassment, less personal and less professional colonoscopy experiences, misunderstandings of the screening process, cancer fears, and poor provider communication pose barriers to timely and appropriate CRC screening, schedule adherence and follow-up care.

Team and Inter-professional Communication

The GO Project: An Innovative and Integrative Approach to Improving Provider Communication and Teamwork

Authors:
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Paul Pitel, Nemours Children’s Specialty Care
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Introduction/objectives: There have been a number of landmark studies documenting the importance of communication for health care variables such as compliance. However, there are few efforts
underway to shift practice patterns in a manner that will improve provider communication and teamwork. We thus devised a comprehensive intervention designed to fully engage providers, staff, patients and their families in the process of improving the health care experience.

**Description of practice innovation:** We developed a comprehensive whole-clinic approach, the GO Project, involving implementation of an intensive 4-8 week multidisciplinary intervention in pediatric subspecialty clinics. Every clinic staff member and provider received assessment, guidance, and coaching in their particular area of functioning within the clinic, using experts in behavior and communication. There was also an intense focus on improving the comprehensive family experience, from check-in to check-out, with a particular emphasis on teamwork and seamless and positive transitions for patients.

**Evaluation/impact:** The GO project was implemented in four pediatric subspecialty clinics: Gastroenterology, Ophthalmology, Otolaryngology, and Orthopedics. Assessment of findings indicates consistent improvement in the patient care experience as well as staff and provider satisfaction. Top box rankings on a measure of patient satisfaction rose 20 percentile points over the period that the GO Project was implemented for these four clinics, from the 78th percentile to the 98th percentile. A standardized staff and provider satisfaction measure was devised and administered prior to and following the intervention. Pre- post-comparisons indicated that increases in total provider and staff satisfaction scores (n = 194) across the four GO Project clinics were statistically significant (p<.0001).

**Discussion/implications:** The GO Project provides a model for a successful “whole-clinic” approach to improving communication and teamwork within the health care encounter. These findings have implications for how we translate empirical findings into clinic-based change.

**Communication between general practitioners and specialists: a qualitative and perceptive assessment**

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**Background:** Communication between general practitioners (GPs) and specialists is an important aspect of qualitative care. Efficient communication exchange is essential and key in guaranteeing continuity of care. Inefficient communication is related to several negative consequences, including patient harm. This study aimed to investigate the perception of GPs and specialists concerning the quality of their mutual communication.

**Methods:** A cross-sectional study was conducted among GPs and specialists. Participants were asked to complete a validated questionnaire concerning several aspects of their communication.

**Results:** Out of 1,912 and 2,263 contacted GPs and specialists, respectively 343 and 392 subjects (response rate: 17.9% and 17.3%). Specialists qualify the GPs’ telephone accessibility as poor; while GPs themselves do not. Specialists think poorly of the GPs’ referral letter. Eighty percent of the GPs feel specialists address their questions appropriately; specialists have a similar perception of their performance. According to specialists, GPs often do not follow their advice. Contrarily, GPs rate their compliance much higher. Less than half of the GPs feel the specialists’ letter arrives on time, whereas specialists have a different and a more positive perception on this.

**Conclusions:** GPs and specialists disagree on several aspects of their mutual communication. These include the perception of accessibility, in both directions, and of the timeliness of written communication. Feedback is positively appreciated, again in both directions. Nevertheless, specialists feel that take up of their advice is insufficient. Hence, there remains significant room for improvement, which would contribute significantly to the continuity of care and patient safety.

**Developing an Interprofessional Education (IPE) Patient-Centered Communications Skills Checklist: The Work of an Interprofessional Faculty Development Team**

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**Introduction/Context:** Despite the call for more interprofessional education (IPE), few faculty members receive formal training across interprofessional lines that promote collaborations and positive attitudes toward other disciplines. One way to enhance IPE effectiveness is to engage faculty from different academic disciplines in a collaboration aimed at developing IPE interventions aimed at improving student learning and assessment across the health professions. To this end, we developed an IPE communication skills checklist that can be used across disciplines.

**Description:** We used the construct of patient-centered communication instruction and standardized patient instructors (SPIs) as a vehicle for health science interprofessional faculty development. Before this initiative the Schools of Medicine, Pharmacy and Dentistry independently utilized a single Standardized Patient Program as part of their communication and clinical skills education. This faculty development activity consisted of five 60-minute sessions on the following
Patients were interviewed and their families were forthoming about their experience of communication and teamwork within the health care interaction. 100% (n = 186) of patients agreed to voluntarily participate in the interview. Cumulatively, the 186 patients provided 930 responses. 87% of responses (n = 809) were coded as reflecting positive aspects of the experience. 10% (n = 93) of responses were coded as neutral and 3% (n = 28) were coded as reflecting a negative experience within the health care encounter. 22% (n = 204) of responses were coded as “actionable”.

**Discussion/implications:** There are advantages and disadvantages to direct patient interviewing immediately following an encounter. Given the immediacy of the encounter, patients are more likely to remember and reflect specific details of the health care visit and to provide actionable suggestions. Having the interviewer/observer present during the encounter also allows for the patient to refer to specific situations that were observed during the structured interview. However, biases toward positive responding were noted. Overall, this interview may provide a way to easily capture detailed reflections directly from families and may serve as a helpful adjunct to other standardized measures of patient experience.

**Navigating Communication and Relational Challenges of Everyday Patient Care - An Innovative, Longitudinal Approach to Interprofessional Education Promoting Patient/Family Engagement and Teamwork**

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**Context:** Breakdowns in communication with patients, families and colleagues can negatively impact quality of care, patient safety and the wellbeing of clinicians. However, most communication training is offered outside practice settings and emphasizes “classic” challenges such as communicating bad news. As an alternative, the Program to Enhance Relational and Communication Skills-Rounds (PERCS-Rounds) has been offered since 2010 to address educational needs and promote interprofessional teamwork within critical care settings.

**Description of innovation:** Based on principles of self-directed and relational learning, topics of the monthly, hour-long sessions are developed collaboratively by representatives of participating units and a facilitating team during preparatory meetings. Rounds are offered on the floors of hosting units to enable broad participation. Each session starts with a presentation of a current communication or relational challenge. After identifying the characteristics of the particular challenge, solutions and strategies are generated through facilitated discussion. Summaries of the discussion and relevant literature are sent via email to participants to reinforce the learning. Additionally, key resources in the hospital are identified and invited to share expertise for further collaboration.

**Evaluation:** Between 04/2010-06/2014, 644 interprofessional clinicians participated (64% nurses/NP, 13% social workers, 6% child life specialists, 2% psychologists, 2% chaplains, 1% physicians, 9% others). Attendance is robust (median: n=18/seminar); 92% of participants rated their participation as “quite” or “very valuable.”
Seminars of particular interest included challenges associated with “care for dying patients,” “use of social media in the relationship with families,” and “civility, incivility and bullying.”

**Discussion:** PERCS-Rounds are an approach to addressing challenging communication experiences in user-friendly educational context. Clinicians of participating units “own” the topics, learn interprofessionally and are supported by program facilitators to meet their learning needs. Attendance and satisfaction rates are persistently high. Increasing physician attendance and evaluation regarding actual behavior change remain challenges for the future.

**Improving Learning Outcomes with Collaborative Team Based Learning**

**Authors:**  
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**Aim:** The aim of this study was to explore the benefits and challenges of implementing a collaborative, team based learning (TBL) model in the undergraduate psychiatric mental health (PMH) nursing classroom. An alternative to the traditional didactic lecture, TBL is a teaching-learning method that follows a specific sequence of individual and group work and testing, combined with immediate feedback, to motivate and engage students to communicate and learn as a team.

**Method:** A pretest-posttest study design was employed. Data were collected in a required fourth year PMH nursing course before and after implementation of TBL. Three variables were selected for comparison before and after implementation: PMH scores on practice NCLEX exit exam, time (in hours) students reported studying PMH outside of class, and satisfaction with the “worthwhileness” of the PMH course. These factors were compared between the traditional didactic approach and the newer, collaborative TBL method.

**Finding:** Data from 347 students were examined over eight consecutive semesters, half before and half after implementation of TBL. After implementation, students scored higher on the practice exit exam and reported increased study time. There were no significant differences between the didactic and team methods on the satisfaction measure. Anecdotally, students reported enjoying working in teams, despite the increase in independent study time TBL required.

**Conclusion:** Students prepared more for class when required to engage with peers in weekly in-class learning activities and tests. This may be the reason PMH exit scores increased and have been sustained over the four semesters since implementation of TBL. TBL created a group process in which small groups of students applied newly acquired knowledge to reach shared learning goals. As a result, students also gained interpersonal and collaborative skills that are critical to practice in today’s complex, team-oriented healthcare environment.

**Pedagogy in Practice: A “How to” Guide to Interprofessional Relational and Communication Training**

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**Introduction/Background:** Programs to support clinicians in communicating difficult news in healthcare have emerged in recent decades, yet few guides exist about how to train faculty. The Institute for Professionalism and Ethical Practice at Boston Children’s Hospital Program to Enhance Relational and Communication Skills (PERCS) is one such program that has existed since 2002. This study aimed to develop a “how to” guide to PERCS, based on the experiences of co-founders, senior faculty and program actors.

**Methods:** Semi-structured qualitative interviews were conducted over 6 months with 7 psychosocial and faculty facilitators; 3 family faculty, and 2 actors. Interviews were conducted in person (8) and by phone (4); they were tape-recorded and transcribed verbatim for analysis. The primary researcher undertook participant observation at 3 different PERCS workshops and reviewed workshop administrative materials. Data analysis followed principles of thematic analysis, using both inductive and deductive techniques.

**Results:** Five key themes emerged as central to developing and sustaining PERCS training: 1) Modeling core relational values; 2) Setting and maintaining ground rules for participants, with an emphasis on safety; 3) Maximizing the impact of improvisational enactments and subsequent debriefing; 4) Customizing new workshops with integrity/credibility; 5) Dealing with constraints and challenges to the PERCS process. Findings also illustrated common pedagogical components across different workshops, suggesting that training is highly structured yet flexible.

**Discussion/Implications:** This study offers insights gained from years of well-evaluated practice about how to conduct effective interprofessional training on difficult conversations in healthcare, and can assist others undertaking faculty training. Findings support the importance of a clearly communicated pedagogy, systematizing learning, and provide structured guidance for successful experiential training.
Relational Coordination in the Operating Room - Different ways of communication and coordination in the interdisciplinary teamwork

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Introduction: In surgical teams, where health professionals are highly interdependent and work under time pressure, it is of particular importance that the teamwork is well-functioning to secure treatment quality and patient safety. Relational coordination (RC) is an expression of the quality of the interdisciplinary cooperation. It is well known that coordination and communication has implications for the psychological safety in the team. There is a need for further knowledge about how to improve RC and patient safety culture in the interdisciplinary team in the operating room (OR).

Purpose: To investigate the characteristics of the interdisciplinary teamwork in selected surgical wards, focusing on RC and patient safety culture. The research question is: 1) How is the interdisciplinary teamwork in OR characterized?

Methods: An ethnographic field study where data is collected through participant observations (35 teams) and semi-structured interviews (15), through a 10 months period in 2014 in two orthopedic surgical wards in a University Hospital in Denmark. Firstly, the data is analyzed and reduced to descriptive form. Secondly, a content analysis on the basis of theory of RC has been used to transform the data to show different typologies of interdisciplinary teamwork. The analysis is still ongoing.

Results: Data describes very complex conditions for the teamwork in the OR. Four preliminary typologies of interdisciplinary teamwork are identified: the Dream team; the Silent team; the Immature team; the High Dynamic team. The teams have a varying degree of coordination based on shared goals and different characteristics of the inter-professional communication are identified: Problem-solving/Blaming; Accurate/Inaccurate; Timely/Delayed and Respect/Disrespect.

Implications: The results will be used to develop an intervention program to strengthen the interdisciplinary teamwork in the OR. An improvement which will result in increased treatment quality; greater job satisfaction and reduce the risk of adverse events.

Conflict Management by Physician and Nurse Practitioner Trainees

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Introduction: Patient-centered medical homes have demonstrated improvements in care delivery, but diversity among team members in these structures may increase conflict. Skilful communication is critical for successful conflict management, but few health professions training programs address this topic, and little is known about trainees’ skills in this area. This qualitative study examined trainees’ responses in simulated, interprofessional conflict interactions.

Methods: We reviewed 33 transcripts from 7 internal medicine and 4 nurse practitioner resident interactions with 3 standardized professionals (2 RNs, 1 social worker). One investigator trained the standardized professionals to deliver conflict-oriented statements directed toward a patient or the trainee’s plan during a 5-minute interaction with trainees. We developed a coding scheme, based on existing frameworks for relationship-centered communication and review of a subset of transcripts, to capture trainees’ responses to these statements; applied the final coding scheme to all 33 transcripts; discussed coding differences to reach consensus; and reviewed coded data to identify opportunities for targeted conflict management training.

Results: We found five types of trainee responses to challenging lines: cognitive approaches (explanations, suggestions, fixes, agreement, and disagreement); questions demonstrating curiosity; reframing to incorporate the patient’s perspective; relational responses; and missed opportunities to build relationship. Trainees frequently used a combination of conflict management strategies, but used relational responses less often when in direct conflict with a team member. Of the relational responses, trainees used empathy least frequently, regardless of conflict type.

Discussion: Trainees used a range of techniques to manage conflict with interprofessional colleagues but could have benefited from improved versatility, especially in cases of relationship-associated conflict. Given the high prevalence of conflict in all medical settings, trainees must receive instruction and practice that support conflict management skills. Further studies examining how trainees manage conflict and the effect of curricula to help expand these important skills are needed.

Communication in healthcare: a systematic review of the literature and practical recommendations

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Objectives: Effective and efficient communication is crucial in healthcare. Written communication remains the most prevalent form of communication between specialized and primary care. We aimed at reviewing the literature on the quality of written communication,
the impact of communication inefficiencies and recommendations to improve written communication in healthcare.

**Design:** A systematic literature review.

**Methods:** A search was carried out on the databases PubMed, Web of Science and The Cochrane Library by means of the (MeSH)terms ‘communication’, ‘primary health care’, ‘correspondence’, ‘patient safety’, ‘patient handoff’ and ‘continuity of patient care’. Reviewers screened 46909 records and 462 full texts were checked against following inclusion criteria: 1) publication between January 1985 and March 2014 2) availability as full text in English 3) categorization as original research, reviews, meta-analyses or letters to the editor.

**Results:** A total of 69 articles were included in the systematic review. It was found that poor communication can lead to various negative outcomes: discontinuity of care, compromise of patient safety, patient dissatisfaction and inefficient use of valuable resources, both in unnecessary investigations and physician worktime as well as economic consequences.

**Conclusion:** There is room for improvement of both content (ensuring the required items, addressal of referral questions, diagnosis and management issues) and timeliness of written communication. The delineation of ownership of the communication process should be clear. Peer review, process indicators and follow up tools are required to measure the impact of quality improvement initiatives. Finally, communication between caregivers should feature more prominently in both graduate and postgraduate training, in order to become engrained as an essential skill and quality characteristic of each caregiver.

**Escalation of Unresolved Conflict to Immobilizing Conflict Cycles in Hospital Communication:**

**Objectives:** Structurational Divergence (SD) theory posits that recurrent intractable conflict cycles are rooted in oppositional meanings impeding successful communication and goal accomplishment. SD-Nexus is the condition of unresolved conflicts rooted in oppositional institutional- and meaning-structures. SD-Cycle is the escalation of those conflicts to immobilization, interrupted goal-attainment, and deficient individual and organizational development, which then serves to exacerbate the initial conflict. Empirical evidence demonstrates that the SD-Cycle predicts negative outcomes among nurses (e.g., burnout, bullying, poor job satisfaction, and turnover). There is no explanation for why the SD-Nexus escalates to the SD-Cycle. The paper presents both quantitative and qualitative analysis of this escalation of SD-Nexus to SD-Cycle.

**Methods:** Quantitative analysis data consist of surveys from 713 nurses (833-bed hospital). Measures of communication predispositions were administered with the standard SD measure. Subjects in SD-Nexus conditions (high immobilization SD-subscale) were selected for analysis and divided into two groups (high and low SD). Communication predisposition variables were examined for between-group differences using t-tests.

Qualitative analysis data consist of observation notes and interview transcripts with 37 nurses, physicians, and other healthcare workers in an Emergency Department (140-bed hospital). All demonstrate SD-Nexus conditions. Data were coded to divide into high- and low-SD groups. Thematic analysis to examine differences between groups is ongoing.

**Results:** Significant t-tests with moderate-to-large effect sizes reveal that ambiguity intolerance (t=2.75; df=336), conflict avoidance (t=2.78; df=179), and the tendency to take conflict personally (persecution t=5.24; df=339; stress t=2.60; df=338; negative relational effect t=2.13, df=341) are associated with escalation from SD-Nexus to SD-Cycle. Preliminary qualitative results indicate agency/autonomy loss characterizes SD-Nexus to SD-Cycle escalation.
Discussion: Reducing SD can bring tangible benefits to healthcare organizations. Identifying individual differences that may make some individuals more susceptible to the damaging escalation of SD can aid in development of training interventions and continuing refinement of the theory.

From Curriculum to Application to Practice: Building Evaluation Bridges in a Longitudinal Interprofessional Program

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Abstract: As the interprofessional teamwork skills application component of a longitudinal interprofessional curriculum, Clinical Transformations (CT) acts as a bridge for learners from classroom conceptual learning to real-life applications in clinical settings.

In early years of the program, pilot data captured teams’ application of the four key principles of TeamSTEPPS and while results showed a gain in content knowledge and increase in the application of TeamSTEPPS in a simulated scenario, post-assessment and a second round of observational checklist results were positively skewed. Observation tools did not address specific teamwork tasks and processes either, resulting in pre and post assessment tools that did not provide meaningful data.

To address these issues, the four assessment tools were benchmarked with instruments used locally and regionally and redesigned. Current tools include an individual conceptual quiz pre-entry to CT, real time observational checklists for team briefs, scenarios, and debriefs; immediate individual and team evaluations of performance post-CT experience; individual evaluation of knowledge retention and application of teamwork concepts; and evaluation of interprofessional skills in current clinical teams 6 months post CT.

Qualitative data demonstrate improved outcomes in learner ability to reflect on team performance, as well as expanded opportunities in peer-teaching and peer-learning through a learner-centered debrief process. An aggregate of quantitative data is currently undergoing analysis but preliminary data shows above average and high performing teams constitute 58% of the sample. Pre and post assessment data also indicates that team members demonstrate an above average understanding of teamwork concepts and skills (90% level).

GPs’ participation in multidisciplinary team meetings in oncology: Interview study in Belgium

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Introduction: General practitioners (GPs) are important members of the multidisciplinary team (MDT) involved in cancer patients’ care. In Belgium, MDT meetings in oncology are reimbursed since 2003 by the National Institute for Health and Disability Insurance (NIHDI). Although important, the presence of the GP is not mandatory, nor is a task description provided. Even reimbursed, the attendance of GPs at MDT meetings in oncology is minimal. Little is known what the perceived barriers for participation are and how GPs perceive their role toward participation.

Objectives: The study objective is to describe:
1. GPs’ perceived roles and their current experiences toward the MDT meetings for oncology patients
2. GPs’ barriers for participation

Methods: Semi-structured interviews until data saturation, with Belgian GPs all having MDT meeting experience. Thematic analysis principles are used to analyze data.

Results: Sixteen GPs have been interviewed. Their perceived role is being the representative of the patient, as they share a history of longitudinal care. The results show that the participation and contribution of the GP is appreciated and respected by the other participants of the meeting. GPs’ perceived input at the MDT meetings is especially important during patients’ later disease stages, or when discussing complex home care situations. The perceived added value of discussing and reaching consensus during MDT meetings promotes GPs’ participation. Through participating MDT meetings, a better interpersonal relationship with some specialists was mentioned. Barriers for participation are mostly practical (timing and quality of the invitation, hospital proximity). These may be overcome through video-conferencing.

Discussion: GPs confirm the necessity of effective collaboration and communication with specialists in the complex situation of cancer patients’ care. A MDT meeting is an operationalization of interprofessional care and fosters interpersonal contacts with specialists, eventually leading to better patient care.
Improvement of Inter-professional Communication and Team-based Care with Implementation of Huddles: A Quality Improvement Study

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Background: A structured communication process or meeting to focus on individual patient care is a critical factor in order to be certified as a patient-centered medical home (NCQA, 2014). The team huddle is an effective process for accomplishing care planning and can yield benefits (Zawaora, et al, 2015), yet inter-professional team-based care can be challenging to implement (O’Malley, et al, 2014) in a manner that all participants value the process (Rodriguez, et al, 2014).

Objective: In a residency practice with 20 residents, 9 faculty and 10 support staff, the development of a viable method for huddling is formidable. This resident-driven quality improvement project will undertake implementation of a consistent huddling process. Physician and staff experience of the process will be evaluated at various points in the implementation period. The Plan Do Check Act (PDCA) cycle will be used to guide the process.

Method: Physicians and staff with patient care duties will be assessed using questions similar to those used by Rodriguez, et al (2014). The questions will assess the frequency of huddles; the respondent’s perceived value of huddling, and their experience of huddling on patient flow and efficiency. Results will be used to guide a process improvement plan which may include some of the following: training on the role staff have in the huddle process, scheduling to create the time to huddle, the minimal necessary elements of a huddle, use of templates, or the electronic medical record to facilitate huddles. Surveys will be periodically re-administered to guide the process and monthly staff meetings will be used for development and communication.

Conclusions: Quantitative and qualitative data will be summarized and the process improvement plan will be described with the intention that this process might serve as a model for other residencies or large practices.

Perspectives of Effective Pediatric Discharge Communication

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Introduction: Poor communication at hospital discharge contributes to adverse events and healthcare costs. We compared discharge communication experiences of parents, primary care providers (PCPs), and hospitalists to identify key components of hospital discharge communication affecting outcomes.

Design/Methods: Qualitative interviews and focus groups were conducted with 10 parents, 13 PCPs and 6 hospitalists. Data were transcribed and collaboratively coded using the constant comparative method. Data collection concluded when thematic saturation had been reached for each group.

Results: All parents described two negative aspects of hospital discharge: (1) “discharge paradox” whereby they are simultaneously told things will be fine at home, yet are trained with modalities such as CPR for serious adverse events or remain under close monitoring until discharge; (2) “care chasm,” the emotional, perceptual, and material gap the discharge process is meant to bridge between hospital care and home care, but often does not. While parents described and hospitalists uniformly endorsed these aspects of discharge, PCPs did not endorse care chasm or discharge paradox as relevant to the discharge process. Suggestions from stakeholders for improving the discharge process fell into two categories: (1) addressing the discharge paradox (beginning the discharge process at admission, discharge readiness assessments, and use of a discharge checklist); (2) addressing the care chasm (improved interactions between hospitalists and PCPs, hospitalists and parents, and parents and PCPs using a variety of communication strategies, changes to the discharge paperwork that provide clarity to PCPs and families, and enhanced communication regarding home management between hospitalists and families).

Discussion: Discharge communication should enhance the hospital to home transition. We identified perspectives of stakeholders about the discharge process which varied by role. Results of this study will be used to develop quantitative measures of discharge communication processes to improve outcomes and reduce costs.

Standardized Patient Simulation to promote interprofessional collaborative practice in evaluating older adults with dementia

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Introduction: We developed a Standardized Patient Simulation for PGY1 Internal Medicine residents and nursing students to work together evaluating an older adult with dementia. The simulation addresses 4 ACGME minimum geriatric competencies for Internal Medicine/Family Medicine residents: medication management, cognitive, affective and behavioral health, complex or chronic illnesses in older adults, and ambulatory care. It includes 4 Core Competencies for Interprofessional Collaborative Practice: values/ethics for interprofessional practice, roles/responsibilities, for collaborative practice, interprofessional communication, and interprofessional teamwork and team-based care. Learning objectives included: demonstration of clear communication and respectful data sharing, synthesis of data for care plan creation, identification of community resources, and consideration of health literacy when communicating with patients and caregivers.

Instructional and/or assessment methods: We piloted a Standardized Patient Simulation (part one in the patient’s home and part two in the physician’s office) emphasizing the collaboration of a doctor and a home health nurse in the care of an older adult with mild demen-
nia. Learners prepared with select readings and an online module on dementia. A debriefing session highlighted the assessment and management of dementia, benefits of team work and community resources related to dementia. Learners received an email from the patient’s caregiver (dated 1 year in the future) seeking help about the increasing caregiver demands with progressive dementia. Together, the learners composed a health literacy appropriate email response, incorporating information about community resources.

Program evaluation results: 22 learners will complete evaluation data by June 2015. We will assess the pre-session readings and module, the debriefing session and the email assignment. Each learner will complete the Attitudes Towards Health Care Teams Scale.

Discussion/implications: This novel Standardized Patient Simulation provided skills in integrating data from different health professionals into a patient’s plan of care. Opportunities for interprofessional learning set a foundation for future collaborative and respectful working relationships.

Teaching and Evaluating Communication Skills (students)

Authentic Communication Assessment of Student Clinicians: Patients Teaching Students

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Introduction: Use of effective clinical communication (ECC) by healthcare practitioners results in several benefits including improved patient satisfaction, improved care outcomes, and reduced patient anxiety. Despite the importance of ECC in quality healthcare and an increasing focus on educating oral healthcare clinicians to be effective communicators, systematic development of dental practitioners’ communication skills tends to be limited. The involvement of patients during development of these skills is also inadequate, despite the extensive literature on patient feedback for practicing oral health practitioners.

Educational Objectives: To address these gaps, a study of assessing dental student clinicians’ communication skills by their patients and student clinician self-assessments was conducted at two university clinics (Canadian and Australian).

Assessment Method: To test the Patient Communication Assessment Instrument (PCAI) and Student Communication Assessment Instrument (SCAI) to assess ECC and to discriminate in differences in terms of patient demographics such as gender, age, and student clinician variables such as gender and year of study.

Results: A total of 3548 patient (PCAI’s) and 591 student self-assessments (SCAI’s) were used for data analysis. Canadian and Australian patients tend to score their student clinicians similarly (PCAI’s), yet higher than their student clinicians’ self-ratings (SCAI’s). Senior student clinicians, regardless of country cohort, had higher communication scores (SCAI’s) than their junior counterparts. Australian junior (third year) dental students held lower self-assessment scores on each of four SCAI subscales than either the Australian senior (fifth year) dental students or the Canadian junior (third year) and senior (fourth year) dental students.

Discussion/Implications: Our study extends previous studies on patient and student-clinician ECC. The impacts these findings have in terms of using patient feedback to provide education to student clinicians in terms of ECC are discussed. Suggestions guide future research in further exploring the impact of ECC as defined by patients and self-assessments of student clinicians.

Enhancing Interpersonal Communication Skills and Humor early on in Medical School: A Mixed Method Intervention Study

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Introduction: Interpersonal skills are an important component in medical care. One unique interpersonal skill is the use of humor. However, the specific manner in which humor can and should be utilized in medical encounters as well as the manner in which interpersonal skills and humor can be taught remains fairly unknown.

Objective: To evaluate the effectiveness of a semester-long intervention focused on enhancing interpersonal skills in general and humor specifically within simulated patient encounters.

Methods: A mixed-method intervention study was conducted that included 36 first-year medical students at Sackler School of Medicine, Tel Aviv University, Israel, 16 of whom comprised the study group and were enrolled in an elective course named “Humor and Creativity in Building Relationships in Medicine”. The quantitative methodology included pre-posttest nonequivalent control group design using self-report questionnaires to evaluate attitudes and self-efficacy related to humor and interpersonal communication. As well as blinded assessment of video-recorded simulations to evaluate humor use and interpersonal communication skills applied. The qualitative component included in-depth semi-structured interviews with the study group participants, using Immersion-Crystallization analysis.

Results: The quantitative findings indicated that post-intervention, study group participants scored significantly higher on the humor factors (attitudes, self-efficacy and behavior), compared to control group; and significantly higher on the interpersonal factors (attitudes, self-efficacy and behavior) and on humor behavior, compared to pre-intervention. The qualitative findings indicated students’ difficulties in learning and applying humor in medical encounters, as opposed to their increased understanding of the importance of interpersonal communication skills, with focus on the beginning and ending of the encounter.

Discussion/implications: This intervention was effective in initiating change in attitudes, self-efficacy and behaviors related to inter-
personal skills and humor. Further research is needed to explore the association between humor and interpersonal communication, ways to effectively teach them and their effects on doctor-patient relationships.

The study was funded by the Magi Foundation.

The Effectiveness of a Communication Intervention in the Major Clinical Year

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Introduction: Effective communication between a provider and patient can lead to higher levels of patient satisfaction and treatment compliance as well as improve the physical and emotional health of the patient. Research has shown that the ideal time to start developing effective patient-provider communication skills is during a student’s clinical training, yet few medical schools have a formal communication curriculum during the clinical year.

Methods: We developed a structured communication curriculum for third year medical students during their major clinical year, involving baseline, interim, and final videotaped mock patient interactions with feedback together with direct instruction by a communications professor. The final mock interviews of the intervention group (n=10) and mock interviews of a control group of third year medical students who did not receive the intervention (n=9) were assessed by three communications professors who were blinded to the study design using our novel communication assessment tool. This tool is comprised of 22 items divided into four subcategories: identification convergence, information seeking, information giving, and nonverbal engagement. There was also a single item rating the overall communication of the provider.

Results: Medical students who received the communications intervention scored higher than those who didn’t overall and in each of the four subcategories, a pattern that was statistically significant using a one-tailed sign test (p=0.031). The subscore for information giving was also significantly higher for the intervention group (Wilcoxon Rank Sum Test, p=0.047).

Discussion: The communication intervention was successful in improving the students’ communication skills, most notably in the area of information giving. A curriculum emphasizing the practical application of communication skills critical to the patient-provider relationship integrated into the clinical year is feasible and can produce measurable improvements in the communication of medical students.

Adapting Patient-Provider Communication when Patients Have Communication Disorders

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Context and Educational Objectives: People with communication disorders are a vulnerable population in healthcare, at increased risk for medical complications and errors [1, 2]. While medical and nursing schools are including patient-provider communication (PPC) training in their curriculum, this training does not typically include how to accommodate the communication needs of patients with communication disorders. Consequently, a group of speech-language pathologists at the University of Washington have developed a program to teach medical and nursing students how to adapt communication to meet the needs of these patients.

Educational objectives include: 1. Understanding how communication disorders impact medical interactions; 2. Identifying key strategies to improve communication with these patients; 3. Obtaining hands-on experience implementing key strategies with simulated patients with communication disorders.

Instructional Methods: This program uses didactic instruction, discussion of video examples of patients with communication disorders, and role-play experiences with simulated patients portraying communication disorders. Communication-enhancing strategies taught as part of this program are based on a mnemonic of “FRAME” [3]:
F: Familiarize with how the patient communicates
R: Reduce the rate of communication
A: Assist with communication
M: Mix communication methods
E: Engage the patient first

Program Evaluation Results: Students complete course evaluations after the program. Students completing this program routinely express increased knowledge regarding how communication disorders impact medical interactions, and confidence in implementing learned strategies with patients with communication disorders. Research is also ongoing to examine the effectiveness of this program on communication behaviors of medical and nursing students. Effectiveness data, currently being analyzed, will be discussed as part of this presentation.

Discussion/Implications: Learning to adapt PPC during medical interactions involving patients with communication disorders can increase the safety and quality of healthcare these patients receive. It also underscores the need for expanded training to reach all healthcare disciplines who interact with patients with communication disorders.

Background: Experience with patients is limited before and during early years of training. Providing students experiences with patients earlier may enhance their ability to empathize with the patient perspective. The Patient Support Corps (PSC) is a service learning program where pre-medical and medical students support patients by helping list questions and concerns before a consultation; and take notes and make audio-recordings during consultations. UCSF and Dartmouth are disseminating and evaluating the PSC.

Methods: We sought to learn if PSC training increases ability to compassionately elicit questions and concerns. Not finding an existing measure, we developed a ten item instrument derived from theory and evidence-based descriptions of compassionate care and question prompting. We administered this draft instrument before and after training 12 medical students. The students role-played patient question-listing sessions with their peers. At the conclusion of each role-play, the coach and simulated patient completed the Interview Rating Scale. After the training, students provided the question-listing service to patients, and we noted qualitative reactions from both parties.

Results: Prior to training, students rated their interviews at a mean level of 68/100. This rose to 85/100 after training. The simulated patients’ rating of their interviewer rose from 70/100 to 89/100. After serving patients, student comments included: “What’s so different about this program is that it forces you to absolutely focus on the patient’s concerns...to not insert what you think is best into the conversation. It’s such a different skill, so valuable to me as I train to become a physician.” Patient comments included: “The question list was great because it was in my own words. I just can’t express enough how helpful this procedure was. I did not have to worry if I forgot to ask something.”

Conclusion: Early results suggest that PSC training may improve interviewing skills and benefit patients.

The Patient Support Corps: Training Medical Students in Patient-Centered Communication

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Medication Management

Are you taking one every day?: Using Face Theory to understand how Pharmacists and Patients talk about Talking Medications

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Introduction: Over half of individuals do not regularly take chronic medications. Medication non-adherence places a significant burden on both individuals and society. Pharmacists are well positioned in community pharmacies to discuss medication taking with patients. Yet, the nature of these conversations may pose potential threat to a patient’s sense of autonomy or competence if the patient had alternative strategies for taking their medications. Face-work Theory was used as a guiding framework to understand interaction processes and identify how autonomy, competence, and fellowship face impact how pharmacist-patient discuss medication taking behaviors.

Methods: The study used an exploratory descriptive study that drew upon principles of ethology. Twenty-five audio-recordings of community pharmacist-patient interactions were collected and analyzed. The average length of these interactions was 3:67 minutes with the maximum time of 9:35 minutes and minimum time was 0:39 seconds. After the interaction, patients completed a written survey on their perception of pharmacist relationships and their satisfaction.

Results: The majority of pharmacists used leading closed questions while exploring how their patients were taking their medications (i.e., “are you taking it in the morning?” or “are you taking one every day?”) or used down graders to minimize the threat. In Face-Work Theory, these strategies are typical ways to achieve solidarity, while also mitigating threats to competence face needs. One pharmacist directly introduced the question of adherence; however the patient provided a vague answer and the pharmacists reverted to a leading question. Patients used solidarity strategies, asserted their expertise and provided vague answers to maintain face when discussing their medication taking behavior.

Implications: There is a tension between pharmacists desire to avoid threatening the patients’ indicated desire to be seen as competent and autonomous and the instrumental task of gathering necessary information to evaluate safe medication use.
Consumer Confusion between Prescription Drug Warnings and Side Effects

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Learning Objectives:
(1) Describe how frequently consumers incorrectly interpret drug warnings presented on direct-to-consumer prescription drug websites.
(2) Discuss how misinterpreting drug warnings on websites might adversely affect informed decision making and lead to medication errors.

Introduction/Objectives: Multiple studies have identified consumers’ difficulty correctly interpreting prescription drug labels—including drug warnings, precautions, and side effects—and the corresponding medication errors that result. Given the increasing popularity of direct-to-consumer (DTC) prescription drug websites, consumers’ ability to correctly interpret side effects and warnings on websites is equally important. This study’s purpose was to explore whether consumers can distinguish between drug precautions (i.e., a type of warning to alert doctors to pre-existing conditions) and side effects (i.e., adverse events caused by drug) presented on DTC websites.

Methods: Participants (n=873) with one of four medical conditions viewed fictitious drug websites for their diagnosed condition and completed a survey assessing recall and comprehension. The websites presented both side effects and precautions for the fictitious drugs. We coded open-ended recall data to identify whether the precaution was (a) not mentioned, (b) recalled accurately, (c) interpreted as a side effect, or (d) used to make other inferences about drug safety.

Results: Approximately 6.5% to 18.6% of participants (n=164) mentioned the drug precautions. Of those participants, only one-fifth (n=34; 20.7%) recalled the precautions accurately. More than half (n=87; 53.0%) interpreted the precautions as potential drug side effects (e.g., “may cause overactive thyroid” versus “tell doctor if you have overactive thyroid”). The remaining participants (n=43; 26.2%) made inferences based on the precaution, such as inferring that the drug should not be taken by individuals with the pre-existing condition.

Discussion/Implications: The findings suggest that at least some consumers are likely to interpret prescription drug precautions on DTC websites as potential drug side effects, which might affect consumer preferences, informed decision making, and medication safety. Healthcare providers should be aware of this potential confusion, ask patients about pre-existing conditions, and explain how these conditions might affect treatment.

Family Members’ Experiences of Medication Communication in a Pediatric Hospital

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Introduction: Family members of hospitalized children play a pivotal role in medication management. Familial involvement in a child’s care contributes to the recognition of adverse drug events, shared decision-making and advocating for the child’s needs regarding medications. Despite the benefits of family-centered care being emphasized for decades, practice recommendations often contrast with families’ experiences. The aims of this research are to better understand family members’ experiences of the communicative processes involved in managing children’s medications, and to explore barriers and facilitators to effective medication communication within a pediatric hospital.

Methods: This study used a qualitative, thematic analysis of 59 semi-structured interviews and 200 hours of observations with pediatric inpatients, family members, nurses, doctors and pharmacists. Data were transcribed verbatim and prominent themes were extracted.

Results: Family members had a need for information regarding medications and reassurance regarding the impact of the medication on their child’s future health. They perceived themselves as advocates for the child and felt that they should bear the responsibility of obtaining knowledge on their behalf; although varied in their desire to be involved in medication decisions. Barriers to medication communication included families’ compromised capacity to synthesize information due to fatigue and stress, language barriers, and miscommunications following transfer of care. Facilitators included positive rapport between health professionals and families, accessibility of hospital staff through technology and tailored use of medical terminology.

Discussion/Implications: The insights gained from this study have the potential to improve relationships between family members and health professionals, maximize engagement with medication management and foster medication adherence in pediatric settings. Recommendations for practice include: closer attunement to family members’ anxieties as well as their capacity to absorb verbal information, the provision of written medication information to families, and improved communication of individualized medication needs, particularly surrounding staff changeovers.
Medicines packages leaflets and their legibility according to patients’ socio-demographics

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Introduction/objectives: Package leaflets (PLs) are essential for safe and effective use of medicines. In Europe, it is mandatory that each packet includes a PL.1 This study aimed to explore how patients’ education and other mastery variables correlate with opinions on PLs legibility.

Methods: Voluntary participants from urban (Lisbon) and rural municipalities in Portugal participated in the study. The inclusion criteria (i.e. adults above 18 years old and being capable of reading/writing in Portuguese) purposively recruited a total of 503 participants, from August to December 2014. Participants were selected to meet 3 homogeneous education strata, i.e. 1 to 6 years of schooling, 7 to 12 and more than 12 years. Participants fulfilled a self-completion questionnaire comprising other demographics, as well as their opinions (expressed on Likert scales) related to design and written information legibility of 12 randomized PLs (6 prescription and 6 over-the-counter medicines).

Results: The sample comprised 53% males, 45% with less than 30 years of age and 55.1% from Lisbon, while education strata were 31.9% (1-6), 36.3% (7-12), and 31.9% (>12). There were no significant associations in opinions with regions, gender, marital or employment status. Statistical associations were found with age ($x^2=9.395; p=0.009$) and income ($x^2=16.284; p=0.012$). Education level ($x^2=42.747; p=0.001$), a literacy indicator (i.e. reading habits) ($x^2=8.581; p=0.014$) and frequency of medicines use ($x^2=6.965; p=0.031$) were also significant. Worst opinions on PLs legibility were from those with less than 50 years of age, above 12 years of schooling, reading 2 or more books per year, a higher income, or a lower medicines use.

Discussion/implications: Higher education and mastery are negatively associated with participants’ opinions on PLs, suggesting that older and less educated population in Portugal might not use or not fully read PLs. Although considered a readable source of medicines information by experienced users, patients should be able to make use of PLs independently from their level of familiarity with these documents.


Ophthalmologist-patient communication and glaucoma medication adherence

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Introduction/objectives: The purpose of our study was to examine the association between provider use of components of the Resources and Supports in Self-Management Model when communicating with patients and adherence to glaucoma medications measured electronically over an 8-month period.

Methods: Patients with glaucoma who were newly prescribed or on glaucoma medications were recruited from six ophthalmology clinics. Patients’ baseline and next follow-up visits were videotaped-recorded. Patients were interviewed after their visits. Patients used Medication Event Monitoring Systems (MEMS) for 8 months after enrollment into the study. Generalized Estimating Equations were used to analyze the data.

Results: Two hundred and seventy-nine patients participated. African American race was negatively associated with adherence. If ophthalmologists provided positive reinforcement to patients about their medication taking and if they encouraged patients to take their medications, patients were significantly more adherent. If ophthalmologists educated patients more about glaucoma, patients were significantly more adherent. Patients on more glaucoma medications were significantly less adherent.

Discussion/implications: Provider communication behaviors, including providing education and positive reinforcement, can improve patient adherence to glaucoma medications over an 8-month period.

Optimization of Complicated Drug Regimens in Community Pharmacy Patients

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Objectives: Patients with co-morbidities often have complicated drug regimens. There is a direct association between the numbers of doses a person takes a day and their non-adherence; hence there is a need to orchestrate and simplify patients’ dosing schedules. Community pharmacies are ideally situated to help patients optimize their complicated regimens by tailoring them to an individual’s typical day and preferences.
This study tested and reports the impact of patient consultations using a Pill-Card developed by the Agency for Healthcare Research and Quality to orchestrate daily dosing to:

- Improve the efficacy of the prescribed drugs
- Reduce the adverse drug events (ADEs)
- Simplify the regimen to decrease the number of times the patient consumes medications daily

**Methods:** A pre-post design was used to evaluate the impact of using the consultation to optimize timing of medication doses for patients with ≥5 prescription medicines. Trained student pharmacists consulted patients. They documented the medication schedules before and after each consult, the number of drug timing changes they made which could improve efficacy and reduce ADEs and whether they reduced the number of times/day patients consume medicines. Patients were also asked if anyone had ever helped them in scheduling doses of their entire regimen daily.

**Results:** The regimens of 210 patients were evaluated. 82% of patients reported no one had ever helped them organize when to take all of their doses daily. All of these patients wanted such help. The students’ assessments of Pill-Card consultations on regimens were reviewed and validated by four independent clinical pharmacists with an overall 90% agreement that the pre-consultation daily regimens could have been improved. The post-intervention analysis found 33% of the regimens were simplified; 76% of the regimens had improved efficacy opportunities, and 56% had reduced risk of ADE’s.

**Pathways linking health literacy, beliefs, and cognition with medication adherence among older asthmatics**

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**Objective:** Low health literacy (HL), certain illness and medication beliefs, and cognitive dysfunction are each strongly associated with poor medication adherence among older asthmatics. We used structural equation modeling (SEM) to determine the pathways linking these risk factors with controller medication adherence.

**Methods:** Asthmatics ages ≥ 60 were recruited from hospital and community practices in New York City and Chicago for the Asthma Beliefs and Literacy in the Elderly (ABLE) study. Baseline data included HL, measured with the Short Test of Functional Health Literacy in Adults, controller medication adherence with the Medication Adherence Rating Scale (MARS), asthma beliefs with the Brief Illness Perceptions Questionnaire (BIPQ) and medication beliefs with the Beliefs about Medicines Questionnaire (BMQ). Measures of cognitive function included the Wechsler Memory Scale II (registration and delayed recall), Trails B (executive function), animal naming (word fluency), letter-number sequencing (processing speed), Mini-Mental State Exam (dementia screener). SEM was performed using MPlus.

**Results:** Among those prescribed an asthma controller (n=412), 36% had low HL, and those with low HL were more likely to have poor controller medication adherence: 78% vs. 53%, p<.0001. In an analysis that adjusted for patient age, sex, race/ethnicity, English proficiency and income, HL influenced adherence both directly (beta=0.09, p<.05), and indirectly via medication concerns (beta=0.21, p<.05), whereas it did not influence adherence through asthma beliefs or beliefs about medication necessity. Cognition lay outside the causal pathways. The model had good fit (CFI, 0.931; RMSEA, 0.051).

**Conclusion:** HL both directly and indirectly (via concerns about medications) influences medication adherence among older asthmatics. Self-management support interventions aimed at improving medication adherence should address medication related beliefs while applying communication strategies appropriate for low literacy populations.
Patient adoption of an internet based diabetes medication tool to improve adherence: A pilot study

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Introduction: Adherence to diabetes medications can facilitate positive health outcomes, but disparities exist by race/ethnicity and health literacy. A potential solution to reducing adherence-specific disparities in this population may be the use of mobile phones to deliver educational content, especially videos regarding common diabetes medication-related problems. This pilot study investigated the effect of a video intervention, MANAGING YOUR DIABETES MEDICINES (MYDM), on patient self-efficacy, problems with using medication, and medication adherence in a rural, mostly African American population.

Methods: Patients prioritized and watched one of nine 2-minute videos with a study research assistant at a clinic or pharmacy, and were given an access code to watch all the videos at their convenience. Self-efficacy was measured with the 19-item Diabetes Medication Self-Efficacy Questionnaire.

Results: Fifty-one patients were enrolled; 84% were African American and 80% were female, with a mean age of 54 years. Seventy-three percent watched at least one module after the initial visit. Improved medication self-efficacy was correlated (r=-0.64) with a decrease in concerns about medications. Patients who read at an eighth-grade or lower level experienced greater improvement in self-efficacy than more literate patients (r=-0.41, p=0.02). Patients’ mean number of problems declined from 6.14 to 5.03. The number of patients with high or medium adherence rose from 33% at baseline to 43% at 3-month follow-up.

Discussion: A practical, customized video intervention may improve patient self-efficacy, reducing problems with medication use, and improving medication adherence in at-risk diabetes patients.

Which questions elicit accurate disclosure of non-adherence when talking to patients?

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Introduction/objectives: Antiretroviral (ARV) medication adherence is critical for HIV-positive patients. This study evaluated how clinicians assess ARV adherence in clinical encounters and which questions elicit accurate responses.

Methods: We analyzed audio-recordings of encounters between 34 HIV providers and 58 patients reporting in post-encounter interviews that they had been non-adherent to ARVs within the past 3 days. We transcribed encounters, abstracted all provider questions about ARVs, and conducted a content analysis to characterize the types of questions used to assess adherence. We then evaluated the frequency with which each question type elicited accurate disclosure.

Results: We excluded 16 of 58 visits because in 8 encounters providers already knew about patient non-adherence prior to the visit and in another 8 encounters the patient disclosed non-adherence unprompted by providers. In the remaining 42 visits, 4 providers did not discuss ARVs (10%), 6 discussed ARVs but did not elicit an accurate disclosure of non-adherence (14%), and 32 discussed ARVs which prompted accurate disclosure (76%). In the 42 encounters, clinicians asked 75 ARV-related questions (mean 1.8 questions/visit). Questions were classified into 4 categories: 1) clarification of medication regimens ("Are you still taking the Combivir?"); 2) broad ("How’s it going with your meds?"); 3) positively-framed ("Are you taking your medications regularly?"); 4) negatively-framed ("Have you missed any doses?"). The 75 questions were classified as follows (disclosure rates in parentheses): 23 clarification (13%), 12 broad (33%), 17 positively-framed (29%), and 23 negatively-framed (87%). Negatively-framed questions were 3.8 times more likely to elicit an accurate response than all other question types (p=0.0001).

Discussion/implications: In this sample, most providers elicited accurate disclosure from their non-adherent patients, but a substantial minority either did not ask or did not elicit disclosure. Providers can improve the probability of disclosure by asking directly about missed doses.
Cancer Care

Communicating about living with cancer in Dutch walk-in homes

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Introduction: Walk-in homes are unique Dutch open facilities offering low-key support to cancer patients and family members. Volunteers help patients and relatives to communicate about the disease and living with cancer. In walk-in homes, visitors meet fellow patients, receive support from trained volunteers, and participate in a variety of stress-reducing activities. The number of walk-in homes did increase to more than 80 in 2014. Supported by the Dutch Cancer Society, it was investigated how visitors are referred to the walk-in homes, their participation and experiences in activities, the effects on quality of life, and how they evaluate their visit.

Method: A sample of visitors of 25 walk-in random selected homes filled out a web-based or postal questionnaire about their activities, received support and the evaluation of the facilities. Studied topics were: background characteristics of the visitors, received information, who did refer to the walk-in homes, their participation and experiences in activities, the effects on quality of life, and how they evaluate their visit.

Results: 711 cancer patients and their relatives (72% vs. 28%) filled out the questionnaire. Five percent of the visitors had been referred by general practitioners, 22% by psycho-oncology nurses, and 6% by medical specialists/oncologists. However, the majority of the visitors had been informed by their own network. Visitors participate is a lot of complementary and supportive activities. Visiting the walk-in homes contributed to a better psychological balance and reported quality of life. More than three quarter mentioned reduced stress levels.

Discussion: Visiting a walk-in house is a first help in a stepped-care model for psychosocial support. Walk-in homes are effective in reducing distress and raising quality of life as visitors report. This unique Dutch support facility needs studies on how to measure effects and to raise the number of referrals by medical professionals.

Considering patient values and preferences enhances patient involvement in rectal cancer treatment decision making

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Introduction: The shared decision making (SDM) model states that in preference-sensitive decisions, patients’ values regarding benefits and harms of treatment and patients’ treatment preferences should be clarified or elicited, in choosing a strategy that best fits the individual patient. The objective of this study is to assess the extent to which values and preferences of rectal cancer patients are discussed and considered when the decision about preoperative radiotherapy (PRT) is made, and whether this makes patients feel more involved in treatment decision making.

Methods: Pre-treatment consultations of radiation oncologists and patients eligible for PRT were audiotaped (N=90). Tapes were transcribed verbatim and coded using an adapted version of the ACEPP (Assessing Communication about Evidence and Patient Preferences) coding scheme to identify patients’ values concerning benefits and harms of PRT and their treatment preferences. Patients filled in a post-consultation questionnaire on their perceived involvement in decision making (N=60).

Results: Patients’ values were discussed in 38/90 consultations (42%), with maximum 4 values per consultation. Values were discussed for 10% of all benefits/harms addressed and most often related to major long-term treatment outcomes. Patients’ treatment preferences were discussed in 20/90 consultations (22%). In 16/90 consultations (18%), the oncologists explicitly considered patients’ values or preferences in deciding about PRT. Patients perceived a significant more active role in decision making if their values or preferences had been discussed or considered during the consultation.

Conclusions: Our results suggest that enhancing the discussion of patient values and preferences will increase patients’ perceived involvement in the decision making process, which brings empirical support to this step within the SDM model.
Discussion of Complementary and Alternative Medicine (CAM) in routine cancer care visits

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Introduction: Complementary and alternative medicine (CAM) use is common among cancer patients but oncologists are rarely consulted about it. It is widely suggested that the more patient-centered the visit the greater the likelihood that a CAM discussion would take place. However, little is known about the relationship between the overall patient-centeredness of cancer visits and the frequency and extensiveness of CAM discussions. This study explores these relationships.

Methods: 323 cancer patients (58% female; average age 61; range 22-90) and 38 oncologists were audio recorded during a routine cancer care visit. A companion was present in 69% of visits. Recordings were coded with the Roter Interaction Analysis System (RIAS) and participants completed pre- and post-visit questionnaires.

Findings: CAM was discussed in 37 (12%) visits; discussion was initiated by the patient and/or a companion almost twice as often as the clinician (65% vs 35%). Occurrence of a CAM discussion was not related to patient sociodemographic variables, pain severity or overall quality of life. In visits with CAM discussions (vs without), both patients and clinicians talked more and clinicians provided more psychosocial and biomedical information (p<.05); patients tended to disclose more psychosocial information (p>.06) and their global affect was judged as more anxious (p<.05). Mean visit length tended to be longer (33 vs 28 minutes; p<.06) with CAM discussions. Patients were more satisfied with their visit (p<.001) and clinician (p<.02) in visits with CAM discussions. More overall visit patient-centeredness was unrelated to the occurrence of a CAM discussion, but marginally related to the extent of CAM discussion (p <.09).

Conclusions: CAM discussions in cancer care visits are infrequent but associated with greater levels of patient satisfaction. The overall patient-centeredness of the visit is not associated with whether a CAM discussion takes place but it appears to facilitate fuller discussion once the topic is broached.

Multiple cancer risk reduction after BRCA1/2 genetic test disclosure: what about cigarette smoking?

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Purpose: This study aimed to measure patients’ smoking patterns for 5 years after BRCA1/2 test result disclosure.

Methods: A national cohort consisting of 621 French cancer-free women from families with BRCA1/2 mutations (mean age (SD):40.5 years (11.5 years)) were included from December 1999 to January 2006, before disclosure of genetic test results, and followed for 5 years. They completed self-administered questionnaires about their cigarette smoking behaviors before receiving their test results (baseline) and 6, 12, 24, and 60 months after disclosure. Multivariate statistical analyses of the changes in participants’ smoking behaviors were performed using a zero-inflated Poisson mixed model.

Results: Baseline smoking was found to depend on age, educational level, marital status, alcohol consumption, body mass index, and cancer risk perception. The zero-inflated part of the model showed the occurrence of no significant changes in the percentage of smokers during the 5 years after disclosure of the BRCA1/2 test results; however, daily smoking among BRCA1/2 carriers decreased significantly compared with that of non-carriers (adjusted hazard ratio = 0.83; (95% confidence interval: 0.69–0.99); P = 0.04) after adjusting for baseline smoking behavior.

Conclusion: It would be worth investigating the possibility of counseling women during the genetic testing process about the multiple risk factors involved in cancer, such as genetic and lifestyle factors.
Using a Question Prompt List to Increase Patient Active Participation in Racially Discordant Cancer Interactions

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Background: Cancer treatment disparities may in part be caused by poor quality communication in racially discordant patient-oncologist interactions. Question Prompt Lists (QPLs) have improved communication in oncology visits, but have not been tested with an underserved minority population. We report on a randomized controlled trial of a QPL designed to increase active participation among Black patients during oncology treatment visits. We hypothesized, first, that patients would react positively to the intervention and bring the QPL to the visit, and second, that the intervention would increase patient active participation and oncologist patient-centeredness during the visit.

Method: Black patients were recruited one week before visiting a medical oncologist to discuss treatment for breast, colon, or lung cancer at two cancer hospitals in Detroit, Michigan, USA. Patients were randomized at baseline into one of three conditions: usual care, QPL-only, or QPL+Communication Coach. Coaches assisted patients to identify questions they wanted to ask. Visits were video recorded and coded for presence/absence of the QPL, patient active participation, and aspects of oncologist patient-centeredness. Conditions were compared with regressions using General Estimating Equations.

Results: A total of 104 patients of 20 oncologists participated. Intervention patients reacted very positively to the intervention (e.g. it was helpful; useful). The QPL was present during 30% (n=12) of visits with patients in the QPL-only condition and 58% (n=18) in the QPL+Coach condition. QPL-only patients used more assertive statements (M=5.11, SE=.72) than control patients (M=3.24, SE=.80; p=.02) and were rated as more active (M=3.63, SE=.10) than control patients (M=3.33, SE=.14, p=.05). Oncologists of QPL+Coach patients were rated higher on in formativeness (M=3.99, SE=.10) than oncologists of control patients (M=3.76, SE=.14; p=.04).

Discussion: The intervention is acceptable and effective in a population of Black patients with cancer. Future research should explore the effects of the intervention on other aspects of the interactions and on outcomes.

Perspectives of patients and physicians on communication during adjuvant hormonal therapy

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Introduction: Adjuvant hormonal therapy (AHT) significantly improves long-term survival of breast cancer patients. However, many breast cancer survivors fail to take the dosage at the prescribed frequency or discontinue therapy. Primary study objectives were to: 1) assess patients’ and physicians’ experiences regarding AHT; 2) examine patient/physician communication during AHT; and 3) explore perceptions of an intervention aimed to promote adherence.

Methods: Patients and physicians were recruited from four oncology clinics located in various regions of the U.S.: Midwest, Northeast, and two clinics in the Southeast. Focus groups (n=3) were conducted with patients who previously experienced AHT and one-on-one phone interviews (n=10) were conducted with oncologists. All transcripts were coded in NVivo independently by two staff members who reviewed all nodes and reached consensus when discrepancies. After transcripts were coded, themes were identified. A node was classified as a theme if it was reported more than once in at least one focus group and/or was mentioned by two or more oncologists during interviews.

Results: Physicians reported encouraging open communication and monitoring symptoms throughout the course of treatment. Adherence to AHT was promoted by offering pill-taking strategies. Most physicians believed the intervention would be beneficial and offered useful feedback. Patients with more severe symptomatology reported communicating with physicians to establish methods for alleviation. Some temporarily discontinued or switched medications midway through treatment in an effort to assuage symptoms. The lack of reprieve from symptoms and/or mistrust of physicians were cited as sources of adherence difficulties. A number of patients believed the intervention would have been helpful, while some were unsure regarding its effectiveness.

Discussion: Data from patient focus groups and physician interviews provided valuable information that was integrated into our intervention. Content was primarily incorporated into a video that patients view prior to the start of AHT. Large-scale research is needed.
Communication Training with Oncology Trainees: Results of a 4-year study

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Introduction: Preparing oncologists to communicate with cancer patients is an important component of their training. Previous U.S. studies have shown significant skill uptake in a nationwide training. A limitation of this approach is its inattention to the hidden curriculum - the implicit learning that happens outside of a classroom through role modeling and transmission of cultural norms. It is also unclear whether skill uptake transfers to real clinical encounters. The purpose of this NIH-funded study was to evaluate a 4-year, institution-based communication training program for oncology trainees.

Method: 264 fellows and residents at Memorial Sloan Kettering Cancer Center (USA) participated in the Comskil Training Program during 2010-14. To address the hidden curriculum, instructors for the course included multi-disciplinary faculty from the training programs. Trainees were assessed through: (1) self-efficacy questions; (2) pre- and post-course video recorded consultations with SPs and real patients; and (3) pre- and post-course assessments of trainees’ communication skills by both SPs and real patients. Videos were analyzed using the Comskil Coding System, which codes for the 20 communication skills (in 5 categories) taught during the program.

Results: There were large significant differences between pre- and post-training self-efficacy ratings (p<.001). Participants increased their skill usage with SPs between pre- and post-training in 4 of 5 skill categories (p<.01); and SP ratings of trainees’ communication skills showed significant differences in 14/17 items (p<.01). Preliminary analysis of clinic consultations showed no differences; only 1/22 items on the patient survey showed a significant change.

Discussion: Our study confirms that communication training interventions for oncology trainees clearly have an impact on skills when measured in standardized settings. In clinical settings, either the differences were not sustained, or we were unable to capture them using our methods. Booster courses and coaching interventions may be necessary to produce sustained change.

The influence of patient treatment goal and oncologist patient communication on patient decision conflict

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Jeffrey Albert, Case Western Reserve University

Introduction: Many patients decide to treat advanced cancers aggressively even though treatment outcomes can be highly uncertain. This can be challenging to patients who may attempt to reduce their uncertainty by asking questions and seeking confirmation of desired outcomes from their oncologists. We investigated this communication dynamic within the context of early stage solid tumor advanced cancer.

Methods: Women newly diagnosed with advanced or recurrent solid tumor cancers were recruited to participate in a prospective observational study of oncologist patient communication. Settings included an academic cancer center and a cancer clinic in a safety net medical center. Following baseline survey interviews, encounters between medical oncologists (n = 14) and their participating patients (n = 79) were audio recorded and transcripts were coded for instances of oncologist acknowledgement and patient unsolicited questioning. Patient reported demographics (age, education), well-being, treatment goal, and communication variables were used to predict patients’ treatment decision conflict.

Results: Hierarchical linear regression produced a significant model overall (R = .62; df = 56, p < .019) that explained .38 of the variance in patient decision conflict. Predictor variables were entered in four blocks that included demographics and well-being, treatment goal, clinician acknowledgement and patient (unsolicited) questions. Patients who reported a more aggressive treatment goal, asked more questions, and had oncologists who provided less acknowledgement reported greater decision conflict.

Implications: The high uncertainty of cancer treatment paired with a strong desire for aggressive care can be a significant driver of oncologist patient communication during encounters. It is important for clinicians to explore the spectrum of treatment options with their patients early on and address treatment uncertainties in realistic but supportive ways.
Are late effects following childhood cancer treatment reflected in emotional concerns expressed during follow-up consultations with adolescent survivors and pediatric oncologists? A video-based observational study

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Introduction: Childhood cancer survivors face many challenges following treatment completion, including experiencing, or increased risk of, late effects; health problems resulting from the cancer or its treatment. To what degree late effects are associated with expressions of emotional concerns by adolescent survivors attending follow-up consultations is not known.

Methods: Video-recordings of 66 follow-up consultations between 10 pediatric oncologists and 66 adolescents, aged 12-20 years, treated for leukemia (72.7%), lymphoma (21.2%) or received hematopoietic stem-cell transplantation for a benign disease (7.6%) were analyzed for overlap between discussions about (potential) late effects and expressions of emotional concerns. The patients were consecutively recruited. Previous studies on the same data-material identified 264 discussions of late effects, and 115 expressions of emotional concerns using the VR-CoDES scheme, across 85% and 50% of the consultations respectively.

Results: The number of late effects expressed and the number of emotional concerns expressed was significantly positively correlated across the consultations (r=0.30, p=0.013). Of the 264 utterances coded as potential late effects, 19% were also coded as emotional concerns. Of those utterances coded as emotional concerns, 49% were also coded as potential late effects. Of the overlapping late effects and emotional concerns, 86% were of a psycho-social nature, with fatigue, psychosocial distress, cognitive/school problems and pain being the most frequently overlapping themes.

Discussion/implications: Potential late effects appeared to be associated with emotional concerns for childhood cancer survivors. The potential late effects most often corresponding with expressed concerns were of a psychosocial nature, likely to influence everyday functioning and ability to achieve developmental goals. Eliciting and exploring patients’ emotional concerns as advocated in the patient-centered framework, would not only serve the purpose of providing emotional support, but may also provide clinically relevant information regarding underlying health problems and adjustment to life after cancer.

Confirming Oncologist Communication Predicts Patient Participation in Early Stage Advanced Cancer Encounters

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Introduction: The time between receiving a diagnosis of advanced cancer and beginning treatment can be disorienting for a patient, challenging clinical communication. The Communication Model of Healthcare Decision Making holds that confirming clinician relational communication can positively influence patients’ participation in a given encounter, thus increasing the opportunity for shared decision-making. Confirmation, or communicating acceptance or regard for another’s experience, is a known predictor of positive affect and interactivity. This hypothesis was tested in clinical encounters in the first months following a diagnosis of advanced cancer.

Methods: Women receiving treatment for advanced cancer at an academic cancer center and a safety net cancer clinic participated in the study. Following baseline interviews, encounters between participating patients (n = 79) and their medical oncologists (n = 14) were audio recorded and coded for instances of oncologist relational communication (i.e., acknowledgement/reassurance) and patient participation (i.e., assertions, unsolicited questions, concerns). Patient reported demographics and physical well-being were included in the model.

Results: Hierarchical linear regression produced a significant model overall (R = .79; df = 61, p < .037) that explained .58 of the variance in patient participation. Predictor variables were entered in four blocks that included demographics, duration of the encounter, physical well-being, and clinician relational communication. Clinician confirmation (β = .27, r²=.04, p < .01) remained a significant predictor of patient participation after controlling for all other predictors.

Implications: During the early stage of advanced cancer treatment, positive relational communication can contribute to a communication climate where patients feel able to ask questions and voice concerns. Clinicians can use simple confirming communication strategies to encourage patient communication involvement, which will likely uncover important patient preferences and values.
Discourse Analysis

Triadic interaction in the dental encounter: dynamic alliances between the dentist, the dental nurse, and the reluctant patient

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Aims: We aimed to consider the nature of interaction in a dental surgery, initially with reference to the traditional ‘dyadic’ paradigm of communication, which considers the dentist as the central participant. Our focus was on the contribution of all participants, and how the interactional dynamic of the dental visit might influence the patient’s engagement in the process.

Materials and methods: As part of a larger discourse analysis study of twenty-two ‘treatment groups’ involving different combinations of dentists, nurses, and patients, the analysis of talk in interaction from one such treatment group is the focus for this paper. The analysis is focused on the linguistic notions of ‘footing’ and ‘participation framework’, which can be described as the alignments people take up to each other in interaction (e.g. what is being said, and by whom). Such an analysis enables the participants’ shifting roles to be mapped in the interaction thus giving an idea of what is going on and what is being achieved in the talk.

Results: On analysis, the interaction is described as interplay of shifting alliances, with the dental nurse assuming a central role. The nurse is shown to align herself with the patient, and the patient consequently appears to show greater involvement in the interaction. By departing from the anticipated team-role of supporting the dentist, the dental nurse establishes a distinct role in a ‘triadic’ interaction.

Conclusions: Many dental interactions involve a trio of dentist, nurse and patient, and many patients are anxious about their treatment. An interactional approach to researching communication in dentistry appears to facilitate a new perspective, triadic interaction, with implications for further research in health promotion, in patient engagement and in interprofessional collaboration.

‘Moderation is key’: the problems of assumed shared understandings of lay terms

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This study uses the Homogeneity Hypothesis of lexical access to analyze how and to what extent a non-medical term such as ‘moderation’ is understood between interlocutors in health care provider-patient interactions. The hypothesis acts as a model that can explain the process through which humans produce and comprehend words. This study demonstrates that the term ‘moderation’ is commonly used in interactions related to chronic illness. Because ‘moderation’ is not identified as a medical term, interactants assume shared knowledge of the word’s meaning. Our analysis suggests ‘moderation’ has become medicalized and an assumed, shared understanding of its meaning may lead to miscommunication. Data indicate a misalignment of conceptual understanding for words such as ‘moderation’.

Terms such as ‘moderation’ represent a quantification of an amount or frequency with which substances are consumed or activities are conducted. Because of the qualitative aspects of the term, changes in quantity or frequency due to varying understandings of the term and concept of ‘moderation’ can change idiosyncratically depending on a given substance or activity and possibly from person to person. We will argue that even when replacing jargon with lay terms only changes the surface form of words, and not the specific meaning health care providers may have in mind. When interpreting lay terms, patients will select a meaning that may not align with the intended meaning of the health care provider. However, sometimes neither interlocutor is aware of the misalignment. In this case study, we show examples of when interlocutors appear to align and misalign but proceed as though a shared sense of understanding exists.

Conversational closings in the human-computer interface in doctors’ consultation

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Background, Significance and Aims: Several studies have shown that patients often bring last minute concerns into play at the end of a medical interview. Such research on closings in a medical context, however, has assumed that medical interviews are dyadic and has not considered the impact of the computer presence as a third party during this stage of the interview. With the introduction of computers into the exam rooms, the study of closings must be revisited. In this paper, we examine the sequential organization and dynamics of the closings between doctor, patient and computer.

Methods: Encounters between the patients and their physicians were video-taped and then transcribed. The transcribed interviews supplied the raw data for the study and allowed primary data analysis to be performed. Discourse-based studies such as Conversation Analysis provided much of the foundation for the analysis.

Results: The majority of medical closings involved providers shifting focus of attention from the patient to the computer. Last minute concerns raised after the closing has been initiated could be triggered by the computer itself. For example, computers’ onscreen prompts compel the provider to attend to that issue before closing. Patients may bring up last minute concerns that providers need to address by consulting the computer. Finally, patients’ concerns brought up after the doctor has logged off the system are sometimes postponed for next visits.

Summary: The presence of the computer adds additional dimensions of interactional asymmetry during conversational closings which might affect patient satisfaction and compliance. These dynamics
thus warrant further investigation to optimize patient-physician interaction.

Understanding Patient Physician Communication and turn-taking patterns with directional microphone arrays

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**Background:** EMR systems can influence the nature of the patient-physician relationship by impacting how they interact and communicate. In order to better inform the design of future EMR interfaces, we must understand the complex nature of current physician-patient-EMR interactions across modalities. Often such insight is gained through costly and time-consuming manual coding of patient-physician encounters. Therefore, along with our infrastructure for capturing video, eye-tracking, body-motion and EMR activity, we developed methods for utilizing directional microphone arrays during real-world clinical encounters to accelerate segmentation and coding of patient-physician communication patterns.

**Methods:** We collected data from 17 physicians across 116 outpatient visits at the VA San Diego and UCSD from a multitude of sensors deployed unobtrusively into the clinical environment. In particular for this analysis we looked at the Microsoft Kinect sensor and the Dev-Audio Microcone directional microphone. Audio from these visits was manually coded through a two-pass method to segment who was talking (physician, patient, patient companion), and later compared with the automatic sensor-based segmentation.

**Results:** Preliminary results show promise that technology can aid in the acceleration of segmentation of physician-patient communication patterns. While Kinect audio range is limited to a 100° arc in front of the device, it provided roughly 65% segmentation accuracy. The Microcone, a 360° microphone array, provided roughly 75% accuracy.

**Conclusion:** A mix of signal processing techniques for angle classification based on data from directional microphones shows great promise towards reducing the need to manually code audio/video files. Next we plan to explore sensor fusion of these two audio devices with additional sensors capturing other modalities (i.e. body positioning) in order to further improve segmentation accuracy. With these early findings we hope to encourage others in this space to consider the adoption of ever-improving sensing systems to accelerate research and data analysis.

Qualitative Research

A Qualitative Exploration of Muslim Women’s Perspectives in Access to Health Care in the United States

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**Objectives:** The purpose of this research was to gain better understanding of the barriers experienced by the immigrant Muslim women in Columbia, Missouri in accessing healthcare services.

**Methods:** A qualitative methodology was used to collect in-depth information from the immigrant Muslim women in Columbia, Missouri. Interview questions about experiences with healthcare related services in the U.S were developed; the topics of these questions included: the availability of healthcare provider, past experiences and future plans for dealing with health issues, communication with the healthcare team and other cultural issues in health, faced specifically by Muslim women. Using the snowball sampling technique, 29 Muslim women were interviewed. Qualitative data analysis was guided by grounded theory. After the data was collected, the recurrent themes were identified, and grouped into major categories for the purpose of analysis.

**Results:** Three major themes emerged from all Muslim women’s interviews: access to healthcare, cultural competence around delivery of care, and the health literacy. Access to health care was the main problem among most of the participants. It was attributed to lack of information about services like; urgent care clinics, department of health or family health centers, access to an interpreter, and financial aid. All participants described their need for culturally competent healthcare providers that would enhance the delivery of health services, treatment and preventive care. Health literacy was low among most of the participants. It was attributed to more information about the role of the family physicians, nurse practitioner, and particularly services for women and children. Moreover, awareness about patients’ right to confidentiality, changing providers, seeking second opinion, and refusing treatment or procedure was lacking.

**Conclusion:** This qualitative research project displays that the immigrant Muslim women in Columbia, Missouri face several barriers in accessing health related services. Through this exploratory study, we were able to determine a number of key issues that influenced their experiences in dealing with health problems. Lack of information about the health care structure, cultural competence around the care delivery, and health literacy were the major barriers highlighted in this study.
Exploring the role of health literacy in the evaluation of the quality of online health information: Insights from a qualitative study

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Introduction: Health literacy has been proven to play a crucial role in how people find, understand and use health information. Less is known about the impact on the evaluation of online health information, a crucial aspect in today’s complex online health information environment. Although past research suggests that people with different health literacy levels use different criteria to evaluate online health information, the extent to which they differ and whether this impacts on their information quality evaluation has not been investigated so far.

Methods: To gain insights into how health literacy is related to quality evaluation of online health information, a series of qualitative interviews was conducted among high (n = 21) and low health literate individuals (n = 23). Participants were asked to describe a recent online search for health information and elaborate on how they evaluated it and on the evaluation criteria they used.

Results: The thematic analysis of the interviews highlighted a lack of awareness among both low and high health literate participants of the issue of online health information quality and a heavy reliance on evaluation criteria not recognized as valid by existing web quality guidelines. Low health literate respondents, despite perceiving themselves as more skilled in evaluating online health information than their high health literate counterparts, reported more often relying on non-established criteria than on valid ones, indicating an overestimation of their information evaluation skills.

Discussion: Our results suggest that low health literacy might impact on people’s evaluation and subsequent acceptance of online health information through a different use of evaluation criteria among people with different health literacy levels. Future research should quantitatively assess the interplay between health literacy, use of evaluation criteria, and evaluation of the quality of online health information. Communication efforts should be devoted to raise awareness to the issue of online health information quality and to promote the use of established evaluation criteria.

Keywords: online health information; health literacy; information quality

Opening the door for communication: A descriptive study of chaplain documentation in the intensive care unit

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Introduction/objectives: Addressing a patient’s spiritual concerns is considered a critical component of patient care, emphasized by the biopsychosocialspiritual model. This is particularly salient in the intensive care unit (ICU), where patients’ and families’ spiritual concerns often drive end-of-life decisions. Hospital chaplains are professionally trained to attend to patients’ spiritual concerns.

Discussion/implications: As members of the patient care team, chaplains may access the medical record to communicate clinically relevant information. The present study suggests that recent emphasis on evidence-based practice may be leading chaplains, at least in the medical center we studied, to use reduced, mechanical language insufficient in illuminating patients’ individual stories. We hope this study will promote further consideration of how chaplain documentation can enhance patient care and convey the unique value that chaplains add to the clinical team.
Use and effect of digital audio recordings in four different outpatient clinics

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Introduction: In previous research tape recording of health consultations has been proven beneficial for cancer patients. Our aim was to investigate a new technology of digital audio recording in routine practice to provide knowledge about patients' use, evaluation and effect of this recording method.

Methods: A total of 4,350 patients were included in a three-armed randomized-controlled trial. One group of patients served as a standard care control group, while the other two groups received either digital audio recording in combination with a Question Prompt List or merely the recording. Audio recordings were conducted by 49 health professionals from the following four specialties: Pediatrics, Orthopedics, Internal Medicine and Urology. Evaluations were based on data from the recording platform and a patient-administered questionnaire. The main outcomes were: Usage of the audio recording, evaluation of the technology and patient experienced effect. Data analysis was conducted using mixed-effects models.

Results: One in every three consultations was replayed; however, the rates were significantly lower in the pediatric clinic where only one in five consultations was replayed. Usage of the audio recordings was positively associated with increasing patient age and first time visits to the clinic. Patients receiving audio recording were less likely to lack information in the subsequent period after the consultation.

Discussion/implications: Digital audio recording technology of health consultations is feasible in routine practice, appreciated by the patients and shown beneficial in terms of information retains. Implementation of the technology in routine practice should be considered.

The Racialization of Disease: A qualitative and quantitative study of race and ethnicity in biomedical research

Author: Francine Small, Frank Consulting

Background: There have been published guidelines covering the use of the terms “race” and “ethnicity” in biomedical research since 2008. They are based on the consensus opinion of genetic researchers and reject any strong biological association/difference between classic racial groups. The inappropriate linkage of race/ethnic groups to cause and/or effect in biomedical research can influence guidelines, policy and ultimately care. This wrongly assumes race (appearance) to be a surrogate marker for biology/genetics. This clearly ignores the well described socioeconomic impact on health care access disproportionately experienced by visible minorities in the United States. This disparity in access to care should be disproven as an explanation for health outcomes before a biologic explanation is offered.

Methodology: This research will determine to what degree the recommendations for the use of “race” and “ethnicity” within biomedical publications has been followed. Publications from 01/01/14 to 01/12/14 were retrieved through Pubmed and selected if the terms “race” or “ethnicity” appeared in the title or abstract. These selected papers were then examined to determine if they stated: a reason for the use of racial categories, whether “race” or “ethnicity” had been defined and associations between race/ethnicity and medical outcomes.

Results: The analysis of the publications revealed that only 4.5% of 224 surveyed papers defined the racial or ethnic groups they used, while at the same time 49% of the papers associated a medical outcome to these undefined racial or ethnic groups.

Conclusions: These results suggest that despite guidelines for the use of the terms “race” and “ethnicity” in biomedical research authors and editors in/of biomedical journals are neither using nor enforcing the use of them respectively. Further research should investigate the health disparities and negative outcomes associated with not adopting the guidelines at a health provider level.

Key Words: Race, Ethnicity, Biomedical Research

Research in Progress

Analysis of adherence notes from a service-oriented community pharmacy

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Introduction/objectives: Medication non-adherence is a significant public health concern with an estimated cost of $300 billion in the U.S. alone. Community pharmacists are well-positioned to intervene, but little is known about how pharmacists approach adherence in practice. The objective of this exploratory study is to classify and quantify medication adherence notes documented by a community pharmacy.

Methods: A service oriented community pharmacy in the Midwest United States developed a computer-based documentation system to augment the prescription dispensing process. This system calculates a 90 day adherence rate and gives the pharmacist a structured space for documenting interventions. A dataset of 3,500 of these notes tagged “compliance” was obtained from September 1, 2014 through February 28, 2015. A retrospective chart review is ongoing. Each note is categorized with a descriptive code. Additional variables include a patient identifier, the drug, whether the patient was counseled, or if the prescriber contacted.
Implementing CollaboRATE in primary care: an interim analysis

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Introduction: CollaboRATE is a patient-reported measure of shared decision making (SDM) developed for use in routine practice. The aim of this study was to assess the impact of delivery mode on CollaboRATE scores, response rate, and representativeness of the respondent population.

Methods: All adult patients visiting a primary care clinic in Lebanon, NH were eligible to receive CollaboRATE within 24 hours of the clinical encounter via one of five modes: 1) paper in clinic, administered by staff; 2) online patient portal; 3) Interactive Voice Response call; 4) text message; and 5) tablet computer in clinic, administered by research assistant. Each mode was introduced for up to three months with data collection beginning in April 2014. For each mode, we calculated the response rate, respondent socio-demographic representativeness, and the rate of SDM reported.

Results: We have completed paper and portal delivery and anticipate completing remaining modes by September 2015. During paper delivery, 542/4692 patients (11.6%) completed the survey. During portal delivery, 1019/4939 patients (20.6%) completed the survey, which represented 1019/3015 patients with portal accounts (33.8%). The respondent population was representative of the patient population on gender for paper and portal delivery. Respondents were older than non-respondents in both modes. In paper delivery, the rate of SDM reported was 80.8%, ranging from 72.3%-93.2% per clinician. In portal delivery, the rate of SDM reported was 71.2%, ranging from 58.9%-82.8% per clinician. While a significantly higher rate of SDM was reported in paper delivery than portal delivery (x2(1)=16.57, p=<0.0001), the rank order of clinicians by rate of SDM reported was similar across the modes.

Discussion/Implications: Many of these adherence notes were prompted by automatic notification that the prescription was late. A majority of notes dismissed these alerts. Given the research demonstrating patients commonly are non-adherent due to beliefs about medicines, pharmacists may be missing opportunities to help patients with adherence rather than accepting explanations for technical reasons for non-adherence.
Vaccination

Assessing Seniors Normative Beliefs and Sharing of Health Information about the Pneumococcal Vaccination

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Stephen Persell, Northwestern University Feinberg School of Medicine
Kenzie Cameron, Northwestern University Feinberg School of Medicine

Introduction/Objectives: Normative beliefs are perceptions of how the population behaves (descriptive norms) and how one believes the population should behave (injunctive norms). We measured normative beliefs, explored differences by race and receipt of the pneumococcal vaccine (PnVx), and assessed if patients discussed pneumonia/PnVx with anyone following a clinic visit.

Methods: English-speaking patients age 65-66 with no previous documentation of receipt or refusal of PnVx completed a telephone survey 1 week following a visit to an academic general internal medicine clinic. We created a 3-item descriptive norm scale (α= 0.79) and a 4-item injunctive norm scale (α= 0.69); participants responded on a 5-point Likert scale.

Results: Participants (N=73) were 63.0% female, 35.6% Black, 56.2% White; 94.5% had some college education. By self-report, 52.1% of participants received PnVx with no variation by race. White participants agreed more that “people think it is a good idea to get PnVx” (3.73 vs 2.92, p<0.05) and “my family members have gotten PnVx,” (2.76 vs. 3.55, p<0.05), compared to Black participants, but no overall differences in either injunctive or descriptive norms were identified. Compared to participants who did not receive PnVx, those receiving PnVx were more likely to agree that “My doctor thinks I should get PnVx” (4.87 vs 4.37, p<0.05) and discuss pneumonia and PnVx with others (X2=8.30, p=0.016). Over half (56.2%) of patients were unaware that Medicare covered PnVx.

Discussion/Implication: Our findings suggest that factors other than injunctive and descriptive norms are driving vaccination behavior; physicians may consider focusing on perceptions such as patients’ susceptibility to pneumonia, clearly communicating the need for vaccination, and ensuring patients know PnVx is covered by Medicare. Based on our results indicating those patients who received PnVx were likely to discuss PnVx with others, future research should assess how best to utilize social networks to improve PnVx rates.

Attitudes of parents toward their sons receiving HPV vaccine

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Introduction: The Human Papilloma Virus (HPV) is a sexually transmitted infection that can lead to cancer in men and women. The Food and Drug Administration (FDA) approved a vaccine to prevent strains of the virus in girls in 2006 and for boys in 2009. Healthy People 2020 calls for vaccination rates for males and females to be at 80%; however, currently only 32.7 % percent of females and 13.5% of males have received three doses of the vaccine. Extant research focuses on parental barriers toward daughters receiving the vaccine. Therefore, the purpose of this study is to understand parental attitudes toward the vaccine for sons.

Method: An online survey was used, which included open-ended questions and the Parental HPV Scale (Thomas et al, 2013). This instrument uses the Health Belief Model (Janz & Becker, 1984) to measure perceived vulnerability, perceived severity, perceived benefits, and perceived barriers towards HPV vaccination.

Results: A total of 185 participants took the survey. Thirty-two percent of participants reported their sons had received the HPV vaccine and 60 % reported they intended to have their sons vaccinated. Parents in this sample lacked accurate knowledge about HPV transmission and consequences. For example, only 26 % of respondents recognized that condoms are not effective at stopping the spread of HPV. Eighty-five percent of respondents correctly identified that HPV can cause cervical and anal cancers in women; however, only 49 % of respondents correctly identified that HPV leads to penile, anal and testicular cancers.

Conclusion: Parents in this sample lack knowledge regarding HPV, including the availability of a vaccine for boys. However, many are in favor of receiving information from their doctor and intend to vaccinate their children based on their healthcare provider’s recommendation.

Table 1 - How parents feel about the HPV vaccine for their sons

<table>
<thead>
<tr>
<th></th>
<th>Disagree/slightly disagree %</th>
<th>Unsure %</th>
<th>Slightly agree/agree %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children should only get vaccinated for serious diseases</td>
<td>53</td>
<td>1</td>
<td>46</td>
</tr>
<tr>
<td>I am more likely to trust vaccines that have been around a while</td>
<td>19</td>
<td>4</td>
<td>76</td>
</tr>
<tr>
<td>Vaccinations are getting better all the time because of research</td>
<td>11</td>
<td>17</td>
<td>72</td>
</tr>
<tr>
<td>Healthy children do not need vaccinations</td>
<td>91</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>HPV is a sexually transmitted disease</td>
<td>7</td>
<td>8</td>
<td>84</td>
</tr>
<tr>
<td>Using condoms can prevent HPV</td>
<td>26</td>
<td>22</td>
<td>53</td>
</tr>
<tr>
<td>Genital warts are caused by HPV</td>
<td>8</td>
<td>26</td>
<td>65</td>
</tr>
<tr>
<td>People with HPV might not have symptoms</td>
<td>0</td>
<td>13</td>
<td>87</td>
</tr>
<tr>
<td>HPV makes you unable to have children</td>
<td>38</td>
<td>36</td>
<td>26</td>
</tr>
<tr>
<td>I worry my child may get HPV</td>
<td>36</td>
<td>16</td>
<td>47</td>
</tr>
<tr>
<td>HPV can cause cervical and anal cancers in women</td>
<td>0</td>
<td>15</td>
<td>85</td>
</tr>
<tr>
<td>HPV can cause penile, testicular and anal cancers in men</td>
<td>6</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Treatment for HPV is painful</td>
<td>17</td>
<td>60</td>
<td>24</td>
</tr>
<tr>
<td>I would vaccinate my son with the HPV vaccine if it were free or low cost</td>
<td>22</td>
<td>15</td>
<td>63</td>
</tr>
<tr>
<td>I would vaccinate my son with the HPV vaccine if he could get it at school</td>
<td>36</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>Required vaccinations protect children from getting disease from unvaccinated children</td>
<td>16</td>
<td>5</td>
<td>78</td>
</tr>
<tr>
<td>I understand what the HPV vaccine is for</td>
<td>13</td>
<td>14</td>
<td>73</td>
</tr>
<tr>
<td>A vaccine against HPV could prevent future problems for my son</td>
<td>16</td>
<td>17</td>
<td>67</td>
</tr>
<tr>
<td>Giving my child a new vaccine is like performing an experiment on them</td>
<td>59</td>
<td>6</td>
<td>35</td>
</tr>
<tr>
<td>Most people I know think vaccinating children against HPV before they are teenagers is a good idea</td>
<td>23</td>
<td>39</td>
<td>38</td>
</tr>
<tr>
<td>A teenager should be able to get a vaccination for HPV without a parent’s consent</td>
<td>53</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Having genital warts makes it very difficult to find a partner</td>
<td>18</td>
<td>27</td>
<td>56</td>
</tr>
</tbody>
</table>

If this new HPV vaccine was available when my son was an infant, I would have vaccinated him | 38 | 26 | 35 |

Shots are very painful for my child so I would rather not vaccinate him | 93 | 3 | 3 |

If the HPV vaccine is not required, I will not vaccinate my son | 60 | 15 | 26 |

I think that even if the vaccine is expensive I will be able to vaccinate my son | 19 | 20 | 61 |

My closest friends are vaccinating their sons against HPV | 17 | 64 | 20 |

Generally, I do what my doctor recommends, so I would vaccinate my son against HPV | 24 | 10 | 66 |

I feel confident I can get my son the vaccine if or when I want to have him vaccinated against HPV. | 5 | 13 | 82 |

Direct versus qualified HPV vaccine recommendations: How providers’ communication style might influence their recommendation

Authors: Jasmin Tiro, University of Texas Southwestern Medical Center
Emily Marks, University of Texas Southwestern Medical Center
L. Aubree Shay, University of Texas School of Public Health
Donna Persaud, Parkland Health and Hospital Systems
Richard Street, Texas A&M University
Simon Craddock Lee, University of Texas Southwestern Medical Center
Austin Baldwin, Southern Methodist University

Background: Professional organizations encourage providers to routinely and strongly recommend the HPV vaccine because provider recommendation is a key determinant of parental decision-making. Less clear is what constitutes a “strong” recommendation.

Objective: We characterized how providers make recommendations and engage patients in a discussion and decision about the HPV vaccine.

Methods: We used the electronic health record (EHR) to identify unvaccinated adolescents ages 11-17 with upcoming appointments at any one of six pediatric safety-net clinics in Dallas, Texas, USA between July 2014 and May 2015. Bilingual staff invited parents who were undecided about the HPV vaccine to participate by allowing their clinic visit to be audio recorded. We are coding physician and nurse statements during HPV vaccine discussions in terms of: making
a recommendation, rationale, partnership building, and supportive talk (Street, 2001). Thematic analysis to illustrate differences between a direct versus qualified recommendations is ongoing.

Results: We have analyzed 50 HPV vaccine discussions conducted in either English or Spanish between parents and 12 providers. Although nearly all providers discussed the vaccine and engaged in partnership building, strength of the recommendation varied. Few providers made direct recommendations, defined as a strong suggestion that was personally owned (e.g., “I really recommend it now because the sooner you get it the more immunity you start to build up.”) Most of the providers qualified their recommendation by using third person/passive voice or coupled it with a disclaimer (e.g., “so it’s highly recommended for him to get it but it’s not required for school”).

Conclusion/Implications: With the push against paternalism in medicine, providers may believe that including disclaimers about the HPV vaccine is necessary for informed decision-making, resulting in only qualified recommendations for a preventive service that has a strong evidence base. Future research should explore whether providers’ strength of recommendation affects HPV vaccine uptake.

Towards the development of a psychological empowerment scale in the context of the MMR vaccination decision making. Results from a focus group study.

Authors: Marta Fadda, University of Lugano
Peter J. Schulz, University of Lugano

Introduction/Objectives: Despite being committed to the immunization agenda set by the WHO, Italy is experiencing a decrease in vaccination rates and a rise in the incidence of vaccine-preventable diseases such as measles. Previous work has speculated that parents’ refusal to have their children vaccinated might be due to a high level of empowerment coupled with inaccurate information on the immunization (Schulz & Nakamoto, 2013). The current research project investigates the concept of parental psychological empowerment as a potential driver in the MMR vaccination decision. The main goal is to gain insights from parents residing in a low MMR coverage area in Italy, in order to explore, conceptualize, and ultimately measure psychological empowerment in the context of such a decision through a self-report scale.

Methods: We held six focus groups with twenty-eight parents of at least one child under the age of twelve months residing in the Province of Trento (Italy). Recruitment was conducted through the local vaccination centers. Both pro- and anti-vaccination parents took part in the study. During the interviews, parents were asked to report their opinion on a number of themes including vaccination competence, parental agency, and information-seeking in the context of the MMR vaccination. Participants then filled out a brief questionnaire assessing their knowledge of childhood vaccinations to operationalize vaccination literacy and a number of socio-demographic variables.

Results: Interviews were transcribed verbatim and thematically analyzed by three coders taking an inductive approach. Results were grouped around five main themes: i) defining competence, ii) fallacy of autonomy, iii) agency through knowledge, iv) the role of the pediatrician in shaping parental self-confidence, and v) need for a vaccination mediator.

Discussion/Implications: To understand what empowers parents in their decision to immunize their children against measles-mumps-rubella will inform the development of an empowerment scale as well as healthcare providers and policy-makers who may in turn incorporate this data when providing accessible and tailored information.

Active Parental Communication during Parent-Provider Discussions about HPV

Authors: Emily Marks, UT Southwestern Medical Center
Austin Baldwin, Southern Methodist University
Simon Lee, University of Texas Southwestern Medical Center
L. Aubree Shay, University of Texas School of Public Health
Donna Persaud, Parkland Health and Hospital Systems
Richard Street, Texas A&M University
Sobra Fuller, Parkland Health and Hospital Systems

Background: HPV vaccine uptake lags behind other recommended adolescent vaccines partly due to parental hesitation and refusal. Poor uptake among underserved populations will exacerbate existing HPV-related cancer disparities. Few have examined how underserved parents express HPV vaccine hesitation and concerns to their provider.

Methods: Staff reviewed the electronic health record (EHR) to identify unvaccinated adolescents ages 11-17 with upcoming appointments at any one of six pediatric safety-net clinics in Dallas, Texas, USA between July 2014 and May 2015. We mailed invitation letters and then called parents to ascertain HPV decisional stage; those undecided about the vaccine were invited to participate by answering a baseline survey, allowing the visit to be audio recorded, and completing a post-visit interview. We applied Street’s Active Patient Participation Coding scheme to examine three active communication forms (asking questions, assertive expressions, and expressing concerns) and conducted thematic analysis to qualitatively examine discussion content.

Results: Of the 581 invited, 102 were eligible and 50 were enrolled (49%). We recorded 50 HPV vaccine discussions between parents and 12 providers (22 in English, 28 in Spanish). Thirty-one (62%) got the vaccine during the visit. Preliminary analyses showed almost all parents engaged in active communication by asking questions; assertive statements and expressing concerns were less frequent. Among parents who did not immediately acquiesce after the HPV vaccine was offered, they expressed hesitancy via all three active communication categories at any one of six pediatric safety-net clinics in Dallas, Texas, USA between July 2014 and May 2015. We mailed invitation letters and then called parents to ascertain HPV decisional stage; those undecided about the vaccine were invited to participate by answering a baseline survey, allowing the visit to be audio recorded, and completing a post-visit interview. We applied Street’s Active Parent Participation Coding scheme to examine three active communication forms (asking questions, assertive expressions, and expressing concerns) and conducted thematic analysis to qualitatively examine discussion content.

Conclusion/Implications: Understanding how undecided parents engage or assert themselves during conversations with provider can help train providers on communication strategies that provide key information, address parents’ hesitancy, and improve parental acceptance of the HPV vaccine.
Palliative and End-of-life Care

A comparison of the quality and content of communication in requests for adult and pediatric organ donation

Authors:
Laura Siminoff, Temple University
Anthony Molisani, Virginia Commonwealth University
Heather Traino, Temple University

Introduction/objectives: Although federal mandate prohibits the allocation of solid organs and tissue for transplantation based on “accidents of geography,” geographic variation in access to and the allocation of transplantable organs is well-documented. The purpose of this study was to assess the role of communication in observed geographic disparities in family authorization to organ donation and, thus, the availability of transplantable organs in the US.

Methods: Interview data were collected from 1,339 family decision makers (FDM) regarding perceptions of the request for donation and requesters’ use of specific communication skills during the request. Comparisons across 8 geographically distinct US donor service areas (DSA) were conducted using the Chi-square and Welch F test statistics. Post-hoc group comparisons were performed using Dunnett’s C test statistic.

Results: Family authorization to organ donation ranged from 60.4% to 98.1% across DSAs (see attached Table 1). Family decision makers from the three regions with the lowest authorization rates (Regions D, E and H) were least satisfied with the time spent discussing donation and with the request process, less likely to report favorable initial reactions to the donation request, and least comfortable with their donation decision. With regard to communication during the requests, families in regions with the lowest authorization rates reported discussion of fewer donation-related topics and employment of fewer donation-related and interpersonal communication skills by corresponding request staff. These families also perceived the highest levels of pressure to donate.

Discussion/Implications: As indicated by these findings, there is considerable variation in the request process and outcomes for solid organ donation nationally. Standardization of the training for organ donation request staff is needed to ensure the highest quality communication during requests for donation, to optimize rates of family authorization to donation, and increase the supply of organs available for transplantation.

Facilitating effective shared decision-making with surrogates of dying patients to manage or avoid potential conflicts

Authors:
Amy Tan, University of Alberta, Faculty of Medicine & Dentistry
Donna Manca, University of Alberta

Introduction: Conflict with families and substitute decision-makers of dying patients can occur more frequently than is ideal in end-of-life care. Understanding how to best manage these conflicts may improve relationships between physicians, and families or surrogates of patients, reduce stress, improve shared decision-making, and ultimately improve the care of dying patients.

Methods: To gain insight, we explored the experiences of Canadian Family Physicians who encountered conflict with a substitute decision-maker of a dying patient. We employed a Grounded Theory methodology with in-depth, semi-structured, audiotaped interviews about recent experiences of conflict. Purposeful sampling sought a maximum sample variation for physician participants. The verbatim transcripts, field notes and project memos were analyzed using an iterative process involving the constant-comparative method to identify emerging key themes and concepts.

Results: Our study found reflections of conflict experiences focused on the physicians’ main concern for the patient: to have a death free from avoidable distress, and in accordance with the patient’s wishes. A framework for achieving a “good death” through finding Common Ground is described in working with families and surrogates of patients. This process involves: 1) building trust through clarifying roles, bringing key players together and delivering small bits of information at a time; 2) understanding through active listening, and finally; 3) informed shared decision-making with the families and surrogates involved. We also describe barriers to achieving Common Ground and what to do when an impasse occurs.

Discussion/Implications: This presentation will describe a framework for developing Common Ground between Family Physicians and substitute decision-makers to assist in achieving a “good death”. We will share how this study has informed education initiatives for medical students, residents and practicing physicians locally. This presentation based on our findings may help physicians, allied healthcare professionals, learners, patients and their families improve end-of-life decision-making and healthcare communication more broadly in different settings.
Relationships Between Personal Attitudes About Death and Communication with Dying Patients: How Do Oncologists Grapple with Mortality?

Authors: Rachel Rodenbach, University of Rochester School of Medicine and Dentistry
Kyle Rodenbach, University of Rochester School of Medicine and Dentistry
Mohamedtaki Tejani, James Wilmot Cancer Center, University of Rochester Medical Center
Ronald Epstein, Center for Communication and Disparities Research, University of Rochester Medical Center

Introduction/objective: Physicians, especially oncologists, face life and death situations and existential questions regularly. However, little is known about how oncologists’ personal attitudes toward death affect and are affected by their care of and communication with dying patients.

Methods: Oncologists (n=25) and oncology nurse practitioners and physician assistants (n=8) participated in individual audio-recorded semi-structured interviews lasting between 20 and 60 minutes. Participants were asked about their approach to conversations about death and dying, how caring for dying patients affected their views on life and death, what thoughts they had about their own mortality, and how those thoughts affected patient care. Audio-recordings were transcribed and qualitatively analyzed.

Results: Participants’ experience and communication with dying patients and their personal views about life and death were clearly observed to impact each other. Belief systems, personal loss, culture, and self-examination played roles in this bidirectional influence. Participants expressed an understanding of their own mortality but with varying levels of acceptance. Providers differed in how directly vs. indirectly they communicated with patients about death and dying. Even those preferring a direct approach, however, spoke of the need to integrate compassion into the conversation and to avoid bluntness. For many, caring for dying patients affected their perspectives on life and death in positive ways, compelling them to live fully each day. Meanwhile, many attributed their acceptance of death and personal philosophies and beliefs to helping them cope with and discuss death and dying with patients. Findings will be illustrated with key quotes.

Discussion/implications: This study explores oncology providers’ perspectives about death, which heretofore has been a largely unexplored factor affecting communication at the end of life. By understanding clinicians’ views, we will help identify areas for physician support and training in order both to promote physicians’ own well-being and to provide better end-of-life care to patients.

Geographic variation in the communication process and outcomes of requests for solid organ donation

Authors: Heather Traino, Temple University
Anthony Molisani, Virginia Commonwealth University
Laura Siminoff, Temple University

Introduction/objectives: Although federal mandate prohibits the allocation of solid organs and tissue for transplantation based on “accidents of geography,” geographic variation in access to and the allocation of transplantable organs is well-documented. The purpose of this study was to assess the role of communication in observed geographic disparities in family authorization to organ donation and, thus, the availability of transplantable organs in the US.

Methods: Interview data were collected from 1,339 family decision makers (FDM) regarding perceptions of the request for donation and requesters’ use of specific communication skills during the request. Comparisons across 8 geographically distinct US donor service areas (DSA) were conducted using the Chi-square and Welch F test statistics. Post-hoc group comparisons were performed using Dunnett’s C test statistic.

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Discussion/implications: As indicated by these findings, there is considerable variation in the request process and outcomes for solid organ donation nationally. Standardization of the training for organ donation request staff is needed to ensure the highest quality communication during requests for donation, to optimize rates of family authorization to donation, and increase the supply of organs available for transplantation.
What are the barriers for medical oncologists to initiate a palliative care discussion to their incurable patients? A qualitative interview study in Flanders, Belgium.

Authors: Melissa Horlait, Vrije Universiteit Brussel
Kenneth Chambaere, End-Of-Life Care Research Group, Vrije Universiteit Brussel (VUB) & Ghent University
Koen Pardon, End-Of-Life Care Research Group, Vrije Universiteit Brussel
Simon Van Belle, Department of Medical Oncology, Ghent University Hospital
Luc Deliens, End-Of-Life Care Research Group, Vrije Universiteit Brussel

Objectives: Before referring their patients to a palliative care service, oncologists need to inform and discuss with them issues of disease stage, prognosis and the possible advantages of specialized palliative care (SPC). This is a very complex and emotional task for the oncologist with which they often struggle. As a result, oncologists refer their patients to SPC too late in their disease course or even not at all. This study reports findings from interviews with Belgian medical oncologists identifying oncologists’ barriers for introducing palliative care in discussions with their patients with advanced cancer.

Methods: An explorative, qualitative interview study with 15 medical oncologists from academic as well as non-academic Medical Oncology Departments in Flanders, Belgium. The transcripts of the interviews were analysed during an iterative process using the grounded theory principles of open and axial coding until a final coding framework was reached.

Results: The study identified seven heterogeneous categories of barriers discouraging oncologists from discussing palliative care with their advanced cancer patients: oncologist-related barriers (e.g. emotional commitment, lack of experience and emotional discomfort); patient-related barriers (e.g. specific patient characteristics and emotional reactions); family-related barriers with regard to the family member attending the discussion; barriers related to the physician referring the patient to the medical oncologist; barriers related to disease or treatment; institutional/organisational barriers (as for example the availability of palliative care and the practical organisation within a hospital); social/policy barriers (e.g. palliative care stigma).

Discussion/implications: The medical oncologists reported a variety of barriers, many of which may be manageable, e.g. through a specific communication training. The exploration and description of these barriers may serve as a starting point for training programs to encourage and support oncologists in introducing and discussing palliative care openly and timely in the disease trajectory of a cancer patient.

Relationship between computer-associated conversational silences and expression of emotion in end-of-life oncology discussions between the doctor, patient, and computer

Authors: Josef Bartels, University of Rochester
Rachel Rodenbach, University of Rochester
Katherine Ciesinski, Eastman School of Music
Kevin Fiscella, University of Rochester
James Dolan, University of Rochester
Ronald Epstein, University of Rochester

Introduction/Objective: Healthcare practitioners must complete specific tasks to achieve patient-centered communication, such as attention to verbal and non-verbal emotional cues, often while multitasking with the computer. We aimed to explore the relationship between computer-associated silence and emotional content in the exam room.

Methods: 124 audio-recordings from the Values and Options in Cancer Care (VOICE) study were screened for computer-associated silences and expressions of emotion (Verona coding definitions of emotional sequences). We evaluated the relationship between computer-associated silence and emotion using a random effects model.

Preliminary Results: Computer-associated silence counts show a negative dose-response association with patient expressions of emotional controlling for conversation length, cancer type, and physician. The total silence length per conversation did not show the same relationship. Computer-associated silences were reliably identified between multiple coders (kappa = 0.82).

Implications: These findings suggest that computer-associated silence may be a proxy for interference between computer tasks and patient communication tasks, and that this interference has an effect on patient expressions of emotion. Further, computer-associated silence may identify computer tasks that are causing interference as some tasks can probably be done without measurable consequence. Communication training should emphasize incorporation of the computer in ways that minimize the number of interferences perhaps by grouping all the computer tasks together at the beginning or the end of the relevant topic using signposting and natural boundary points. Beyond physician training, comparing the number of distracted silences may allow evaluation of electronic health record design in order to minimize multitasking interference.
Can We Improve the Function of Advance Care Planning Documents Through Technology? What the Literature of Ethics, Law, and Communication Tells Us

Author: Jennifer Freytag, Texas A&M University

Introduction: Despite advances in shared decision-making and end-of-life care communication, the wishes of few patients, even the most critically ill, are recorded in advance care planning (ACP) documents. And research suggests that even when ACP documents have been completed, care often does not comport with patients’ wishes. This study reviews the literature on the use of ACP documents in the clinical setting and presents three key limitations that technology can address.

Methods: Literature involving the intersection of ACP with ethics, law, and communication was collected via searches of ten major databases. Five search strings were used, and inclusion criteria were established for both empirical studies and commentary involving ACP documents.

Results: Analysis of the literature revealed three key ideas that limit the use of ACP documents. First, these documents generally identify specific courses of action to be taken, as opposed to patient goals of treatment. Specific courses of action are useful in a limited number of circumstances, while goals of treatment are more useful for decision-making throughout the course of treatment. Second, ACP documents are difficult to change or modify over the course of a patient’s treatment. Goals and wishes change over time and throughout a disease cycle, and ACP documents do not adapt to these changes. Finally, many ACP documents do not require the involvement of important parties in their formation. These parties can include physicians, surrogates, and other interested family members.

Discussion: This analysis argues that the three limitations that are clearly identified in the literature can be addressed using technological interventions, which include digital document storage and signatures, periodic and regular goals assessments using decision-making software, and electronic notification for important parties.

The Incorporation of a Real Life Inter-Professional, Palliative Care-Ethics Experience into a Required Critical Care Acting Internship

Authors: Gino Farina, Hofstra North Shore-LIJ School of Medicine
Joseph Weiner, Hofstra North Shore-LIJ School of Medicine
Alice Fornari, Hofstra North Shore-LIJ School of Medicine
Samuel Packer, Hofstra North Shore-LIJ School of Medicine
Frederick Smith, Hofstra North Shore-LIJ School of Medicine
R. Ellen Pearlman, Hofstra North Shore-LIJ School of Medicine
Jessica Byrne, Hofstra North Shore-LIJ School of Medicine

Objective: To develop a meaningful PC/ethics clinical experience for senior medical students to prepare them for future practice regardless of specialty choice.

Methods: The Hofstra North Shore-LIJ School of Medicine requires a 4 week Acting Internship in Critical Care (AICC). The AICC Director assigns each student a patient with advanced illness. After clinical contact with the patient and the inter-professional team, the student presents the case at a weekly meeting to faculty and peers, focusing on communication or bioethical challenges. Medical school faculty assure the presentation integrates discussions on patient-doctor-team communications skills. A write-up is submitted that follows a “PC/Ethics Consult” template, including discussion of ethical pillars, interprofessional PC considerations and a reflective exercise on the experience. Completion of the oral presentation and write-up contribute to their grade.

Satisfaction data from 28 of the 29 graduating students assessed 6 criteria, scored from strongly disagree (1) to strongly agree (4).

Better understanding around end of life care with regards to:

<table>
<thead>
<tr>
<th>Legal issues</th>
<th>Ethical issues</th>
<th>Feeling comfortable engaging in conversations around the subject</th>
<th>Resources available</th>
<th>Different cultures and religious beliefs</th>
<th>Being better prepared to deal with these issues in residency</th>
</tr>
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<tr>
<td>3.4</td>
<td>3.4</td>
<td>3.2</td>
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We conclude that it is feasible to incorporate a real life PC/Ethics, interprofessional experience into a required Acting Internship in Critical Care. Students report they are better prepared to handle end of life issues in residency. We are working on a more applicable written exercise and uniform experiences across different discipline-based ICUs.
Goal Communication in Palliative Care Decision-Making Consultations

Authors: Robert Gramling, University of Rochester, Mechelle Sanders, University of Rochester, Susan Ladwig, University of Rochester, Sally Norton, University of Rochester, Ronald Epstein, University of Rochester, Stewart C. Alexander, Purdue University

Introduction: Palliative care promotes patient-centered outcomes, but the mechanisms underlying these effects remain poorly understood. Identifying, clarifying and prioritizing patients’ goals are conceptually fundamental to the process of patient-centeredness and are the main reasons for palliative care referral. However, very little is empirically known about the content or process of goal expression in the natural setting of palliative care. The purpose of this study was to describe the frequency, types and determinants of goal expression in palliative care consultations.

Methods: This is a cross sectional, direct observation study of 71 audio-recorded palliative care consultations with hospitalized patients (and families) referred for palliative care “goals of care clarification” or “end of life decision-making”. We coded digital audio files using reliable methods and linked conversation codes to clinical record and brief clinician interview data.

Results: Approximately 7 out of 10 conversations included at least one goal expression and one-third contained expressions of goals relating to both quality-of-life and length-of-life. Goal expressions were 2.7 times more frequent in conversations where patients/families exhibited existential suffering (p=0.001) and this association persisted when controlling for potential confounding. Goal expression was not associated with other conversation features, including expression of distressing emotion, communication about prognosis, duration of conversation and active participation of the patient (versus proxy).

Discussion: Goal communication is common in palliative care decision-making settings and strongly influenced by existential suffering.

Research in Progress

Young Parents’ Use of Online Review Information

Authors: Fabia Rothenfluh, Università della Svizzera italiana, Evi Germeni, Università della Svizzera italiana, Peter J. Schulz, Università della Svizzera italiana

Introduction: Consumers increasingly rely on electronic word-of-mouth (eWOM) to make decisions about purchases in tourism (e.g. tripadvisor) and commerce (e.g. amazon). Nowadays, physician online rating websites (PORW) have also gained popularity; yet, the effect of PORW on health consumers’ decision-making process remains largely unknown. The objectives of this study are: (a) to understand the evaluation criteria that individuals apply when using PORW to choose a physician; and (b) to explore the extent to which these criteria are the same as for other consumer services or products.

Methodology: An exploratory qualitative study will be conducted, consisting of 10 focus groups with young parents residing in the German-speaking part of Switzerland. Participants will be requested to complete two search tasks (finding a hotel on tripadvisor.de and a pediatrician on jameda.de) and subsequently discuss their experiences in the focus group setting. Eligibility criteria will include: (a) being at least 18 years of age; (b) being physically and cognitively able to participate in a group discussion; (c) having a child aged less than 3 years old; and (d) being fluent in German. With participant permission, focus group sessions will be recorded and fully transcribed. An inductive thematic approach will be employed for the analysis of the data.

Expected results: The study is expected to provide insights into young parents’ search strategies and guiding criteria when choosing a pediatrician and a hotel based on online reviews. Personal and shared preferences, as well as potential differences in terms of gender and parenting experiences will be exhibited. Additionally, the outcomes will elucidate whether individuals’ search strategies and decision-making processes are similar or diverse for physicians and commercial online rating websites.

Patients’ Perceptions of Challenges in Patient-Centered Care

Authors: Lidia Little, Rutgers University, Elizabeth Bromley, University of California, Los Angeles, Marian Katz, Veterans Health Administration, Greater Los Angeles, Health Services Research and Development

Introduction: Patient-centered care is replacing the biomedical and physician-centered model that has dominated the field in the past. Theoretical models and previous research suggest that a patient-centered approach may improve patient satisfaction and improve health outcomes. While there is tremendous support for the change, there are many interpretations of what constitutes patient-centeredness and the underlying concepts often remain unclear. For instance, patient participation in the treatment process is highly encouraged but standards for participation remain vague, the concept of participation is ill-defined.

Methods: Using semi-structured interviews, this paper explores patients’ perspectives of their experience in a hospital designed to be patient-centered. This implementation focused on creating a home-like environment and improving the patient experience, from the size of the rooms to the amenities and communication protocols. Although hospital design and the philosophy of care were developed specifically with patients in mind, patient challenges in role adjustment and decision-making arose. Twenty-five hospital patients were recruited using a sampling template to ensure diversity in age, gender, reason for admission and length of stay. The interview data were analyzed using the thematic analysis.

Results: Results show that patients appreciated available amenities and comforts. Nevertheless, patients faced challenges with adjusting
to the sick role. Several challenges that arose included a struggle with voicing their opinions about treatment; confusion regarding their role in the hospital structure and maintaining control over their routine despite the facility’s attempts to make the hospital feel more like a home environment.

**Discussion:** These results provide insights into the nature of patients’ experiences and suggest that even at a patient-centered facility, a patient-centered philosophy of care rests on the human dimension - the quality of communication and interaction - and a facility’s ability to support patients in adjusting to a new role in a hospital setting. The findings also highlight areas for improvement in the implementation of a patient-centered philosophy.

**Determining an optimal format of engaging women of low socioeconomic status diagnosed with early stage breast cancer in decision making**

Authors: Shama Alam, The Dartmouth Institute for Health Care Policy & Clinical Practice
Stuart Grande, The Dartmouth Institute for Health Care Policy & Clinical Practice
Glyn Elwyn, The Dartmouth Institute for Health Care Policy & Clinical Practice
Marie-Anne Durand, The Dartmouth Institute for Health Care Policy & Clinical Practice
Sanja Percac-Lima, Harvard Medical School

**Introduction/Objectives:** Women of low socioeconomic status (SES) diagnosed with breast cancer experience higher mortality rates, are less likely to undergo breast-conserving surgery and less likely to be involved in treatment decisions. They also tend to report higher decision regret, poorer knowledge and lower health literacy. Our goal was to test the acceptability and usability of two picture-based encounter decision aids (Picture Option Grids), a text-based encounter decision aid (Option Grid) and a question-prompt list targeting women of low SES facing a treatment decision about early stage breast cancer.

**Methods:** The pictorial decision aids were derived from the text-based decision aid (www.optiongrid.org) and are evidence-based. We used semi-structured interviews (n=20), focus groups and a web-based questionnaire (n=250) with patients of low SES, clinicians and other community stakeholders to determine the optimal format, layout and content of the encounter decision aids and to acceptability of the question-prompt list in women of low SES.

**Results:** We are currently recruiting participants for focus groups, semi-structured interviews and have launched a web-based questionnaire. In the semi-structured interviews and focus groups, we will ask whether the content, layout, and format of the decision aids and question-prompt list are appropriate or can be improved. Specifically, we are examining the wording, order of information provided, and use of images or cartoon characters. Initial data from our stakeholder focus group highlighted many barriers women of low SES face when trying to play an active role in decision making.

**Discussion/Implications:** Preliminary results demonstrate that a picture-based encounter decision aid is usable and considered useful if a modification including a question on treatment costs is applied. Results from the remaining semi-structured interviews, focus groups and web-based questionnaire will further determine the usability and acceptability of these encounter decision aids and question-prompt list.

**Potpourri**

**Advice From Pregnant Women Who Use Substances on Strategies to Increase Patient Comfort during First Obstetric Visits**

Authors: Treston Clark LaRue, University of Pittsburgh
Cynthia Holland, Magee Women’s Research Institute
Jill A. Tarr, Magee Women’s Research Institute
Keri Rodriguez, Center for Health Equity Research and Promotion (CHERP) VA Pittsburgh Healthcare System
Kevin Kraemer, Division of General Internal Medicine, School of Medicine, University of Pittsburgh
Doris Rubio, Dept of General Internal Medicine, School of Medicine, University of Pittsburgh
Nancy Day, Dept of Psychiatry, University of Pittsburgh
Robert Arnold Dept of Medicine, General Internal Medicine, Center for Research in Healthcare
Judy Chang, Magee Women’s Research Institute

**Objectives:** To describe the perspectives of substance using women in regards to how obstetric providers’ communication influences their comfort and what interaction behaviors they suggest to increase patient comfort regarding discussing their substance use.

**Methods:** We conducted semi-structured qualitative interviews with pregnant women who had either: (1) disclosed drug use, (2) tested positive for drug use, and/or (3) admitted alcohol use during their pregnancy. Subjects were asked to describe what influenced their comfort and willingness to talk about their substance use and communication elements that would improve comfort. Transcripts were coded using an open, editing approach and reviewed for thematic patterns.

**Results:** Eighty-five pregnant women were interviewed; 65 disclosed using drugs or had positive urine drug screens, 15 admitted using alcohol. 50% disclosed their substance use to their obstetric provider; 50% did not. Themes identified (1) providers who conveyed friendliness, engagement, and competence elicited more comfort which facilitated disclosure, (2) providers who used judgmental language or discussed punitive consequences of substance use decreased comfort and willingness to disclose, and (3) providers who took more time and clearly communicated to inspired more trust and comfort. Participants identified specific provider behaviors to increase patient comfort including: spending less time on a computer or medical document, providing more eye contact, determining patient understanding, acknowledging difficulty in talking about
sensitive topics, and communicating that they care about the woman and her baby.

**Conclusion:** Obstetric providers need training on communication skills and strategies to improve patient comfort and facilitate discussions on sensitive topics such as perinatal substance use.

**Experience and Feasibility of Using an App in an Ecological Momentary Assessment of Early Breastfeeding**

Authors: Jill Demirci, University of Pittsburgh School of Medicine Judy Chang, University of Pittsburgh Debra Bogen, University of Pittsburgh

**Introduction:** Ecological momentary assessment (EMA) is a novel data collection method that samples subject experiences close to, or concurrent with, when they actually take place. EMA permits nuanced measurement of human behaviors in the contexts in which they occur. In the current study, we assess the feasibility of EMA to track early breastfeeding behavior through a mobile phone app.

**Methods:** We approached women during their birth hospitalization to take part in an ongoing study tracking breastfeeding through 8 weeks postpartum. The study goal was to develop content for a breastfeeding support intervention. Eligible women (e.g., first-time mothers, smartphone access, no conditions affecting milk supply) downloaded a commercially available smartphone app (Baby Connect), entered feeding information and thoughts about breastfeeding as they occurred, and emailed the data weekly. We called participants at 8 weeks to assess their experiences using the app.

**Results:** Among 90 women approached, 37 were eligible and participated. Reasons for study non-participation among those eligible (n=47) included too busy/tired for enrollment (n=5), inconvenience of entering data (n=4), and already downloaded a similar app (n=1). To date, 23 women sent at least one week of app data and five sent complete feeding data for 8 weeks. Fifteen remain in active follow-up. Twenty-one women logged at least one diary entry; two logged daily entries. Experiences with the app ranged from “helpful” (observing trends for daily planning; n=7) to too time-consuming, “annoying,” or anxiety-provoking (n=4). Technical issues included downloading difficulties, few breastfeeding customization options, asynchronous participant compensation, and time required to enter and compile large quantities of data.

**Conclusions:** Despite technical issues and some participant dissatisfaction and non-use, EMA via a mobile app is a feasible method to capture detailed behavioral and thought-process data related to breastfeeding. Future studies considering apps for data collection should explore options for automation and customization.

**“It’s not pain there, it’s inside there”: Physicians’ and patients’ use of body-oriented gestures in primary care consultations**

**Author:** Jennifer Gerwing, Akershus University Hospital

**Introduction/objectives:** The semiotics of gesture use in clinical communication are understudied, despite abundant theoretical and methodological tools available from basic research. This paper presents an innovative, clinically-relevant gesture analysis drawing on this research. The objective was to analyze gestures that referred to the body. How prevalent were these body-oriented gestures? How did they relate to accompanying speech? How did physicians and patients use them?

**Methods:** Source materials were the video excerpts from two publicly-available training DVD’s (~29 minutes), which had used illustrative excerpts from actual primary care encounters (12 patients and 9 physicians). A microanalysis of face-to-face dialogue located and analyzed the function of all gestures. Then a detailed qualitative analysis focused on gestures with a semantic function that were also body-oriented (i.e., indicated a part or region of the body, represented an action, or portrayed an attitude or emotion).

**Results:** There were 416 gestures (patients = 238; physicians = 178). Of these, 291 served semantic functions (patients = 175; physicians = 116). Patients used 104 body-oriented gestures, and the gestured information complemented but did not always overlap information in the speech. E.g., a gesture might indicate the relevant body part (e.g., the chest), but speech conveyed the sensation (e.g., pain, lack of pain, tenderness, itchiness), the intensity, or time (e.g., duration, past, present). Physicians used 30 body-oriented gestures to anchor their questions or explanations, often without naming the body part or region in speech.

**Discussion/implications:** Physicians and patients integrated body-oriented gestures with accompanying speech in sophisticated and systematic ways. Clinical implications are (1) mutual observation facilitates efficient information exchange; (2) looking elsewhere may render verbal messages ambiguous or incomprehensible. These results break ground for further inquiries that could focus on factors affecting how information is distributed in gesture and speech (e.g., whether and how patients adapt to lack of physician gaze).
“I don’t care about marijuana” - Obstetric Providers’ Responses to Pregnant Patient Disclosures of Marijuana Use

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Objective: To describe obstetrical care providers’ counseling approaches in response to patients’ disclosures of marijuana use during direct observation of first prenatal visits in an urban outpatient clinic setting in Pennsylvania.

Methods: We audio-recorded patient-provider conversations during first obstetric visits. Audio recordings and verbatim transcripts were reviewed for patient disclosure of past or current marijuana use. Providers’ responses to these disclosures were qualitatively analyzed.

Results: Among 468 audio-recorded patient-provider obstetric conversations, 87 patients (19%) disclosed marijuana use during their first obstetric visit. In 24% of these visits, obstetric providers did not respond to marijuana use disclosures and offered no counseling. In 19% of the visits, providers simply asked when the patient had last used marijuana, without offering any additional information or guidance. When providers did respond to positive disclosures only 15% discussed specific risks involved with perinatal marijuana use while 14% used more generic statements discouraging marijuana use in pregnancy that did not address why it was important not to use marijuana during pregnancy. Providers most frequently (25%) used punitive counseling techniques such as mentioning the need to send urine for drug screens and warnings that child and protective services will be involved if the patient or baby tests positive for marijuana at the time of delivery. In less than 1% providers offered referrals to support services or resources such as social work or behavioral health.

Implications: Providers need additional training on information about perinatal marijuana use and communication skills to use when counseling pregnant patients on marijuana.

Translating CollaboRATE: A Spanish version for use in the United States

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Introduction/Objectives: CollaboRATE is a patient-reported measure of shared decision-making (SDM). As 13 percent of United States (US) residents speak Spanish at home, CollaboRATE should be accessible to Spanish speakers. This study aimed to develop and assess the accuracy and interpretability of a Spanish translation of CollaboRATE for use by Spanish-speaking patients in the US.

Methods: Stages included 1) two independent professional translations; 2) third party review of translations and recommendation on a single version; 3) four rounds of cognitive interviews with a total of 28 Spanish-speaking members of the population recruited within an urban US health center, with iterative item refinement between each round.

Results: While many of the initial interview participants expressed confusion with the first two items, refinement following the first two rounds of interviews enhanced comprehension for 5/6 participants in round 3. The third item’s focus on ‘choosing what to do next’ was poorly understood throughout the first three rounds of interviews. A fourth round sought feedback on an improved third item, which was well-understood by 4/6 participants.

Discussion/Implications: In developing this translation of CollaboRATE, it was apparent that maintaining strict fidelity to the original English questionnaire in structure and content required sacrifices in interpretability. To maximize fidelity to the original translation while ensuring adequate interpretability, we incorporated feedback from four rounds of cognitive interviews to arrive at a version to be tested in real clinical practice.

While survey translation best practices recommend a thorough translation process before beginning cognitive interviews, the extensive interview process undertaken here revealed that significant further changes were needed beyond the initial translation stage. This suggests that, in a resource-limited environment, it may be more productive to invest in several rounds of cognitive interviews with iterative item refinement to improve a basic translation than in an extensive initial translation process.
Obstetric Providers’ Attitudes and Counseling Strategies Regarding Perinatal Marijuana Use

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Objective: To describe obstetric provider attitudes, beliefs, approaches, concerns, and needs about addressing perinatal marijuana use with their pregnant patients.

Methods: We conducted 29 individual semi-structured interviews with obstetric care providers and asked them to describe their thoughts and experiences regarding addressing perinatal marijuana use. Interviews were transcribed verbatim, coded and reviewed to identify themes.

Results: Providers felt using marijuana during pregnancy was not as dangerous as using other drugs or tobacco and thus admitted considering marijuana use a lower priority than other pregnancy or behavioral risk issues. Providers thought most patients did not view marijuana as a drug and may be ashamed to disclose use. They described their most common strategy to address marijuana use was to ask their patients directly about their use. Most provider counseling strategies focused on marijuana’s status as an illegal drug and the risk of child protective services being contacted if patients tested positive at time of delivery. All 29 providers felt they could not counsel effectively because they were not familiar with the risks of marijuana use in pregnancy. Another barrier identified by providers regarding counseling on marijuana was lack of time during the visit.

Conclusions: Obstetric providers describe a need for more information and knowledge about health consequences associated with perinatal marijuana use to improve their counseling strategies for pregnant patients who use marijuana. Future studies should address ways to improve obstetric providers’ counseling, to assess changes in providers’ attitudes as more states consider the legalization of marijuana and how this information can be disseminated and implemented to improve provider counseling on marijuana use in pregnancy.

The availability, quality, and impact of decision aids for medical versus surgical methods of early abortion: A systematic review and environmental scan

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Introduction/objectives: In the US, women value receiving trustworthy information to facilitate their choice between medical and surgical early abortion. However, the number, quality, and impact of decision aids currently available to support women’s decision-making is unknown.

Methods: We developed a protocol for a simultaneous systematic review (SR) and environmental scan (ES) to identify, appraise, and describe the impact of scientifically evaluated and non-evaluated early abortion decision aids with a particular focus on those available to women in the US. The SR involved searching PubMed, Cochrane Library, CINAHL, EMBASE, and PsycINFO databases for peer-reviewed articles that assessed early abortion decision aids. The ES involved searching the Internet and mobile application stores and consulting key informants. We plan to rate the quality and readability of decision aids using standard tools and conduct a directed content analysis to examine the communication of information.

Results: The SR identified 2,886 unique articles. Twelve articles were reviewed in full and one was included. This article described a randomized trial of a 3-page decision aid conducted with 328 women in the UK in 2002. The ES, which remains ongoing, has identified several additional decision aids.

Discussion/implications: Preliminary results suggest that, while a number of early abortion decision aids are available to women, the overwhelming majority have not been scientifically evaluated. Therefore, the forthcoming quality and readability rating and content analysis will provide critical and complementary evidence about how well women are currently supported in their decision-making. Our presentation will discuss the value in and challenges of identifying and appraising decision aids developed and delivered in the real world. We will also explore the language in decision aids that may promote or undermine quality decision-making. Lastly, we will discuss the status of patient-centered decision support for early abortion methods and how this applies to other stigmatized health decisions.
Nursing

Exploring Close Nurse Friendship Communication: An Analysis of Artifacts and Storytelling

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Introduction/objectives: The validity of data analysis can be improved by having participants integrate visual images with descriptive dialogue about their experiences (Liebenberg, 2009). A unique way of using this method includes study participants using physical objects as metaphors to more effectively communicate with researchers. Although scholars have used such techniques in varied organizational contexts, one area of study in which the use of artifact description has not yet been examined is within workplace friendships, particularly between nurses. Researching nurse friendship is important because the nursing profession is laden with numerous stressors, and supportive communication from friends reduces healthcare workers’ stress, burnout, and turnover (Wright, Banas, Bessarabova, & Bernard, 2010).

Methods: Participants are six pairs of nurse best friends, employed full-time at a large Midwest hospital. A mixed qualitative approach was used, consisting of on-the-job observations of each friend pair, individual interviews, and pair interviews. In pair interviews, participants brought an artifact that represented the best friend or friendship.

Results: Participants’ descriptions of artifacts were found to strengthen characteristics previously noticed in observations and individual interviews and reinforced responses during pair interviews. The artifacts prompted stories about three themes: 1) the foundation of the friendship; 2) the intensity of the friendship; and 3) humorous communication used to cope with stress. These stories helped research analysis by delving into the friendship and exposing major supportive communication behaviors.

Discussion/implications: Using participants’ personal artifacts to describe their close friendships offers a novel technique to gain deeper understanding of the complexities of close workplace friendships, especially in high-stress health professions such as nursing. Artifact data gave insights into the friendship that were not gathered from research observations and interviews. This methodological strategy provides a unique way to involve researchers in the intimacy of participants’ friendship.

It’s fundamental: Teaching communication skills foundational to nursing practice

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Communication is essential to safe care of patients, improved interprofessional relationships and retention of health care practitioners (IOM, 2010), yet the direction in nursing education has been away from teaching communication skills and towards adding further technical skills. Strategic psychomotor skills are critical but inadequate in preparing expert nurses. To restore teaching interpersonal skills and cultivate resilient nurses capable of care of self and others, a new course was designed and implemented in the first semester of the second year of a four year curriculum.

Implementation of this innovative nursing course will be described through discussion of the teaching modules. Assignments to build communication skills, cross-cultural experiences and capacity for compassionate care of self and others will be shared. All modules were grounded in an appreciative practice approach to promote communication and discovery of capacity in self and others. Content was experiential with modules focused on self-reflection, and communication with individuals, families, and colleagues. Team work was modeled in class through small group discussion. Introductory modules on coaching behavior change were included and students were asked to keep a personal self-care journal, designed to develop empathy for the challenge of implementing healthy behavior change for self and others. A 4-hour experience of mindfulness based stress reduction was included. Reflective journals, assigned throughout the course, fostered contemplative practice.

The class consisted of 89 second-year undergraduate nursing students, divided into 3 groups. Initial outcomes of the course, based on formative and summative student evaluations and completed assignments indicated acquisition of communication and self-care skills. Qualitative and quantitative data from course and teaching evaluations will be presented.

Teaching communication skills through experiential modules focused on care of self and others has the potential to improve patient-centered quality care, inter-professional communication and retention of new nurses.

On Being Present, Not Perfect: Facilitating Undergraduate Nursing Student Learning from a TEDTalk with Reflective Writing

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Introduction/Objectives: TEDTalks enable speakers to present their most innovative ideas, in less than 20 minutes. The TEDTalk “On
Being Present, Not Perfect” coupled with reflective writing offers educators an interactive means to teach communication and relational skills.

Methods: Undergraduate junior pediatric nursing students independently viewed the TEDTalk and wrote brief reflections guided by questions, What was the most meaningful part of the TEDTalk? What resonates with you personally and professionally? The TEDTalk was viewed a second time in class supported by the Facilitator User’s Guide which functioned as a springboard to discuss general principles of communication.

Results: This non-graded, non-required assignment was completed by 23/25 (92%) of students of which 100% provided consent. Qualitative analysis of the reflective writing identified three primary themes: Value of Communication; Empathic Presence; and Professional Role Development. The TEDTalk was described as a unique learning experience that modeled inspiration, commitment and empowerment to the nursing students. When incorporated into a 3-hour lecture, the TEDTalk generated lively discussion that was considered time well spent.

Discussion/Implications: The “TEDTalk On Being Present, Not Perfect” with reflective writing was a powerful, well-received learning experience. The power of the TEDTalk lies in the “flipping” function wherein content is initially introduced outside of class, thus better utilizing class time to enhance application of course content. As educational programs compete with online and open course-ware, TEDTalks provide meaningful no-cost content that can easily be integrated into class lecture, discussion and on-line activities. Undergraduate nursing students identified “On Being Present, Not Perfect” as an inspirational learning experience, emphasizing the inherent value of presence in the patient-provider relationship. The accompanying Facilitator Guide provided faculty with additional strategies to encourage novice health care professionals to critically reflect and incorporate effective communication skills, prior to entry into practice.

Perceptions of relevance and sufficiency of information: A qualitative multiple-case study of information exchange between inpatients and nurses in acute general ward settings

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Objective: To explore the relevance and sufficiency of information exchanged by inpatients and nurses in surgical and medical ward settings.

Methods: A multiple-case study design was used. Each case comprised one patient, the nurses interacting with that patient, and the interactions between them. Interactions were observed and audio-recorded remotely. Individual interviews with patients and nurses followed, and were related to, the observations.

Results: There were 19 cases, comprising 19 patients, 22 nurses and 47 interactions. The longest interaction was 24 minutes and 33 seconds and the shortest was 10 seconds. Patients described information as being relevant for their wellbeing, involvement in their treatment and care, and for socialisation. Nurses described information as relevant for patient assessment and as an ethical obligation. Sufficiency of information, as perceived by participants, was explained by: having no more questions; ongoing information sharing; good patient/nurse relationships; and, the use of lay terms. However, the observation data suggest that information exchanged by patients and nurses was insufficient, due to withholding information, paternalistic practice and lost opportunities.

Conclusion: Patients’ wellbeing, and their involvement in treatment and care, may be detrimentally affected if personally relevant information is not exchanged due to assumptions being made. Actively encouraging patient contribution in healthcare interactions, and assessing their preferences for information, may help nurses tailor information to patients’ needs. Sufficiency of information, as perceived by participants, depends on the criteria applied. Patients report sufficiency of information, however, held up against contemporary models of information exchange, sufficiency may be lacking. A rethink of the fit of contemporary models to ward-based nursing practice is required. Policymakers should target policies on shared decision-making and information exchange across a range of different healthcare environments.

Existential issues and concerns of elderly during home care visits

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Introduction: The older population is increasing worldwide, which is demanding for the health care systems. Today a shift of care of elderly can be seen from institutional to home care. Knowledge is needed on the communication of caring encounters that take place in the homes of elderly people. The aim of this study is to explore communicative challenges in encounters between nurse assistants and older persons during home care visits.

Methods: In this qualitative study, being part of the research program COMHOME, audio recordings from authentic dialogues between nurse assistants and older persons in need of homecare services in Sweden were analyzed. The data material consisted of 90 audio recordings of authentic encounters between 14 nurse assistants and 36 older persons in Swedish home care services. A qualitative in-depth content analysis was performed on selected audio-recordings to further explore communicative challenges in these encounters.

Results: Communicative challenges were found to be related to existential issues of the older person; that is worries and concerns
on aging, weakness and life coming to an end. During home care visits the elderly explicitly expressed these issues in the verbal communication during home care visits. These issues were sometimes hard for the nurse assistants to respond to, as they needed to focus also on the task at hand for the home visit.

Discussion/Implications: The importance of individualizing care and taking a person-centered approach are today evident. Person centered care is a highly relevant area; and current practices of care do need to allow patients to express their care needs and priorities. Overall more attention needs to be paid to existential aspects of elderly during home care visits. To provide best patient care, knowledge about existential concerns of elderly needs to be acknowledged in the organization of home care services.

Medical Student Education

An innovative integrated communications curriculum, and assessment and remediation framework for medical students

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Introduction: Medical students focus on learning about disease pathophysiology and manifestations. They often default to a biomedical model of patient interviewing, rather than focusing on the illness experience and the quality of the patient interaction.

Educational Objectives: We recalibrated our communication skills training with an emphasis on fostering the doctor-patient relationship from the outset of training. Our new curriculum integrates other aspects of physician identity formation, including empathy advancement, ethical decision-making, and clinical reasoning.

Methods: We developed a flexible, evidence-informed framework to explicitly guide students through a patient-centered interview. We mapped a new four-year small-group Communications curriculum for the class of 2017, allowing the step-wise development of skills, and longitudinal and vertical integration with other courses, while including the full age spectrum of patients. Small-group facilitators were recruited for their expertise in communication. Role-playing the patient enhanced the students’ appreciation of the patient perspective. Peer feedback facilitated students to learn techniques from each other. Videotaped interviews enabled self-assessment, and facilitator assessments, that could be reviewed with the student. Year 2 involved more standardized patients with more complicated patient contexts, to prepare the students for Clerkship. Advanced topics, such as interviewing with interpreters, advance care planning, and patient error disclosure, are planned for Clerkship.

Program Evaluation Results: Students in this new curriculum have had a positive experience. Faculty members perceive enhanced patient-centered communication skills and attitudes about the doctor-patient relationship in this cohort, compared to previous years. Analysis from course evaluations and focus groups with students from this class will be shared. We will show outcomes of this new curriculum with a comparison for one specific session with the previous curriculum, using old and new assessment rubrics.

Conclusions/Lessons Learned: We will share the lessons learned in the development, implementation, and integration of this new communication program with key professional identity development, and discuss our innovative approach to the longitudinal assessment and remediation of students’ patient-centered communication skills.

Creative Art and Medical Student Development

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Objective: Although many medical schools include arts-based activities, goals vary widely and most have not been formally studied. We sought to understand whether creation of an interpretive project based on illness narratives had an impact on medical student professional identity development.

Methods: The Family Centered Experience is a required 2-year course in which students are paired with families living with chronic illness in order to explore the experience of illness through home visits, small group discussions, readings, and reflective writing. During the program, students create an interpretive project that expresses their understanding of what they have learned. Project examples include painting, sculpture, poetry, film, and live performance. To investigate the impact of these projects, we performed individual interviews with sixteen student-artists. Open-ended questions were used to illuminate student perspectives about the conceptualization and presentation of the projects, the dynamics of teamwork, and the possible meanings the projects had for professional goals and identity. Interview transcripts were thematically analyzed using Grounded Theory.

Results: Three major themes emerged: the creation of art impacted students’ personal development and professional development; and prompted reflection on humanistic values. Sub-themes included reflection on past experiences, an appreciation of art as a creative outlet, and enhanced self-discovery. Professional development sub-themes included a positive impact on self-confidence, reflection on group dynamics and teamwork, and an appreciation for the community and talent of their peers. Finally, students reported enhanced reflection on the experiences of those with illness and reaffirmed the humanistic goals of medicine.

Conclusion: Medical educators often struggle to teach and assess humanistic and professional values. The current study found that the narrative-based creation of art encouraged reflection on self while enhancing the development of a compassionate, collaborative, and patient-centered professional identity. Creative art can serve as an effective educational tool to promote a reflective, humanistic practice.
Patterns of emotional interaction between medical students and simulated patients in OSCE consultations

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Background: Medical students respond differently to specific emotional cues (Zhou et al. 2013). We previously reported that typically, a cue occurring earlier on in a consultation will be responded to by the medical student by providing space to the patient to explain further and expand. This was the first study of its type, but was limited to immediate responses of the clinician to the exhibited patient cue or concern. Dedicated software - THEME recognises patterns in timed sequences of data recording. A binomial statistical approach is adopted to identify probabilistic links of codes to each other, using a ‘critical interval’. Hidden patterns are then revealed whose reliability can be assessed.

Aim: To identify patterns of patient emotional cues and concerns, and medical students’ responses over extended sequences of interaction.

Method: Forty 2nd year medical students volunteered to participate in a 5 minute duration OSCE scenario about Irritable Bowel Syndrome with an experienced simulated-patient. Video-recordings were analysed with the Verona Codes system (VR-CoDES) including time stamps, and biographic information. Data were formatted for entry into THEME Noldus™ application. Patterns were sought with sequences consisting of at least two pairs of patient cue or concern/student response sequences.

Results: Patients exhibited 59 concerns and 295 cues. Students responded with 221 opportunities for providing space to the simulated patient and closed down on 133 occasions. There were 9 patterns of sequences (p<.05) with combinations of cues and responses. One interesting pattern, in particular, extended for over 10% duration of the interaction. The student tended to provide space to emotional cues that were ambiguous but then closed down the patient who described physiological or cognitive cues. Less able students showed this pattern.

Conclusion: This sequence analysis approach is explorative and able to identify complex patterns that were tentatively associated with past performance history of the student.

Using a standardized communication model: Characteristics of effective medical interviews identified by senior medical students before and after a change in interviewing curriculum

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Background: While several educational scholars have argued that using a standard communication skills model (i.e. Calgary-Cambridge, Segue, etc.) enhances teaching of communication skills to medical learners, there is little published evidence that tests this argument. This study asked senior medical students what they would teach junior students about medical interviewing before and after the implementation of a formal communication model as part of curriculum renewal.

Methods: A mixed methods design was used with two cohorts of senior students at a US medical school: cohort 1 (N = 107, 2009) and cohort 2 (N=55, 2013). Interviews were conducted with both cohorts. Thematic analysis of interview data identified common themes students identified as teaching points.

Findings: Both cohorts emphasized flexibility as a key aspect of effective interviewing. Pre-intervention students’ responses varied widely and showed difficulty articulating a consistent set of effective communication skills beyond using direct questions to gather medical content. Post-intervention students explicitly identified the formal communication model and structure they were taught in the pre-clinical years as what they would use to teach junior students effective interviewing. They emphasized both the medical content and the process of interviewing, including specific skills for information gathering and relationship building.

Discussion: This study provided support for the use of a consistent communication model when teaching medical learners. Following curriculum change, students were much more able to identify specific skills and structure for teaching effective interviewing. These students had a shared language with which to discuss interviewing techniques and found the methods they were taught in the pre-clinical years useful in their clinical experiences. Flexibility was mentioned by both groups, indicating that while structure is important when first learning to interview, it should be made clear to students that such a model is a foundation rather than a restrictive format to guide clinician-patient encounters.
Patient-centered Communication

A Content Analysis of Patient Voice in Patient-Centered Communication

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Introduction/objectives: Patient-centered Communication (PCC) is the gold standard in effective clinical communication. Feedback from Standardized Patients (SPs) provides one strategy to teach PCC. Learners report favorably on SP feedback, but little is understood about the nature or quality of the feedback, particularly the degree to which it provides learners with a deeper understanding of patient-centeredness. We analyzed SP feedback and its alignment with the Kalamazoo Essential Elements Communication Checklist (adapted version) (KEECC-A) 1 and SP training.

Methods: Following encounters in a four-station residency OSCE, SPs provided verbal feedback based on the KEECC-A, a validated measure of PCC. Employing a purposive sampling strategy, we transcribed 80 videotaped feedback sessions. Using the seven global categories / corresponding behavioral anchors of the KEECC-A, and factors reflective of SP training, we developed a codebook and conducted a deductive content analysis.

Results: Transcripts yielded 395 feedback occurrences incorporating KEECC-A criteria. Three global categories comprised most of the feedback: 1) Sharing Information (37.2%) with understanding therapeutic options as the most frequently identified behavioral anchor (82%), 2) Building a Relationship (27.6%) with non-verbal skills most frequently identified (52.3%), and 3) Understanding the Patient’s Perspective (15.4%) with all behavioral anchors equally identified. Least employed categories were Providing Closure (3.5%) and Gathering Information (2.8%). Across all global categories, 10% had no corresponding behavioral anchor. SPs were encouraged to provide constructive feedback on both strengths and weaknesses. Feedback was largely positive (72%) across all categories, with most negative feedback occurring in the two least-frequently identified categories.

Discussion/implications: Salient to this research are frequency and quality of feedback elements in the KEECC-A. Findings provide insights specific to PCC, including emphasizing interpersonal connections and forging partnerships in care. Identification of least-frequently employed feedback informs future application of the instrument among learner levels.

Outcomes also suggest opportunities for instrument validation grounded in the patient perspective, as well as extending or refining analytical elements. Additionally, findings suggest opportunities for health communication and SP scholarship.

A Criterion Standard Research Rating Method for a Patient-Centered Interaction

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Background: In 1998, we developed the first evidence-based patient-centered interviewing method, and we developed a procedure to rate it. The rating procedure was valid and reliable but too long and subjective to be a criterion standard for rating a patient-centered interaction. We report improving it by dichotomizing items.

Method: Criteria again were derived from the 5 steps and 21 substeps of the patient-centered method, but we now dichotomized them; item criteria were detailed in a codebook. Requiring 48 hours, we trained two coders who were advanced undergraduate Communication majors unaware of the aims of the study. They reviewed 45 videotapes of learner-simulated patient (SP) interactions where learners had widely varying patient-centered skills. When trained, coders rated 20% of a new set of 136 tapes of learner-SP interactions. We evaluated inter-coder reliability using Cohen’s kappa for each of the six variables (below) of the coding scheme and for all items combined. Percent of agreement was calculated for each item, variable, and the overall scheme. We monitored reliability by dual ratings of 5 tapes every 30 tapes rated on the remaining 80% of tapes.

Results: During an iterative process, 45 original dichotomized items were reduced to 35. Trained coders required an average of 20 minutes to rate one tape. The six variables (and no. of items) were: agenda-setting (3), physical story (2), personal story (6), emotional story (15), indirect skills (4), and general (5); kappa’s ranged from 0.86 to 1.00. The overall kappa was 0.90, and percent of agreement was 97.5%. Percent of agreement by item ranged from 84-100%.

Conclusion: By dichotomizing items, we developed a shorter, more reliable coding method to rate a patient-centered interaction. Its origin in the first evidence-based patient-centered method further commends its use as a criterion standard for research evaluations of patient-centered interviewing.

Moving from Patient-Centered Care to Patient-Partnersed Innovation with Pain Management

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Pain was identified as one of the five HCAHPS drivers to top box overall hospital ratings at UPMC. Most importantly, striving for an acceptable level of pain control and doing everything we can to reduce our patients suffering is simply the right thing to do. To be successful, we needed to acknowledge that the first requirement for a positive experience was to identify our customer’s expectations. Former UPMC patients, who responded unfavorably regarding pain
on the HCAHPS survey, were invited to participate in one-on-one video-taped interviews. Our patients clearly “defined the problem”. Common themes across the interviews were “delays in receiving pain medication” and “unsympathetic staff” and these became areas of intense focus. We maintained that formal tie with the voice of the customer in both the design of tests of change and data collection. We asked in-patients on our 62-bed medical surgical pilot unit what was a reasonable time from when “they asked for pain medication until the nurse administered the medication”. Response mean time was 15 minutes and set our target goal. To measure the times from the “ask” to the “give”, we engaged patients as data collectors in a very unique and transparent process. And, with each test of change we continued to solicit feedback. From Pain Hotlines, to Pain Business Cards, to the strategic use of space and color with Pain Communication on the whiteboards, achieving upward trends was not just accomplished FOR our patients but WITH our patients. HCAHPS pain scores were 54% at baseline for our first quarter and 66.3%, 77.6% and 79.1% for each of the three subsequent quarters; an increase of 32%. We are currently spreading these strategies from the pilot unit to the rest of the hospital units (at UPMC Passavant) with planned enterprise deployment to all 14 UPMC acute care hospitals.

Promising Practices for Achieving Patient-centered Hospital Care: A National Study of High Performing United States Hospitals

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Introduction/Objectives: Patient-centered care is integral to healthcare quality, yet little is known regarding how to achieve patient-centeredness in the hospital setting. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measures patients’ reports on clinician behaviors deemed by patients as key to a high quality hospitalization experience. We conducted a national study of hospitals that achieved the highest performance on HCAHPS to identify promising practices for improving patient-centeredness, common challenges met, and how those were addressed.

Methods: We identified hospitals that achieved the top ranks or remarkable recent improvements on HCAHPS and surveyed key informants at these hospitals. Using quantitative and qualitative methods, we described the interventions employed at these hospitals and developed an explanatory model for achieving patient-centeredness in hospital care.

Results: Fifty-two hospitals participated in this study. Hospitals employed similar interventions that focused on improving responsiveness to patient needs, the discharge experience, and patient-clinician interactions and communications. To improve responsiveness, hospitals employed proactive nursing rounds (reported at 83% of hospitals) and executive/leader rounds (62%); for the discharge experience, multidisciplinary rounds (56%), post discharge calls (54%), and discharge folders (52%) were utilized. To improve clinician-patient interactions and communications, hospitals promoted specific desired behaviors and verbal and non-verbal communication standards (65%) and clinicians were held accountable to those. Similar strategies were used to achieve successful implementation including data feedback, and employee and leader engagement, training, and accountability.

Discussion/Implications: High-performing hospitals employed a set of patient-centered care processes and behavioral standards and involved both leaders and clinicians in ensuring that patient needs and preferences are addressed. The vast majority of high-performing hospitals employed multilevel strategies and interventions to ensure that their patients receive high quality hospital services that are sensitive to their individual needs and preferences. The most commonly reported challenge to achieving success was consistency in practice.

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Striking the Balance: A Case Study in Exemplary Patient-Centered Communication

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Introduction/objectives: Despite its promise to improve care, patient-centered communication (PCC) is not fully realized in practice. Adopting PCC is complex given the cultural shift needed to move clinical encounters from traditional, disease-focused discussions to those focused on patient priorities. There are many compelling models of PCC, but a lack of in-depth examples derived from observations of actual encounters. We present a case study of PCC, identified through our larger work examining PCC at 10 Veterans Health Administration (VHA) facilities.

Methods: We conducted ethnographic observations at two facilities who were leaders in implementing PCC. We documented observations using a field note template, including a 27-item PCC behaviors checklist, based on the literature and VHA’s model. Qualitative techniques, combining a priori and emergent procedures, were used to analyze the data.
Results: We observed a variety of clinical encounters, and identified one exemplary case highly aligned with PCC criteria. In this case, a nurse and health coach met with an unstably housed patient with multiple morbidities, including a history of substance abuse. The providers demonstrated all PCC behaviors identified in our field note template. The day prior, the patient had a three-hour urgent clinical encounter for dangerously high glucose readings. The patient had previously established the present appointment to discuss smoking cessation. Despite the diabetic emergency, diabetes was only addressed in the context of smoking—the patient’s priority. The providers assessed the patient’s life context, discussed tailored steps to meet the patient’s goal of cigarette reduction, and adapted previously successful techniques to overcome drug use, such as identifying a “smoking sponsor” and using religion to combat cravings.

Discussion/Implications: By highlighting how providers can attend to patient priorities while seamlessly addressing clinically important factors, this case exemplifies PCC in practice. Despite multiple health concerns, the providers waited for opportunities to discuss recommendations tailored to patient-initiated questions.

Provider-patient Communication

Communication Barriers in LGBTQI Patient-Provider Experiences

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Background: The lesbian, gay, bisexual, transgender, queer/questioning, Intersex (LGBTQI) community represents a growing and underserved population in the US. LGBTQI healthcare experiences and provider practices in the oncology setting are less known. This goal of these studies was to assess and compare the knowledge, attitudes, and practice behaviors of providers regarding LGBTQI health, as well as the LGBTQI population’s perceptions and health care experiences.

Methods: A 33-item web-based survey was emailed to providers at an oncology institution. The survey included: demographics, knowledge of cancer risk, attitudes, practice behaviors, and open-ended comments. In addition, members of Equality Florida™ (EF) participated in a 60-item web survey assessing knowledge of cancer risk and experiences with health care providers.

Results: 113 providers completed the survey. Less than 50% reported accurate knowledge of LGBTQI cancer health risks and concerns; 74% of providers do not ask patients about sexual orientation or gender identity and 72% did not feel well-informed on LGBTQI healthcare needs. The most reported comment was “I treat all my patients the same, I do not need to know.” 632 EF members (41% gay men, 29% lesbian) completed the survey. 67% reported always or often disclosing their sexual orientation/identity to providers when asked and 39% experienced negative reactions in a healthcare setting. Medical settings were perceived as safe when equality signs and gender-neutral language in documents was present. 85% of LGBTQI respondents regarded it “highly important” that their provider knew their sexual orientation/gender identity.

Conclusions: Recent American Medical Association (AMA) policies uphold the need for providers to inquire about sexual orientation/identity to prevent failures in screening and diagnosis. Knowledge gaps and practice behaviors among providers indicate a need for additional training and education. Not asking about sexual identity or gender orientation is in direct conflict with AMA and National Institute of Health Guidelines. Results from the LGBTQI population highlight perceived discrimination concerns and the desire to disclose as well as guidance on how to improve the perception of “safety” for disclosure in healthcare settings.

Promoting the communicative health literacy of people with intellectual disabilities: A review

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Introduction: Research has focused on communication difficulties in health consultations as one factor reinforcing the health inequalities experienced by people with intellectual disabilities (ID). Whereas research has identified the deficiencies of health staff in adapting their communication for patients with ID with repeated calls for staff training and improvement in this area, the communicative health literacy capacities of people with ID and opportunities for developing and enhancing these have received less attention, despite promising findings with mainstream populations. Indeed, the health literacy concept itself as it relates to people with ID has not been systematically explored. This review drew together intervention studies where key components addressed the health communication of people with ID.

Method: A systematic review of research literature relating to people with ID published between 1995 and 2015 was conducted using search terms that mapped onto key aspects of communicative health literacy. A narrative synthesis was conducted, with common themes and concerns identified through a more detailed thematic analysis.

Results: Fourteen full-text articles were included in the review. Most addressed “communication difficulties” on the part of people with ID as a barrier to healthcare, with interventions designed to promote describing symptoms, asking questions and requesting clarification. The role of carers was highlighted as potentially both promoting and impeding the health communication of people with ID. Interventions used a variety of teaching approaches as well as communication aids and health records to support communication and reduce anxiety. There was a lack of evidence for the impact of interventions in real-life health consultations.

Conclusions: Communicative health literacy interventions for people with ID not only promoted communicative skills, but also addressed some of the emotional and social contexts of health communica-
tions. However, the impact of institutionalized power differentials between patients with ID and health professionals tended to be overlooked.

Improving YNHH hospitalist communication with patients

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Objective: To improve YNHH hospitalists’ communication with patients and increase the HCAHPS MD communication score by 2% or more in 6 months.

Methods/Plan: To train all YNHH hospitalists on patient-centered interviewing, within 3 months. Then track the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) MD communication scores over a 6 month period.

Do: On October 23rd, 2014 we trained 4 hospitalists during a two-hour session which comprised of an initial overview and didactic session followed by role-playing using case scenarios.

Study: We obtained feedback from those hospitalists and adjusted the training session.

Act: We trained 126 day and night-time hospitalists (86% of a team of 146), using facilitators between 10/23/14 - 2/23/15. Most daytime hospitalists were trained October to December 2014.

Results: The Hospitalist MD Communication scores increased by 5.4% between October 2014 and March 2015 (from 71.5 to 76.9%). There was a consistent upward trend except for February 2015 when scores were lower than expected at 67.4%. Scores however rose to 76.9% in March 2015. The Listening and Courtesy composites rose significantly from 66.7 and 80.9% in October 2014 to 73.2 and 83% respectively in March 2015. The scores for Explaining things in a way the patient understands rose from 67 to 74.3% in the same period.

Discussion: HCAHPS MD communication scores increased after training by 5.4% in 6 months, largely due to increases in the domains of Listening and Courtesy. The training provides tools to improve patient perception of courtesy and listening but does not emphasize explaining.

Possible causes for a drop in scores in February 2015 are: less practice of these skills weeks after the initial training dates and the effect of patient census increases on practice.

A coaching program will commence May 2015 to encourage consistent practice and help sustain gains.

The effects of providers’ empathy and expectations on patients’ post-operative pain; an RCT performed in daily clinical care

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Introduction: Good communication is a core component of palliative and end-of-life (cancer) care. Despite the growing evidence base for the effects of certain communication elements on patient outcomes (e.g., empathy), other elements (e.g., the effect of discussing prognosis) have produced mixed results. Moreover, recent evaluations of communication skills training have been contradictory at best. This symposium tries to shed more light on the challenges and possible solutions in how to teach and evaluate communication (skills trainings) in palliative care, and how to implement study and training results into clinical care as well as generate new research directions.

Presentations: The researcher: Towards a better evaluation of communication (skills trainings)

The potential of using theoretical models, longitudinal designs focusing on patients’ proximal and distal outcomes, and taking into account appropriate mediators/moderators when evaluating communication (skills trainings) is discussed. Examples are provided.

The teacher: Towards a better teaching of communication skills the potential of using an approach integrating different skills, mandating trainings, and involving patient and family caregivers to improve communication skills trainings is discussed. An example of a novel communication training approach is provided.

The practitioner: Towards a better implementation of effective communication skills preconditions for successful implementation are discussed, such as convincing clinicians their peers are doing something different/better, using a script and ensuring enough time. Examples of successful implementation are provided, alongside a discussion of how clinical propositions (i.e. AMEN) raise new research questions.

Discussion: Key propositions towards better evaluation, teaching, and implementation of communication (skills trainings) in advanced cancer (and related diseases) are discussed with the audience. Attendees are encouraged to share their experiences and clinical/research ideas. By doing so, this symposium aims to provide an impetus to improve communication studies, trainings, and implementation from a research, teacher and clinician perspective, with the ultimate aim of improving patients’ outcomes.
When do patients conceal information from their physician?

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Introduction: Often, moments arise when patients are confused by information they are given; worry that they misunderstood information, or miss something their physician said. These events represent information-exchange opportunities that can “make-or-break” patient-physician communication; patients may actively withhold from seeking out more information when they need further clarification. However, no measure exists to assess the extent to which patients conceal information when further clarification is needed. This study aimed to assess patients’ prescriptive norms about engaging in information-exchange and behaviors associated with concealing information.

Methods: We conducted a survey of 338 patients (60% female; mean age: 36; 80% white). Borrowing from work on concealing negative feelings within close relationships, we created a 7-item scale of concealing information behavior within medical encounters (i.e. “When I feel uncertain about what my physician says, I am careful not to express it”; α=.94); and a 10-item prescriptive norms scale (i.e. “It’s okay for patients to ask physicians to repeat themselves, if they missed what was said”; α=.95). All items were measured from not at all to very much.

Results: Overall, patients believed that acting on opportunities is prescriptively normative (M=6.41; SD=.83). Majority of patients (77%) agreed that it’s okay to ask physicians to repeat themselves, ask questions even if unprompted, and for further clarification. However, two-thirds felt that physicians are bothered by patients that ask too many questions, of which one-quarter felt that these patients receive worse care. Nearly half of patients reported concealing information when they were confused, 25% reported delaying asking their physician to repeat unclear information, and 20% pretended to understand more than they did.

Discussion: Despite patients’ beliefs that their role in information-exchange is fundamental to the encounter, our findings suggest that patients are less likely to engage in this process when they are uncertain about what the physician is communicating.

Teaching and Evaluating Communication Skills

A faculty development program on Clinical Communication in a Portuguese Medical School: Impact on teaching and clinical practice

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Introduction with Institutional Context and Educational Objectives: Clinical communication skills (CCS) are among the core competencies in Medical Education, and essential for providing quality health care. To integrate CCS in the curriculum; it is important that faculty have efficient and effective CCS and be able to teach, observe, evaluate and provide feedback to learners. Therefore, a greater emphasis on faculty development in the domain of teaching and assessing CCS is required. There is a lack of outcome-based research about CCS teaching and assessment processes in Portuguese Medical Education. In order to promote an action plan for more effective CCS teaching and assessment in medical curricula, a Faculty Development program on CCS was implemented at the University of Porto, School of Medicine. The aim of this program was to promote and improve integrated teaching skills of CCS in clinical practice.

Instructional and Assessment Methods: The program included 6 different 2-days experiential modules, facilitated by 9 internationally recognized faculty experts. A pre and post course assessment was administered to 13 participants and to 15 control group members.

Program evaluation results: After the program, we observed: (i) significant differences between participants and controls in their ability to identify CCS principles (P = <0.001) and CCS teaching principles (P = 0.004); (ii) significant differences of participants with regards to definition of CCS (P = 0.003), skills spotting (P = <0.014) and feedback (P = <0.016). Importance of teaching CCC and participants’ confidence levels were also significantly different after the intervention (P = 0.001).

Discussion/Implications: Results suggest the program has a very positive impact on faculty’s recognition of the importance of CCS and its integration in their teaching and clinical practice. Faculty development programs can be valuable and effective tools for promoting better integration of CCS in health professional training.

This work was financed within the project CostProMed - PTDC/SAU- SAP/112908/2009 and CoachComProMed - 177/ID/2014
Communication training that works- A large scale communication intervention for all staff members

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Introduction/objectives: In 2011 an ambitious communication program was launched at a large regional hospital in Denmark. It was designed with the purpose of creating sustainable improvement of the communication and thereby: increase the patient-centered dialog in the consultations, improve the health professionals’ self-efficacy, and the patients’ experiences and assessment of the communication. We will present specific elements of the program and a preliminary assessment of the training course based on feedback from the clinical staff at the departments.

Methods: The cornerstone of the program is a mandatory communication course based on the Calgary Cambridge Guide. The elements of the program are: 1) education of local trainers; 2) communication skills training for health professionals employed in clinical departments (2+1 day); 3) education of new staff; 4) courses for health professionals in service departments; and 5) maintenance of communication skills. The program includes all having contact with patients corresponding to approx. 3000 staff-members.

In order to evaluate the effectiveness of the training course the health professionals’ self-efficacy are measured by Self-Efficacy Questionnaire (SE-12) before and after the training course.

Result: So far all 19 clinical departments have been included in the program and 1003 health professionals have completed the training course. A total of 907 (90.4%) have responded to the questionnaires showing that the self-efficacy of the health professionals increased significantly according to all twelve questions about specific communication skills and that 93 % feel they have become “better” or “much better” at communicating with patients.

Implications: By using a communication program that includes education of local trainers and involves the entire organization we have shown some of the positive effects of implementing communication skills training in a large organization. It is an initiative that can pave the way for other initiatives focusing on improving the communication skills.

Teaching Healthcare Professionals about Health Literacy: Convergence of Three Curriculum Studies

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Introduction: Studies show that healthcare professionals are inadequately trained about low health literacy among patients. Health professions educators lack adequate evidence to guide the design and implementation of optimally effective health literacy curricula.

Objectives: We sought to determine whether commonly used methods for teaching about health literacy were effective among different types of health professionals, and whether educational gains were stable over time.

Methods: We conducted 3 related studies among different cohorts of health professionals, each using the same validated survey instrument, with a pre- and post-training design, to assess participants’ perceived knowledge, perceived practices, and planned behaviors regarding health literate communication with patients. Study 1 examined pre- and post-training differences among 58 practicing physicians, nurses, and other health professionals participating in a half-day training. Study 2 examined the long-term effects of a 1-hour didactic session on 107 1st-year medical students, followed by a more in-depth didactic session 12 months later. Study 3 examined the stability of perceived and planned behaviors among 12 Family Medicine residents participating in a series of trainings over 18 months.

Results: Significant positive changes in perceived knowledge and planned behaviors were observed in all three studies. In Study 1, however, some of the gains among non-physicians were not observed among the physicians. In Study 2, viewing a health literacy video was effective in promoting planned behaviors among medical students; however, the majority of gains regressed to baseline over 12 months of follow-up. Study 3 showed sustained gains related to knowledge, but regression to baseline behaviors over a series of health literacy trainings spanning 18 months.

Implications: These data offer strategies for curriculum design (content, instructional methods and timing) for varying health professions audiences. Further direct observation studies are recommended.
Addressing family non-disclosure and conflict using family meetings

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Introduction: In Arab and Muslim cultures, families are centrally involved in medical care and decision-making. While there are many benefits of family involvement, families can also make healthcare communication more challenging. Family non-disclosure (e.g., families requesting the patient not be told of a diagnosis) and family conflict are examples of difficult family interactions. Physicians in Qatar asked how to interact better with patients and families in these situations. We developed a teaching module on family meetings to specifically address the issues of family non-disclosure and family conflict as part of a larger, 2-day communication skills curriculum.

Method: The module consists of a lecture, discussion, and role play with SPs. We present a general framework for family meetings, focusing specifically on strategies to address family non-disclosure and family conflict centered on an empathic negotiation approach. The 2-part role play scenario first addresses family non-disclosure and then family conflict. Participants completed a post-course evaluation. They were asked to rate the usefulness of the module for their communication with patients, on a 4-point scale from very useless to very useful, and to rate their satisfaction with the whole training.

Results: In this academic year to-date, 145 physicians and 71 residents (n=216) have participated in the module. (We will be able to report on n=400 by the conference). 97% of participants reported the module was useful or very useful for their own communication with patients. Satisfaction with the training is high; with 88% reporting satisfied or very satisfied.

Discussion/Implications: Our teaching module on challenges related to communicating with families in Arab/Muslim cultures has been evaluated well. Future work could explore the impact of the training on real experiences with families. Continuing to help physicians with effective and compassionate communication skills to address challenging interactions is critical to achieving good healthcare for patients and families.

Communication of complex information and risk in Genomic Medicine: A post-graduate teaching innovation

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Introduction/Context: Communication of complex genomic information provides challenges, with consultations concerning predictive testing (e.g. for cancer or neurodegenerative diseases); pre-natal testing; or the diagnosis of rare genetic disorders. Discussions involve exploration of detailed medical and family histories, explanations of genetics, and risk communication. Making informed decisions about genetic testing includes obtaining consent, preparing patients for the implications of test results, raising possibility of incidental findings, and uncertainty about outcomes. The literature identifies that consultations are largely educational and scientific rather than psychosocial (Paul et al, 2014).

Instructional and assessment methods: A Post-Graduate Certificate in the Interpretation and Clinical Application of Genomic Data (PGCert ICAG) was introduced in September 2014. The programme was developed for Clinical Geneticists in Residency and includes a teaching module aiming to enhance a clinician's ability to communicate genomic data effectively and sensitively to families and patients, as well as to other healthcare professionals.

A three-hour workshop includes i) one hour of didactic teaching, focusing on Shared Decision Making and Risk Communication strategies, and ii) experiential learning through role-play, co-facilitated by a Consultant/attending Clinical Geneticist and a Communication Skills professional. Trainees will implement their skills in clinical practice and reflect on real consultations.

Program evaluation results: Objective assessment will take place with three 15-minute OSCE stations (November 2015). Subjective pre- and post-course evaluation identifies perceived confidence, understanding of risk communication ‘best practice’, and free text comments. Results from the course evaluation will be presented.

Discussion/Implications: As the field of Genomic Medicine continues to expand rapidly, Clinical Geneticists are required to both interpret and explain increasingly complex genomic data. Tailored communication skills training for Residents aims to enhance their ability to help patients and their families make informed decisions about genetic testing and to understand the implications of test results for future outcomes and management.

Pediatric and Adolescent Medicine

Child/teen attitudes about ADHD communication with their providers and medication adherence

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Introduction/objectives: The purpose of the study was to examine:
(a) children/teen perceptions of communication with their pediatric providers about attention deficit hyperactivity disorder (ADHD) and how it could be improved, (b) where children/teens currently learn about ADHD and where they would like to learn about it, and (c) child/teen reported adherence to their ADHD medications.

Child/teen attitudes about ADHD communication with their providers and medication adherence

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Introduction/objectives: The purpose of the study was to examine:
(a) children/teen perceptions of communication with their pediatric providers about attention deficit hyperactivity disorder (ADHD) and how it could be improved, (b) where children/teens currently learn about ADHD and where they would like to learn about it, and (c) child/teen reported adherence to their ADHD medications.
Health information seeking, provider communication and health literacy for adolescents

Methods: Seventy children with ADHD ages 7 through 17 were interviewed and parents completed demographic questionnaires at two pediatric clinics.

Results: One third of the children/teens wanted their providers to discuss ADHD with them more during their medical visits. The average child/teen had many questions about ADHD and its treatment. Close to three quarters want to know if they will grow out of ADHD. Almost two-thirds want to know how their ADHD medicine will affect them. Seventy-four percent of the children/teens stated that they may not take their medications on non-school days. The provider’s office was the place where most children/teens wanted to learn about ADHD and its treatment.

Discussion/implications: Children want their providers to engage them more during medical visits and they have many questions about ADHD and its treatment. Providers should attempt to engage children/teens more during pediatric ADHD visits.

Stop, Look, Listen: Fostering Intra- and Interprofessional Collaboration in Child Abuse Recognition and Reporting

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Introduction/educational objectives: Child abuse is a major societal concern that requires a complex response from clinical and social welfare professionals. However, research has demonstrated that clinicians often fail to report injuries that they suspect are likely caused by child abuse. Barriers to reporting include: fear of negative outcomes for the family, uncertainty about the likelihood of abuse, and unfamiliarity with the investigative process. SLL is an interactive e-learning tool designed to increase confidence and comfort among primary care pediatric clinicians in recognizing and reporting physical child abuse. SLL follows children and families through both the clinical and investigative process, stressing inter- and intraprofessional communication. Healthcare providers work through clinical challenges in a simulated, safe environment that enhances their ability to address this critical public health issue.

Instructional and/or assessment methods: An interdisciplinary team of child abuse experts developed six “virtual cases.” They are organized into basic and advanced units. The cases illustrate a series of clinical encounters and concomitant investigative processes. At multiple points, clinicians are encouraged to explore alternate pathways. Effective communication with other clinicians (colleagues, child abuse specialists) and collaboration with child welfare services is modeled. Pre- and post-tests allow learners to see how their choices match those of child abuse experts. 37 pediatric clinicians field-tested the program in a preliminary evaluation with a 12-item survey.

Program evaluation results: The survey showed the following results: 97% described SLL as “easy to navigate,” 83% said it was “constructive to compare responses,” 92% would recommend SLL to a colleague, and 66% planned on making changes to their practice.

Discussion/implications: Learners responded positively to the realistic vignettes and their relevance to actual practice. Preliminary data indicate increased confidence in recognizing and reporting physical child abuse. SLL is a valuable tool for training physicians to recognize and report physical child abuse and encouraging collaboration with child welfare workers to keep children safe.

Findings suggest that adolescents with lower health literacy are more likely to seek information from a health provider and may have more difficulty using the internet for health information.
Talking About Weight: How Perceptions of Provider-Parent Communication and Relationships Predict Child Weight-Related Outcomes

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Introduction/objectives: Well-child visits are an opportune time to discuss weight-related topics. Although parents see pediatric health care providers as trusted sources of information related to child weight, the actual influence of provider-parent communication on weight-related outcomes is unknown. This study examines how changes in preschoolers’ weight-related behaviors and BMI relate to parent perceptions of the information received, the usefulness of the information, and the relationship they have with their pediatric provider.

Methods: Parents of preschoolers (N=291) completed two surveys one year apart; assessing the communication of weight-related information during well-child visits, perceived informational influence/usefulness, relationship quality (e.g., interpersonal treatment, trust, satisfaction, autonomy support), and frequency of children’s weight-related behaviors (food consumption, physical activity, and TV viewing). Children were weighed and measured each year. Hierarchical multivariate regression was used to examine how these perceptions predicted changes in weight-related outcomes.

Results: The number of weight-related recommendations provided did not significantly predict outcomes. Parental beliefs that weight-related information received during well-child visits influenced their decision-making predicted decreases in daily minutes of child TV viewing (p<0.01) and BMI percentile (p<0.001). Discussing the risks and consequences of being overweight had mixed results, predicting anticipated decreases in unhealthy food consumption (p<0.05), but increases in TV viewing (p<0.05) and BMI percentile (p<0.01). Satisfaction with information quality predicted increases in physical activity (p<0.05), while satisfaction with quantity predicted significant decreases (p<0.05). Most surprisingly, positive assessments of provider-parent relationship quality predicted increases in unhealthy food consumption (p<0.05) and BMI (p<0.01).

Discussion/Implications: Results suggest that relying heavily on providing weight-related information and developing/maintaining relationships may not lead to positive weight-related outcomes, and may, in fact, have the opposite effect. Satisfied parents may not equate to healthy kids. Effective communication strategies should consider perceived message quality and usefulness in decision-making. Risk communication should be tailored to the behavior being targeted.

Developing a framework for involving adolescents in shared treatment decision-making in healthcare

Author: Imelda Coyne, Trinity College Dublin

Introduction/objectives: Shared decision making (SDM) is a process in which children, parents, and healthcare professionals share information, express treatment preferences, and agree to the decision made. Although considerable work exists around adults’ participation in SDM, this work cannot be easily extrapolated to children because of: adults’ concerns about children’s competence to participate, parents’ desire to protect children from distressing information, burden of decision-making and child’s position in the triadic relationship. This paper will outline a framework for involving children and young people (CYP) in shared treatment decision-making.

Methods: We conducted a secondary analysis of qualitative datasets from three completed studies on shared decision-making with children and young people (aged 7-16 years) in Ireland. Study one explored CYP with cancer preferences for decision-making, study 2 explored decision-making with CYP with acute and chronic illnesses, and study 3 explored decision-making with CYP with mental health issues. The data from the three studies had been previously analyzed using the constant comparative method and managed with NVivo. The datasets were re-examined to draw out the concepts central to decision-making and to establish commonalities and differences.

Results: The antecedents included demographics, experience, information provision, salience, and beliefs. The influencing factors on decision-making included trust, relationships, nature of the illness, and utilities (usefulness and achieving one’s goals). The concepts central to the decision-making process were trust, control, and cooperation. The actions to promote decision-making included information-sharing, eliciting preferences, offering choices, negotiation and flexibility.

Discussion/Implications: Although significant conceptual work has taken place to delineate the concepts underpinning SDM, much of this work is based on research with adults. This framework requires further development and refinement. In the meantime it may be useful as a guide for professionals who want to promote and facilitate children and young people’s participation in shared decision-making in a healthcare environment.
Decision Aids and Decision Making

On a learning curve: Interviews with clinicians using the knee osteoarthritis Option Grid to support shared decision making

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Background: Shared decision making interventions are easier to introduce if they have minimal impact on clinician workload. We examined the views of clinicians about their intended, and actual, use of Option Grids within clinical consultations. Our aim was to assess the clinicians’ reactions to the concept of using these tools, to anticipated challenges, and to track their views about feasibility and acceptability as they proceeded to gain experience using the tool with multiple patients in the intervention phase of a trial.

Methods: This qualitative interview study was embedded in a trial designed to evaluate the impact of introducing Option Grids into consultations conducted by six physiotherapists in an osteoarthritis interface clinic in the UK. We conducted interviews with clinicians at two time points. The first interview was conducted after they had viewed the Option Grid and told about its proposed use. The second interview was conducted after clinicians had received training to use the Option Grid and had used it with six patients each. Data were analysed thematically.

Results: At initial interviews, the six clinicians voiced concerns including prior experience that patients do not expect to be involved in decision making and that the tool would lead to increases in the duration of clinical encounters. At the second interview, clinicians noted that the tool challenged their usual way of behaving and communicating, that they had grown in confidence and had learnt to personalize the grid to the patient’s needs, and they described that the tool, by providing a clear comparison frame, had enabled their approach to be more neutral.

Conclusions: The clinicians became more confident that the Option Grid was acceptable to patients and were therefore willing to explore how best to use them in their clinical encounters. How best to introduce Option Grids to clinicians will need careful consideration.
Designing a toolkit to support the implementation of information sharing in primary care settings

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Introduction/Objectives: The Veterans Health Administration (VHA) has invested in technologies to support “patient-mediated” information sharing with the goal of promoting patient engagement and improved communication. Unfortunately, use of these technologies remains limited. The Blue Button (BB), a feature of VHA’s web-based portal, enables patients to create an electronic file of self-entered and medical record information. Evidence suggests that clinical team member endorsement of technologies like BB is important to their uptake among patients, yet few resources exist to support providers in this role. We used multiple data sources to understand perceptions of BB among VHA primary care teams and applied these insights to design a toolkit to promote BB use.

Methods: We conducted an online survey (N=228; response rate=20%) and follow-up semi-structured, audio-recorded telephone interviews (N = 20) with primary care team members in a single VA geographic service region. Analysis of survey data was descriptive; interview transcripts were coded by multiple team members following rapid assessment procedures.

Results: Survey findings revealed that about half of respondents (53%) had heard of BB. Over 60% reported that they rarely or never discussed BB with patients; however, 56% agreed or strongly agreed that they would be supportive of efforts to increase use of BB. Interviewees struggled to describe how BB could support their daily clinical practice. Using these findings, we followed an iterative process to design 23 toolkit items which we organized into three categories: (1) Awareness tools; (2) Understanding tools; and (3) Go-deeper tools. The toolkit is currently being piloted at two VHA facilities.

Discussion/Implications: Toolkits of the kind we designed are a necessary resource if clinical teams are expected to endorse use of information sharing technologies. We expect that our toolkit will help to demonstrate the value of BB to various stakeholders—an important first step towards its broader implementation.

Primary Care Physicians’ Perceptions of Shared Decision Making for Cancer Screening

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Introduction: Physician’s perceptions of shared decision making (SDM) remain underexplored, and SDM is not well integrated in practice. We describe primary care physicians’ (PCPs’) perceptions of SDM for cancer screening.

Methods: Between 3/15-5/15, we administered a mailed survey to a sample of PCPs randomly selected from the American Medical Association’s master file. Using the first n=257 returned surveys, we report PCPs’ ratings of the importance of (1) SDM for cancer screening overall and for 11 specific screening scenarios of different US Preventive Service Task Force evidence grades (i.e., Grade A-B/offer service vs. D/discourage use vs. C-I/selectively offer), and (2) different communication behaviors to SDM. Differences in “very important” ratings by evidence grade were tested with repeated measure ANOVAs.

Results: Respondents were on average aged 52 years (sd = 11); 64% male and 76% white. 76% endorsed SDM as very important to cancer screening in general, but ratings of specific screening scenarios varied from a high of 72% for colorectal cancer (CRC) screening in adults 50-75 years (Grade A) to 62% for mammography before age 50 (Grade C) to 36% for CRC screening in adults 85+ (Grade D). On average PCPs were significantly (p<0.01) more likely to endorse SDM as very important for Grade A-B screening (65%) vs. 53% for Grade C-I and 46% for Grade D. Over three-quarters endorsed discussing test benefits (79%) and encouraging question asking (78%) as very important SDM behaviors, but only two-thirds indicated it was very important to present cancer screening as a choice (67%), discuss screening risks (66%), or elicit preferences for involvement in the decision (64%).

Discussion: PCPs’ perceptions of the importance of when to use SDM for cancer screening as well as the communication behaviors important to SDM is varied, and may contribute to lack of integration into primary care decision making.
Patient Participation In Treatment Decision-Making For Localized Prostate Cancer: Results from a randomized clinical trial

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Introduction/objectives: Patients with Localized Prostate Cancer (LPCa) who actively participate in consultations with their treating physicians make more informed treatment decisions and achieve higher satisfaction. This study aimed to examine the efficacy of a nurse-led intervention in improving patient participation in treatment decision-making for LPCa.

Methods: Data included 170 transcribed audiotapes of consultations for patients in a randomized trial that focused on LPCa treatment decision-making. Patients who were newly diagnosed with LPCa within 4-5 weeks were randomized into 3 groups: intervention for the patient (TD, N=60), intervention for the patient and caregiver (TS, N=57), and usual care (control) (N=53). The information about treatment options and communication strategies were delivered using a booklet, a DVD and 4 telephone calls.

Medical interviews were recorded post-intervention and transcribed verbatim. Using manifest content and thematic analyses and Atlas Ti, data in each transcript were categorized by 5 domains of treatment decision-making (health history, survival/mortality, treatment options, impacts, and preferences) and 4 levels of patient participation (‘none,’ defined as treatment topic not discussed; ‘low,’ defined as patient listening only; ‘moderate,’ defined as patient asking questions, and ‘high’, defined as patient and physician actively interacting). Coding discrepancies were resolved. GEE modeling was used to achieve the research aim.

Results: Compared with the control group, higher percentages of patients in the TD and TS groups demonstrated moderate to high levels of participation in discussions of: 1) survival/mortality; 2) treatment options of watchful waiting; 3) treatment risks; and 4) treatment preferences.

Discussion & Implications: We examined the efficacy of a multidimensional intervention in improving the levels of patient participation in treatment decision-making for LPCa. Evidence indicates that refining communication skills related to asking questions, obtaining answers, clarifying information and asserting a preferred treatment can enhance patient participation. Our findings have implications for improving future clinical practice.

Health Literacy

Functional Health Literacy in Immigrants - A Comparative Analysis of three Immigrant Groups in Switzerland

Authors:
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Introduction: Research from the US has shown that racial/ethnic minorities are particular afflicted by limited health literacy and related health outcomes. Yet little is known about this relationship outside of the US. Further, only little of the research has focused on how health literacy might be distributed across different immigrant groups and whether other factors such acculturation might play a role in this relationship.

The objective of the following study was to test whether health literacy and variables of acculturation are independent predictors of general health status among three different immigrant groups in Switzerland and to compare them to the native population.

Methods: 1100 face-to-face interviews were conducted with Swiss natives, or first generation immigrants from Kosovo, Portugal or Serbia. Functional health literacy was assessed with the Short Test of Functional Health Literacy (S-TOFHLA) in the respective native languages of the different immigrant groups. Acculturation was assessed by asking participants about being confident in reading and understanding health information in the language of the host country, as well as length of stay, educational years spent and age when taking residency in Switzerland.

Results: Preliminary analysis showed that in adjusted analysis perceived difficulties in understanding medical information and not being confident with filling out medical forms in the host country’s language were more important predictors of general health status than functional health literacy or any other acculturation variable (p<.05).

Discussion: Our results suggest that even though people might be health literate in their own language, lack of understanding of medical information in the new host country may lead to worse health outcomes and disparities. In particular in the clinical setting limited language proficiency might be a significant obstacle to successful disease treatment and prevention.
Patient characteristics associated with electronic health literacy (e-health literacy)

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Introduction/objectives: Health literacy and numeracy skills are associated with accessing and using online health information. We examined the association between health literacy and numeracy skills and three aspects of e-health literacy: the perceived usefulness of online health information, the ability to distinguish between high and low quality online health resources, and the confidence using online health information.

Methods: 1,622 patients hospitalized with cardiovascular disease at Vanderbilt University Hospital completed an interviewer-administered survey that collected age, gender, race, income, education, health literacy assessed with the Short Test of Functional Health Literacy in Adults (STOFHLA) and the Brief Health Literacy Screen (B HLS), and numeracy assessed with the shortened Subjective Numeracy Scale (SNS). We used multivariate ordinal regression to examine predictors of e-health literacy.

Results: The sample was on average 56.9 ± 12.0 years old, 84.4% White, 33.2% college educated, 10.5% with inadequate/marginal health literacy on the STOFHLA, and 24.0% with limited numeracy on the SNS. Fourteen percent of patients said the Internet was not useful for making health decisions, 27.4% were unable to distinguish the quality of online health resources, and 34.4% were not confident using the Internet to make health decisions. Being younger, more educated, more health literate and more numerate were associated with perceiving electronic health literacy (e-health information) to be more useful, the ability to distinguishing between high and low quality online health resources, and the confidence using online health information. Being male and non-white were also associated with being more confident.

Discussion/implications: Higher health literacy and higher numeracy skills are associated with perceiving online health information to be more useful, the ability to distinguishing between high and low quality online health resources, and having more confidence in using online health information. Providers and researchers should be aware of this when recommending patients access and use online health information.

<table>
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<th>Usefulness of e-health information</th>
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<td>1.12 (1.03, 1.21)**</td>
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*p<0.05, **p<0.01, ***p<0.001

The Role of Health Literacy in Explaining Health Disparities - A Systematic Review

Authors: Sarah Mantwill, University of Lugano
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Introduction: Health literacy is commonly associated with many of the antecedents of health disparities. Yet the precise nature of the relationship between health literacy and disparities remains unclear.

Adding to Berkman and colleagues’ work (2011) a systematic review was conducted with the aim to contribute to a better theoretical understanding on how health literacy potentially contributes to health disparities by including a systematic definition of what health disparities should entail.

Methods: Five databases, including PubMed/MEDLINE and CINAHL, were searched for peer-reviewed studies using strict inclusion criteria. Publications were deemed relevant when (1) they explicitly acknowledged the role of health disparities and/or (2) results were presented by comparing two or more groups in order to investigate the health disparity. Two reviewers evaluated each study for inclusion and abstracted relevant information. Findings were ordered according to the disparities identified and the role of health literacy in explaining them.

Results: 37 studies were included for final analysis. We found some evidence on the mediating function of health literacy on self-rated
Developing a collaborative partnership between researchers, community organizations, and persons with low health literacy to improve relationship-centred care

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Context: Low health literacy is a major barrier to healthcare, hindering effective communication between healthcare professionals and persons living with multiple chronic conditions. It especially affects recent immigrants, persons with low levels of education who have poor command of English or French, and persons on social welfare.

Objectives: The overall goal is to establish a sustainable partnership between researchers, community organizations, and groups of patients with a low level of health literacy who can act as experts to improve communication and care relationships.

Methods: Our study fits into a larger research program aimed at enhancing the healthcare experience of persons living with multiple chronic conditions and especially those confronted with social inequalities in healthcare. We use a participatory action research approach that ensures active and equitable participation of non-academic researchers in all research stages. Community organization leaders’ expertise was key to facilitating group discussions.

Results: Our results highlight basic conditions needed for patients to participate as research experts despite low health literacy levels. Three groups of persons with low literacy met regularly in three different locations in the province of Quebec, Canada: a large metropolitan city, an urban city, and a semi-urban city. Our patient-expert groups identified key challenges related to navigating healthcare and developed corresponding solutions that met their expectations and needs. This study also pinpointed key process elements for establishing a multi-site partnership with persons with low literacy.

Discussion: This study provides original data on a unique patient engagement research experiment involving persons with low health literacy. With the help of patient-experts, results will be shared with key decision-makers to help them bridge the gap between patient expectations and healthcare professionals’ communication skills. Innovative tools for patient engagement in research and training will be disseminated internationally.

Health education in traumatic spinal cord injury: Challenges of building health literacy overnight

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Introduction/objectives: Traumatic spinal cord injury (tSCI) is an example of a profoundly life-changing event. In the months after the injury, patients need to learn not only what SCI is but also - and most importantly - how to manage it. On the one hand, the complexity of the condition and the number of specialists involved in its management require an optimal collaboration among health professionals to provide evidence-based and consistent information. On the other hand, since the education received is essential to ensure appropriate self-management in the community setting, it is important that patients understand the information, learn how to apply it and start as soon as possible to apply it to minimize the impact of their new condition in their life. The building of health literacy (HL) should therefore be at the core of education for people with tSCI. The aim of this paper is to review the literature about HL in the field of SCI and discuss its implications for patient education.

Methods: Systematic and critical review of the literature about HL in the field of SCI.

Results: Despite the growing literature about HL and its acknowledged value in promoting self-management and health promotion, only six articles were identified. Studies mainly focused on functional HL (e.g. to evaluate the level of readability of information, information provision, information retention). Critical skills, such as the ability to evaluate new information in light of one’s own situation or problem solving, were only sparingly targeted.

Discussion/implications: The results point to a reflection on the role of patient education in a context that seems to be still mainly biomedical and in which the challenges of education are multiplied by the complexity of the condition. Suggestions of how to advance/ enhance this area are presented in light of other fields in which HL is more developed.
Simulation and Technology

Taming unstructured data: Analyzing empathy skills in virtual clinical training

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Aaron Kotranza, Shadow Health Inc. 
Jordan Neil, University of Florida

Introduction: Empathy is a core skill for healthcare professionals. Empathic skills are associated with improved patient satisfaction as well as clinical outcomes. Assessing empathy in clinical environments is challenging due to limited opportunities for training and feedback. The development of virtual training simulations can help overcome these challenges. The current study examines nurses’ empathic abilities during a simulated virtual health history exam. During the exam, nurses encounter up to nine patient disclosures warranting an empathic response based on the type and quality of their questions. Completed health history exams yield rich, unguided data on empathic attempts. While it is possible to easily identify whether nurses recognize opportunities for empathy, assessing the quality of responses is problematic due to the large amount of unstandardized data.

Methods: Data include empathetic statements by undergraduate nursing students while conducting a simulated health history exam (N = 212). Responses were content analyzed guided by message design logic, a communication theory that explains individual variation in how messages vary in content, organization, and potential effectiveness.

Results: Of 1908 potential empathic opportunities, nurses encountered 868 (45.5%). Of 868 encountered opportunities, nurses responded with an empathic statement 388 (44.7%) times. Most nurses encountered four opportunities and produced two empathic statements per exam. Empathic statements were coded as utilizing expressive, conventional, or rhetorical logics.

Discussion: The results show that student nurses recognize opportunities for empathy in response to self-disclosures about half the time. Furthermore, the variability in the quality of empathic responses demonstrates the need for communication skills training and assessment in the health professions. The coding system developed in the current study has the potential to be automated to provide real-time evaluation and feedback on nurses’ communication skills in virtual training environments and to examine the association between empathy and clinical outcomes longitudinally.

Learners’ Preference for Simulation Location in Program to Enhance Communication and Relational Skills (PERCS) Workshops

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Introduction/Objectives: During Program to Enhance Communication and Relational Skills (PERCS) workshops, interprofessional learners engage in simulation-based enactments of difficult conversations with actors portraying patients and family members. The objective was to examine learners’ preferences for location of the simulations, either in the specially-equipped simulation suite or “live” in the room.

Methods: From 2011-2013, PERCS interprofessional workshop participants completed post-questionnaires including items examining the preference for location for simulation-based enactments. Respondents indicated whether they preferred simulations held in: 1) specially-equipped simulation suite; 2) “live” in the room; or 3) both locations equally.

Results: 121/153 (79%) of respondents including nurses (36%), psychosocial professionals (21%), chaplains (12%), physicians (9%), medical interpreters (7%), others (12%), unknown (2%) completed questionnaires. Respondents ranged in age from 21-76 years (mean 49.6) and had 0-50 years (mean 20.2) experience. Of all participants, 49.6% felt both locations were equally preferable. 41.3% preferred “live” in the room,” and 9.1% preferred the simulation suite. Many respondents reported a deeper connection to enactments that took place “live” in the room. Of the subset of 16 volunteers who participated in the enactments, 62.5% reported both locations as equally preferable, 25% preferred “live” in the room, and 12.5% preferred the simulation suite. Qualitative comments illustrated respondents’ experience of the different locations.

Discussion/Implications: Overall, half of participants reported simulation suite and “live” in the room enactments to be of equal preference for simulated enactments. However, when preferences for location were stated, “live” in the room was favored. Volunteers who participated in enactments often remarked how real the simulations felt, and the “live” setting enhanced observers’ experience of that realism. The findings have implications regarding planning and design for simulation-based communication and relational learning activities. Learners acknowledged the merits of both locations, yet simulations held “live” were preferred over costly, high fidelity simulation suites.
Nonverbal Communication in Virtual, Clinical Weight Management Discussions; Influences of Racial Concordance, Incidental Emotion and Causal Attributions

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William MP Klein, National Cancer Institute

Introduction/objectives: Given racial disparities in obesity and obesity-related diseases, it is crucial to examine the experiences and reactions of minority patients interacting with racially discordant providers, and to understand how facets of the medical encounter (here, attributions and emotional state) influence weight management interactions. Examining nonverbal behaviors offers a window into patients’ implicit cognitive, attitudinal and affective processes related to these experiences.

Methods: One-hundred-and-ninety-eight overweight women were randomly assigned to exposure to a video to elicit either fear or anger, then interacted with a white simulated, virtual reality physician who provided information on either genetic or behavioral underpinnings of body weight. We assessed nonverbal/paraverbal behavior within the virtual interaction (gaze direction, interpersonal distance, voice pitch and pitch variability). We also measured explicit, self-report reactions to the interaction (perceived stigmatization, trust in the physician).

Results: Racially discordant participants who were angry and received genetic attribution information exhibited more physical nonverbal behavior indicative of interpersonal distancing (looking away, increasing interpersonal distance; \( F(1,186)=3.99, p=.047 \) and \( F(1,186)=5.95, p=.016 \), respectively). Voice pitch was also reduced among racially discordant participants receiving genetic information, though irrespective of emotional state, \( F(1,183)=7.42, p=.007 \). Self-report outcomes (perceived stigma, trust) were likewise more negative among racially discordant participants who received genetic information, \( F(1,187)=5.65, p=.019 \) and \( F(1,187)=6.37, p=.012 \), respectively. Self-report outcomes were uncorrelated with nonverbal behavioral outcomes.

Discussion/implications: Racial discordance between patient and physician can introduce difficulties into clinical interactions that can be further compounded by contextual aspects of the interaction (e.g., emotions and content of the encounter). By better understanding processes in play when discussing weight-related genetic information, we may be able to better shape future clinical communications.

A Two-Way Path Toward Effective Clinical Communication in the Pediatric Intensive Care Unit: A Simulation-Based Bootcamp

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Deborah Rooney, University of Michigan

Introduction with institutional context and educational objectives: Effective communication with patients and parents improves satisfaction and reduces healthcare costs. Few graduate medical training programs offer formal clinical communication training. The simulation-based “Communication Bootcamp” offers a novel learning opportunity for both fellows and parents, while creating a care team that employs effective two-way communication.

Fellows will be able to:
- List the four core principles of patient family centered care.
- Practice using patient family center care core principles in conversation.
- Identify and discuss barriers to achieving effective clinical communication with patients and parents.
- Use clinical communication skills at the bedside.
- Self-evaluate and reflect on personal bedside clinical communication skills.

Instructional and/or assessment methods: The program transformed into a 2-day, informal, authentic, two-way discussion among parents and fellows in the Pediatric Intensive Care Unit. On-going formative assessment was performed to measure 8 fellows’ bedside communication skills. Three parallel forms, targeted to the fellow, parent/caregiver, and other healthcare providers consisted of 5 items scored on 4-point scales ranging from 0 (Unacceptable) to 3 (Above expectations) to evaluate different aspects of care (engagement, respect, information, responsibility, hope). From July 2014-January 2015, 59 patient interactions were assessed with these measures. Responses by role were compared using Kruskall-Wallis test, and trends over time were analyzed using a Rasch model.

Program evaluation results: Healthcare providers’ [Observed Average = 2.8] and parents/caregivers’ ratings [Observed Average = 2.6] were higher than fellows’ [Observed Average = 1.8] across all aspects, \( p<0.5 \). Trends indicated improvement across all aspects over time, but statistical significance was not reached. Evaluation is on-going and updated results will be presented.

Discussion/implications: Preliminary findings suggest the “Communication Bootcamp” improves Pediatric Intensive Care Unit fellows’ communication with patients and their parent/caregivers. Future work includes analyses of fellows’ reflective notes, and evaluation of patients’/families’ attitudes toward the program. Structured simulation programs focused on communication can be effectively implemented into a graduate medical training program.
Re-aiming in Midstream: How RE-AIM framework can redirect health tailoring technology intervention for success with skilled nursing facility (SNF) patients

Authors: Glen Cameron, University of Missouri
Kartheek Dobbala, University of Missouri

Introduction: Skilled nursing stays are pivotal moments in patients’ health and can be fruitful points of intervention. As part of the PCORI research program funded by AHRQ, this pilot study aimed to assess use of a digital health technology platform designed to improve patients’ abilities to stay healthy and age in place. The platform used tailored health information, in combination with health indicator tracking and social networking capabilities. The study incorporated formative qualitative research interviews and a pilot launch of the actual digital health platform with patients. To evaluate the reach and representativeness of the population and SNF settings, the RE-AIM evaluation model was used to identify barriers and define course corrections.

Method: Over five months, 22 patient interviews were collected to assess patients’ attitudes, perceptions and values around digital health technology. RE-AIM’s evaluation model looked at measures of reach, efficacy, adoption, implementation, and maintenance and was coded using NVivo qualitative software.

Results: Using the RE-AIM model, three primary factors indicated the planned intervention needed to be re-directed. First, the reach was limited to motivated, cognizant and middle-class or higher SES patients. Second, the intervention showed modest efficacy due largely to psychosocial factors occurring during this SNF transition. These factors included patient confusion, anxiety and overstimulation, all which impede uptake of a new technology, even among early technology adopters. Finally, key SNF administrator turnover limited the adoption of the intervention.

Discussion: After evaluating the data through the RE-AIM framework, the research team determined that SNF settings are key moments in patients’ lives but do not always make for the best moment to introduce new technologies that can supplement learning and self-care. By refocusing the study’s digital health intervention to reach patients’ circles of care, instead of the patients’ themselves, the research team anticipates a faster adoption rate of the technology.

Mental Health

Asking for Help: Factors Influencing Disclosure of Depression Symptoms among Women

Authors: Elizabeth Jacobs, University of Wisconsin-Madison
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Rebecca Schwei, University of Wisconsin-Madison

Introduction/objectives: Depression is a major public health problem that disproportionately affects women and may adversely impact their long-term health and quality of life. Healthcare providers are more likely to initiate treatment when patients disclose symptoms of depression; therefore, efforts to facilitate symptom disclosure are critical for improving treatment outcomes for women. This qualitative study explored the experience of self-disclosure of depression to providers among African American, Hispanic and non-Hispanic white women.

Methods: 24 women with depression were recruited for interviews to evaluate decision making about depression care from the patient’s point of view. Interviews were recorded, transcribed verbatim, and coded by 2 reviewers for interpretation using NVivo software. Themes were developed using content analysis.

Results: We interviewed 10 white, 9 black, and 5 Hispanic women. Participant’s PHQ-8 scores ranged from 3-24 (mean 14.7; scores ≥10 identify current depression). Two main thematic categories related to the decision to disclose emerged: patient beliefs and patient-provider relationship factors. Women spoke a great deal about how their personal beliefs impacted their willingness to disclose their depression symptoms to their primary healthcare provider. Patients highlighted how patient-provider relationship factors such as confidentiality, provider asking, interpersonal competence, time, and trust in their provider either facilitated or made it difficult to disclose depression symptoms to providers.

Discussion/implications: Women still possess beliefs that prevent them from disclosing their symptoms to primary care providers. What emerged from this study is how potentially modifiable aspects of the patient-provider relationship as well as women’s beliefs about where and to whom they should share how they were feeling influenced their willingness to disclose depression symptoms. Interventions that support providers asking about depression along with increased public education about the integration of behavioral health and primary care may be key strategies for encouraging women to disclose depression symptoms in primary care settings.
Background and aims:
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Clinical Practice
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Competing priorities in depression care: A US national survey
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Glyn Elwyn, The Dartmouth Institute for Health Policy and Clinical Practice
Background and aims: In this study, we aimed to identify what information matters most to consumers and clinicians making a depression treatment decision.

Methods: We administered cross-sectional surveys to convenience samples of adults with depression and clinicians who treat depression. Quotas were applied to the consumer population to reflect age, gender and educational attainment of adults with depression in the US. A list of 20 common questions about depression treatments were provided and participants were asked to rank their top five. Clinicians were asked to provide rankings according to both consumer and clinician perspectives. Consumers also completed CollaboRATE a measure of shared decision-making.

Results: Of the 471 clinicians and 1557 consumers who attempted the surveys, 244 clinicians and 972 consumers responded to questions beyond those establishing eligibility. The most highly ranked question for both consumers and clinicians was ‘Will the treatment work?’. Both Consumers and clinicians ranked ‘What are the side effects of this treatment?’ and ‘How long before the patient feels better?’ in their top 5. However consumers also included and ‘how much does this treatment cost’ and ‘is the treatment covered by insurance?’, while clinicians did not include those items. Yet, when considering the questions from a consumer’s perspective, clinicians do include cost and insurance. Only 18 percent of consumers reported a gold-standard experience of SDM on CollaboRATE.

Conclusion: There is substantial concordance in information priorities between consumers and clinicians when considering depression treatment options. However, it appears that clinicians place less emphasis on cost and insurance coverage. This mismatch, coupled with consumer reports revealing a lack of shared decision-making, suggests that while clinicians often recognize what information is most important to consumers making depression treatment decisions, competing priorities in the clinical encounter can preclude focus on the information of most importance to consumers.

Health Literacy Mediates the Relation between Health Conditions, Depression, and Quality of Life via Control Beliefs
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Introduction: Research suggests that health literacy mediates the relation between health status and outcomes, but this has not always been rigorously statistically evaluated and possible mechanisms for mediation have not been explored. The purpose of this study was to evaluate the extent to which health literacy mediates the relation between health status, depressive symptoms, and quality of life and to assess whether health control beliefs are a possible link.

Methods: Data from a larger study included 380 participants’ report of health status (aged 18 to 85, with approximately half of the sample Spanish speaking). Participants also completed FLIGHT/VIDAS, a valid computer-administered measure of health literacy, the SF-36 (a measure of health-related quality of life) and the CES-D (a measure of depressive symptoms). Mediation models assessed the relations among health status, depression, and quality of life. Multiple mediator models assessed the extent to which higher levels of health literacy were associated with health control beliefs (agreement with “I am in control of my health care”) that in turn were related to...
Helping mothers expect the unexpected in childbirth: How prenatal communication can improve treatment of postpartum depression

Authors: Christy J.W. Ledford, Uniformed Services University of the Health Sciences; LaKesha N. Anderson, National Communication Association

Introduction: Postpartum depression (PPD) affects 10 to 20 percent of new mothers annually (Schneider, 2006). Risk factors linked to PPD include unexpected complications such as emergency C-section, preeclampsia, excessive bleeding, and persistent pain after delivery. Studies identify lack of social support as a risk factor for PPD, and suggest a link between incidence of PPD and physician support. Poor patient-provider communication during the prenatal period has been connected to detrimental events, whereas effective communication is shown to positively impact patients’ physiological status and psychological distress. One element of prenatal communication is shared decision-making. When providers do not explain factors affecting labor and delivery or work with mothers to set expectations, women’s birth experience suffers. This study explores the connection between self-perceived readiness for delivery and PPD.

Method: The study was conducted in the obstetrics and family medicine departments of a community hospital. Screening for inclusion criteria occurred from October 2013 to January 2014. Mothers (n = 82) completed the Edinburgh screening tool at intake and at six-weeks postpartum. Patient activation (PAM) was measured at 32-week gestation; readiness for delivery was measured at 36 weeks. A regression model using PAM, intake Edinburgh score, and two readiness items (ability to cope if delivery does not progress as planned, and ability to adjust to changes during delivery) was tested for effects on the postpartum Edinburgh score.

Results: A linear regression model including intake Edinburgh, PAM, coping, and adjustment explained 19% (R²) of the variance in postpartum Edinburgh, F(4, 72) = 3.96, p < .01. Intake Edinburgh significantly predicted postpartum score, β = .24, t(72) = 1.98, p < .05. Decreased coping was associated with increased postpartum score, β = -.42, t(72) = 2.40, p < .05.

Discussion: Results demonstrate two actionable implications. Readiness for delivery may be an additional screen for mothers at risk for PPD. Also, results identify an intervention target. Better prenatal communication, specifically addressing expectations and coping ability, may reduce incidence of postpartum depression.

Patient Education and Health Behavior

Increasing Utilization of Self-Management Support Groups in the PCMH

Authors: Theresa Lengerich, Bethesda Family Medicine Residency Program; Pershing Rebekah, Bethesda Family Medicine Residency Program; Stephen Zitelli, Bethesda Family Medicine Residency Program; Kaycee Bailey, Bethesda Family Medicine Residency Program

Background: The 2014 PCMH guidelines encourage primary care practices to assist patients with self-management of chronic diseases and health behavior change. To fulfill this goal, Bethesda Family Medicine, an urban family medicine residency began offering weekly smoking cessation, chronic pain support, and behavior change groups. The patients who have attended these groups have benefited greatly (Buelterman, 2015a; Buelterman, 2015b) but the rate of attendance has been low.

Objective: The challenge of patient engagement in behavior change is well documented (Torda, Peikes, Han, & Genevro, 2010) but little is known about patient preferences to obtain such help from their medical home. To design group programming that is most relevant to an urban, low SES population, a quality improvement team was convened and identified that voice of the customer (Desai & Shrivastava, 2008) was needed to design the most relevant group programs to offer.

Methods: A survey was individually administered to patients after their doctor visit. The survey, incorporating items adapted from Lorig and her colleagues (2001), was designed to assess patient knowledge, self-efficacy and preferences related to attending behavioral change groups in PCMH. Additionally it assessed patient understanding of what it means for their doctor to be a part of a medical home. The goal is to obtain a convenience sample of approximately 60 adults and to analyze results for themes and plan programming accordingly. Survey administration began in April 2015 with the goal of completion July, 2015.

Conclusions: We will summarize quantitative and qualitative data from the survey and describe how patient preferences are used to activate patients to attend self-management groups in the PCMH. Successes, challenges, and lessons learned will be discussed.
Consistent Patient Education: Meeting the Challenge of Integration within a Large Academic Medical Center

Author: Connie Feiler, UPMC

Introduction: Patient education is one of the primary opportunities to communicate with our patients, with the ultimate goal of improving health outcomes. UPMC, a world-renowned health care provider and insurer based in Pittsburgh, Pennsylvania, is an integrated health delivery system with over 20 hospitals, 500 doctors’ offices and outpatient sites, 3,500 employed physicians and 60,000 employees.

Yet, integration of so many patient care entities has led to a current state of fragmentation in the patient education program. Each touch point and computer system within UPMC uses its own teaching materials, leading to inconsistent patient instructions with potential harm due to conflicting information. An analysis completed by the UPMC Patient Education Governance Committee, consisting of clinical and quality leadership, concluded that UPMC relies on 11 different vendors to supply patient education content, in addition to internally developed education materials.

Practice Innovation: Our vision is to transform the current system of providing patient education into a more comprehensive system wide approach throughout UPMC that engages patients, their families, UPMC Health Plan members, and our healthcare professionals. Ultimately, our patients will be better prepared with consistent education messages leading to enhanced self-management skills and improved health outcomes.

Impact/Discussion: Over the past year, national best practices for patient education were researched and implemented, leading to development of a Strategic Plan for Patient Education. We also examined and strengthened our teaching strategies, addressing concepts of Health Literacy and Teach Back, to promote greater communication and expectations among caregivers to reinforce key messages for improved teaching effectiveness. Sharing lessons learned, quality outcomes, and the practical steps we took to improve our patient education program would be an honor and have potential to help others with this common goal.

Measuring Behavioral Signs of Physician Professionalism: The Professionalism Assessment Tool

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Introduction/Objectives: In 2009, Green, Zick & Makoul (GZM) published an article detailing how patients, physicians, and nurses define and prioritize behavioral signs of professionalism. Guided by the content of this work, we tested a new Professionalism Assessment Tool (PAT). Our objectives were to: (1) test the reliability, validity, and feasibility of the PAT; (2) provide systematic feedback on perceptions of professionalism.

Methods: We used the GZM article as the basis for developing a version of the PAT encompassing all 14 items that nurses deemed both very important and observable; the items employ a 5-point scale (never, rarely, about as often as not, most of the time, always). Other items designate physician specialty, respondent familiarity with the physician, respondent role, practice site, and practice setting. The PAT was administered on paper; all items fit on one side of one page. Nurses, advanced practice registered nurses (APRNs), and physician assistants (PAs) used the PAT to gauge behavioral signs of professionalism exhibited by post-graduate trainees (residents) during targeted portions of the 2013-2014 and 2014-2015 academic years; multiple PATs were collected per resident.

Results: Administration of the PAT focused on residents in internal medicine (n=79), ob/gyn (n=16), and surgery (n=49). Reliability was extremely high (Cronbach’s alpha > 0.95). Rigorous item-generation work reported in the GZM article assured content validity; this study established discriminant validity, predictive validity, feasibility, and practical value. While there were no statistically significant differences by program year, there were marked differences by program, with residents in internal medicine scoring higher on all items. Across all three programs, items with the lowest scores were directly related to communication (e.g., communicates clearly and effectively = 55% “always”).

Discussion/Implications: The PAT is a viable instrument for obtaining useful data on professionalism exhibited in everyday clinical practice, and highlights the importance of communication in healthcare.

Using Value Scores as an Incentive and Means to Finding Patients Lost to Follow-up

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A frequent challenge of communication with patients lies within the means of communication. Primary care physicians as well as entire medical systems frequently encounter patients that are “lost to follow-up”. These patients typically interact with a system by seeing a PCP or being hospitalized. They are given follow-up or asked to make follow-up appointments and are frequently not seen by the system for any continuity.

As a means of measuring continuity, the Value Index Score (VIS) is an overall score given to the Tulane University Medical Group (TUMG) that gives a reported score to measure the “overall quality” of an institution’s healthcare management. TUMG has recently received information regarding the VIS and used the VIS as an incentive to identify gaps and holes in the quality of our care. The VIS measures six different domains of care and identifies areas of deficiency in systemic care. In response to continuity of care domain that left room for improvement, TUMG has responded with standardized means of...
communication and outreach to patients traditionally called “lost to follow-up”.

We have implemented a systemic and standardized means of communicating with these patients to “find” patients that are lost to follow-up. We have utilized the services of a patient outreach coordinator to reach patients that have been seen in our clinics and hospitals at a prior date but have not been seen by our hospital system within the past calendar year. With the use of the value index score, we were able to locate 704 patients assigned to us that have not been seen within the last year. Our coordinator systematically reached out to these patients and brought them into our primary care offices.

To date, our systemic and coordinated outreach to patients has identified and located 309 patients and established their first visits.

Internet and Mobile Technology

A Smartphone-based Online Support Group for People Living with HIV

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Introduction/Objectives: People living with HIV (PLWH) often have unmet needs for support and information. Online support groups (OSGs) have the potential to overcome barriers to meeting these needs. Our study analyzes an innovative OSG delivered through a community message board (CMB) within a clinic-affiliated Smartphone application (Positive Links, PL).

Methods: For this pilot study, 38 HIV-infected patients were recruited through provider referrals. Participants received cell phones with the PL application that included the opportunity to interact with other users on a CMB. Logistic regressions investigated associations between participant characteristics and posting on the CMB. CMB messages were analyzed qualitatively using a Grounded Theory approach.

Results: 24 participants posted to the CMB; 14 did not. Participants had lower odds of posting if they were white [OR 0.20 (0.05-0.84), p=0.028] and had private insurance [OR 0.07 (0.01-0.41), p=0.003]. Participants had higher odds of posting if they had unsuppressed viral loads [OR 5.13 (1.13-23.30), p=0.034]. Of the 840 CMB messages over 8 months, 62% had psychosocial content, followed by community chat (29%), and biomedical content (10%). Of psychosocial content, posts frequently described stressors and coping strategies. Of community chat content, greetings were most common and included messages welcoming new members. Of biomedical content, most posts discussed medications, the importance of adherence and support for others having difficulty.

Discussion/Implications: This CMB on a clinic-affiliated mobile app may reach vulnerable populations, including racial/ethnic minorities and those of lower socio-economic status, and potentially provide psychosocial support to PLWH. Participants who posted on the CMB expressed support for each other, appreciation for the community, and a perception that the app played a positive role in their struggles with HIV. Next steps will include investigation of possible benefits from the app in improving social support, linkage and retention in HIV care, and health outcomes for PLWH.

Content of Patient-Provider Secure Messages at Two Veterans Affairs Medical Centers

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Introduction/Objectives: Secure messaging (SM) is increasingly being implemented by healthcare organizations to enhance patient-provider communication between visits. We sought to understand
how patients and primary care teams are utilizing SM by analyzing message content.

Methods: We assessed 1,000 message threads initiated between January and March 2013 at two Veterans Affairs Medical Centers. We sampled threads from teams based on SM volume and frequency of provider response. Messages in each thread were coded for a number of factors including message content and tone.

Results: The majority of message threads (93.4%) were initiated by Veterans or family caregivers, and only 6.6% were initiated by the clinical team. The majority of patient messages were focused on medication renewal and refill requests (47.5%), scheduling issues (17.6%), medication issues unrelated to renewals/refills (13.2%), and health issues (11.6%). Patients also used SM to request referrals (7.2%), address administrative concerns (6.3%), request test results (5.5%), ask about testing (5.4%), inform their clinical teams about relevant information (4.9%), discuss the patient portal or SM usage (4.0%). A small number of SM could be considered chatty (2.2%) or confusing (1.5%), but very few contained offensive or threatening language (0.2%), or clinically urgent content inappropriate for SM (0.7%). Clinical team-initiated messages were most often about test results (27.3%) or medication renewals and refills (24.2%). Providers conveyed empathy in 3.9%, provided reassurance and encouragement in 3.2%, and showed evidence of strong partnering and shared decision-making in 4.5% of threads.

Discussion/Implications: Despite provider concerns, very few messages contained clinically urgent content inappropriate for SM. There was variation across teams and across sites in message content and tone. Proactive use of SM by teams remained low. Educating providers on the most effective ways to use SM, including more proactive use of SM by clinical teams, may further improve SM-based communication with patients.

Evaluating the effectiveness of plain language integration in a cancer clinical trials website/app

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Introduction/context: Searchable websites/apps have made finding cancer clinical trials easier than ever. However, medical jargon used in trial titles and descriptions presents a barrier to the general public. People search for and find a trial online but may not understand its description or purpose. Integrating plain language into clinical trials apps can help diverse users understand and act upon information they find. Yet, this method has received little scholarly consideration.

Description of practice innovation: In 2014 a health literacy team from the Office of Patient and Public Education (OPPE) at University Hospitals Seidman Cancer Center (UHSCC) facilitated integration of plain language titles and trial purpose statements into all (140+) open clinical trials on our searchable website/app. In early 2015 user testing of plain language purpose statements began. The goal is to determine user comprehension of: a. the treatment being studied; b. cancer type under consideration and; c. basic inclusion/exclusion criteria.

Evaluation/Impact: As of mid-April 2015, 420 user tests of 15 clinical trial purpose statements using 216 adult volunteers from diverse populations were completed. Volunteers were given a screen shot of the trial details page, asked to read the plain language purpose statement and answer 3-5 questions to test comprehension. Purpose statements with less than an 80% correct answer rate for comprehension questions were revised and retested.

The majority of comprehension questions asked showed adequate user understanding (above 80% correct rate). Barriers to comprehension were identified and seven purpose statements were revised and retested. Detailed evaluations will be shared as well as future direction for the project.

Discussion/implications: Plain language descriptions are an effective means of enabling diverse users to understand and act upon trial basics found online. Website/app use has prompted calls to the UHSCC Cancer Information Line requesting more information and/or next steps needed for trial participation.

Does This Mean It Works?: Learning about Skin Cancer Research on Social Media

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Introduction: Skin cancer is one of the cancers that can be prevented with easy behavioral steps like applying sunscreen and staying out of direct sunlight unprotected. Even if health protection recommendations sound straightforward, their abundance leaves health consumers uncertain about the best course of action. The problematic integration theory posits that uncertainty associated with health recommendations may arise due to personal experiences or prior knowledge that contradict presented evidence or conflicting evaluation of possible health decisions.

Methods: Social media provide a robust environment where health organizations can share results of research, disseminate health promotion messages, and engage in a direct dialog with their audiences. This study used social media communication data to assess audience reactions to health promotion and health research messages. Specifically, comments (N = 238) related to skin cancer topics posted to the National Cancer Institute Facebook page between 2011 and 2014 were collected and analyzed using constant comparative method.

Results: The data showed that audience members comment to both share knowledge and personal experiences and actively seek additional information as well as to question shared information as conflicting with their personal experiences. This study provides evidence for further development of the problematic integration theory. Findings for practical implications suggest that health organization can use social media data for effective audience engagement but may need to develop processes and standards for removing self-promotion (advertising) comments and for responding to audience questions to support the online dialog.
Discussion: While surveys can provide evidence for predefined questions, the analysis of unguided comments and conversations among health information consumers provide a base for richer understanding of the issues related to uncertainty about health recommendations, audience information needs, and identification of potential barriers for health protective behaviors.

Can we stop people’s flying blind on the web? Investigating the role of cognitive biases during consumers’ online health information search via a general search engine

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Introduction/Objectives: One of the main purposes to use the Internet is the seeking for health information. This procedure mostly starts with the use of a general search engine. However, recent research reveals that online health information seekers are oblivious to the existence of false or misleading information on the web but are rather flying blind. They seem to be directly, yet unconsciously, influenced by the results yielded by a search engine, which has detrimental effects on knowledge, attitudes, and consequent decision-making. This study seeks to identify cognitive biases during the online search of health information and to stop consumers’ flying blind by increasing the salience of factual evidence and awareness for false health information.

Methods: During an online experiment 282 participants were asked to search for information about vaccination. A full 3x2-factorial design was employed with availability of factual information as the first factor and the warning of the presence of false information as the second. Objective data such as cursor movements and search behavior were collected and compared with participants’ answers in a post-test survey about their self-reported search experience, attitude, and knowledge about vaccination.

Results: Preliminary findings show order effects in consumers’ online search behavior. Results further indicate discrepancies between people’s actual search behavior and their conscious recall of the search. While the active search elicited a balanced elaboration of the topic, participants’ vaccination knowledge scores were yet low.

Discussion/Implications: Consumers’ unreflective absorbing of online health information and their biased search behavior call for further research on how to design a deblasing search environment. However, the tensions between an effective but still external valid and realizable intervention make this a challenging endeavor.

Getting the Questions Right: The Use of Social Media Conversations to Inform a Clinical Research Information Tool

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Introduction: Social media can reach large audiences and support active dialog between health research organizations and health consumers. Only 10-20% of social media users participate in active communication, their voices create a record of unguided, audience-initiated communication and can be indicative of the issues and questions shared by broader audiences. This study reports preliminary research aimed to inform a development of an information tool that would address questions about clinical research and provide current and potential research participants with relevant information.

Methods: The data for analysis were drawn from the posts (N = 1,975) and comments (N = 4,537) to the National Cancer Institute Facebook page between 2011 and 2014. The posts were filtered for the inclusion of research terms (N=716 with 1,244 associated comments) and questions posed by commenters. The final dataset included 139 comments from social media users. Comments were read and analyzed using constant comparative method to develop categories and identify recurring topics. The study received IRB approval prior to data collection.

Results: Questions from the audience formed three groups. First, general clinical trial literacy questions addressed randomization, clinical trial phases, and research logistics. Second, reasons for clinical trial participation and support questions addressed decisions for enrollment and differences in financial support. Third, trial-specific questions focused on side effects, co-morbidities, and available treatments for specific diseases and conditions.

Discussion: Social media comments provide a valuable source of audience-initiated questions. Some comments addressed general clinical trial questions but others evidenced prior knowledge about clinical research. Comments reported here where posted by active health information consumers, and triangulation with data from other sources is necessary to identify the differences between engaged and unengaged audiences.

Patients’ Perceptions of Electronic System Messaging With Physicians

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Background: Although electronic messaging has been used to improve the medical care of patients in various studies, there are concerns by physicians about the appropriate use of the messaging. Concerns by physicians include the possibility of urgent medical problems not being addressed in a timely manner since e-mails are not always attended to as rapidly as a telephone call. There is also the concern of the inappropriate use of e-mail for sensitive
issues or those requiring face-to-face communication. Recent studies assessed only those patients who have e-mailed about medical problems, so the fraction of those with such problems who e-mailed vs. called or sought medical care cannot be determined. In addition, there are no prior studies assessing patient who have not yet signed on to such systems, since all studies to date have, by design, involved patients already familiar and utilizing regularly an electronic messaging system. We therefore conducted a survey of patients who signed on, and have not yet signed on, to a messaging system as to their perceptions about its use.

Methods: A survey was developed which uses hypothetical scenarios in which patients might use electronic messaging vs. the telephone to communicate with their physicians. The survey was validated among 20 General Internal Medicine faculty, and then pretested in 30 patients in a university faculty practice. The survey instrument asks how likely they would send an e-mail message via the electronic messaging system to their physician in 12 different scenarios. The hypothetical scenarios vary according to the urgency and seriousness of the symptoms and possible underlying diagnoses, with 2 of the scenarios deemed acceptable for patients to e-mail their physicians, and 10 deemed as unacceptable for electronic messaging to be used to communicate the problem. A total of 500 patients in a university faculty practice completed the questionnaire. The total number of correct responses to scenarios was calculated and used to compare electronic messaging users and non-users via student T tests. The total number of scenarios that were deemed as a correct response was used as an independent variable in analyses of the impact of demographic variables via multiple regression analyses.

Results: Of the 500 responses, 33 had no access to e-mail of any kind and were therefore eliminated from the analysis. The respondents were largely well educated, with about 2/3 having signed up for the electronic messaging system. A large portion of respondents incorrectly used electronic messaging in the hypothetical scenarios, with 7% and 26% indicating they would not use electronic messaging in the two situations which were deemed appropriate for electronic messaging and 27-59% likely to use it in the 10 situations which were deemed inappropriate. Patients who had signed up for electronic messaging were significantly more likely to appropriately use electronic messaging than those who had not signed up for it (p < 0.001) and female patients were more likely to correctly use electronic messaging than male patients (p < 0.001).

Conclusion: Patients may have inaccurate perceptions of the appropriateness of using electronic messaging for relating symptoms of an urgent nature and receiving test results which should be conveyed in person. Those patients who have not signed up for electronic messaging, and therefore have not received guidelines about its use, are particularly at risk for misperceptions about using the system. All patients who use electronic messaging should be educated about its appropriate use.

Text Messaging Program to Improve Medical Follow Up for Patients Receiving Sexual Assault Exams

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Context: US Department of Justice estimates 290,000+ victims of sexual assault over age 12 annually in the US. Physiologically, they suffer unintended pregnancy, sexually transmitted infections, HIV transmission, and sometimes disability from physical injuries. Psychologically, sexual assault victims are six times more likely to experience post-traumatic stress disorder and more than 13 times more likely to abuse alcohol or drugs. Almost one-third contemplate suicide. And 17% attempt suicide compared to one-half of one percent of the adult population. Medical follow-up for victims is non-existent or inadequate in most communities.

Description of practice innovation: Barriers to medical follow-up after sexual assault include little funding and the challenges of communicating with a highly sensitive population. Our research team has piloted a low-cost, automated and personalized text-messaging program to improve follow-up care for victims of sexual assault. The program enables full expression of the US Dept. of Justice National Protocol for Sexual Assault Medical Forensic Examinations. Using electronic propinquity theory we designed a communication protocol to promote affiliation, trust, and willingness to accept and use health information.

Evaluation: Results from the first 15 months are favorable. Costs are low. More than half of eligible patients enroll. A majority of patients engage in bidirectional texting and make follow-up appointments. The Sexual Assault Response Team successfully provided rapid consultations in response to patients’ distress texts.

Discussion: Electronic propinquity theory appears to provide a useful framework for designing low-cost health communications. We discuss how propinquity theory informed the use of text messaging as a tool to increase acceptance of follow-up (for both patients AND SANEs!) and issues in the development of our text-based patient follow-up. We review collaborative efforts to expand access to the program, as well as possible adaptations for other populations such as non-offending caregivers of children who have been sexually assaulted.
Use of mobile phone to promote governance and equity within the health system: Experience of rural health district in Burkina Faso

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Introduction/objective: The use of mobile phone has been described as offering a remarkable potential to deliver primary health care. It is widely used in low- and middle-income countries to support health care delivery such as maternal and child health care. In Burkina Faso, high maternal mortality rates and persistent numbers of people living with HIV are priorities to address by government. A strong primary health care approach is required to ensure that people are able to access adequate, affordable and equitable health care.

Here we described an innovative mobile phone platform that helps to overcome barriers of access to health service community members.

Methods: A mobile phone project was implemented to enhance better access to health information and care delivery for mother, newborn and people living with HIV. An interactive voice system was developed and incorporated major local languages to overcome literacy barrier. In addition, an automatic patient’s reminder system for follow-up appointments was incorporated.

Results: Overall 423 pregnant women, 319 newborn mothers and 116 HIV/AIDS patients were followed-up by the system in 2014 by community health workers. An average 177 patient’s reminder for appointment was completed. There was an 8% increase of antenatal care uptake and 3.5% for newborn BCG vaccine and better compliance of HIV patients to antiretroviral services.

However, running mobile devices in remote areas is challenging. About 29% of cell phone devices were damaged. Community data synchronization within national health system and system interoperability were a big challenge faced.

Discussion and implications: Use of mobile phone at community level is undoubtedly a powerful tool to increase their equitable access to health care information and participation to local health care governance. However the issue of cell phone robustness and availability of sustainable source of energy need to be more explored.

Keywords: mobile phone, maternal and child health care, equity, access to care, governance, Nouna, Burkina Faso

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Construction and Validation of the E-SEGUE, a tool to assess communication in the computerized setting

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Introduction/objectives: The introduction of computers into primary care has established the computer as an active “participant” in the medical encounter. The existing communication assessment tools do not take into account the changes in physicians’ behavior caused by computer use, nor do they refer to the challenges entailed in maintaining patient-centered behaviors when the medical encounter includes the computer. The primary objective of this study is to develop and validate a physician communication skills assessment tool, based on a robust methodological measurement construction process. We selected an existing framework, the SEGUE, as a foundation for developing an integrated tool for assessing physician communication skills in the computerized environment.

Methods: The main stages included in this study are: construct definition, item generation, content validity assessment, scale purification and refinement, development of scale’s norms, statistical validation of the scale and an additional refinement of the scale’s norms. We refer to the integrated tool as the e-SEGUE.

Results: The item generation process was on the literature and has resulted in the generation of 27 items. Experts and novices participated in two panels commenting on the items validity, clarity and encounter stage distribution. Five items were discarded, producing a total of 22 items that construct the e-SEGUE. The final stage of the validation process included inter-rater reliability (IRR). The mean Kn calculated for the entire sample shows that 70% of the items received between moderate and perfect agreement with a mean Kn of 0.703 which is considered moderate agreement.

Discussion/implications: The e-SEGUE communication assessment tool have been constructed and validated. Further validation of the e-SEGUE is called for. It can serve as a benchmark for appropriate EMR use by physicians. In addition, though the patient-centered approach mainly targets the physicians’ behavior, research on the patients’ perspective regarding the e-SEGUE items is also warranted.
Cross-cultural Communication

It is all about the language? - Communication barriers in collaboration between international doctors and colleagues

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Introduction: Several studies worldwide have described language barriers as an issue for new international medical graduates (IMGs) and concluded that IMGs need both language training and language tests. Sufficient language skill is important for patient safety and for the well-being of both IMGs and their colleagues. In this Norwegian study, we investigated how recent IMGs and their Norwegian colleagues emotionally handled experiences of language barriers in everyday work practice.

Methods: We interviewed 16 IMGs who had recently begun working in Norway, and 12 doctors, nurses, and healthcare leaders who have extensive experience working with IMGs. Participants were encouraged to share experiences of collaboration in everyday work practice. Data was analysed by the Systematic Text Condensation method.

Results: The IMGs described a loss of professional communication skills, a loss of identity that resulted in uncertain communication, and awareness that their language challenges made them a burden for coworkers. Most described an experience of becoming introverted in their practice because of an inability to handle communication as they desired.

Colleagues recounted that even a small language deficiency spread uncertainty about the IMG’s knowledge and skills. This uncertainty made these colleagues act differently when collaborating with IMGs than with other colleagues.

Both studies demonstrated that situations that were conceived as language barriers were indeed also about cultural differences, unclear authority conditions, awareness of xenophobia, and a general lack of understanding about systems and procedures.

Discussion: Even small language barriers provoke emotions of uncertainty for both IMGs and their colleagues. Acculturation is a process of adaptation for both the immigrant and the native citizens that they interact with. Both IMGs and their colleagues need support in handling the uncertainty that is inherent in their collaborations.

Accountability and trust in intercultural and Swedish medical consultations

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Introduction/objectives: Sweden is a multicultural society. In 2013, 56% of physicians who were granted medical licenses had been educated outside Sweden (Socialstyrelsen, 2013).

Trust is a fundamental part of physician-patient relationship. Trust is even more important in intercultural consultations, when language problems and cultural differences might have a negative influence on physician-patient relationship.

This study illustrates how trusting and distrusting is expressed in medical consultations between Swedish patients and their foreign and Swedish physicians. The strategies used by the physicians for enhancing trust in their patients are presented.

Methods: Transcriptions of 63 video recorded foreign physician-Swedish patient and Swedish physician-Swedish patient consultations are used in the study. The data was analyzed using activity-based communication analysis and discourse analysis.

Results: Analysis of data shows how communication can lead to increased or decreased trust, and in some situations have no apparent effect. The accounts can possibly lead to trusting if they correspond to the uncertainty or needs the other party expresses, assuming willingness to collaborate and cooperate. Counteracting distrust using accounts is complicated, especially when this becomes unexpectedly needed in ongoing interaction.

Uncertainty about quality of foreign physicians’ medical education, language proficiency and cultural differences in views on hierarchy are some of the factors that influence Swedish patients’ trust in foreign physicians. Showing empathy and initiating personal disclosure, providing support and reassuring, and taking extra time are the strategies used by foreign physicians to enhance trust.

Discussion/Implications: Knowledge and understanding of challenges experienced and strategies used by physicians and their patients related to trust could reduce stress and anxiety in consultations in general, and in intercultural consultations in particular. It can lead to better patient care and health outcomes.
Peer Language Navigators (PLNs): Bridging Gaps in Understanding and Services in Multicultural Anchorage Alaska

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Introduction/Context: Anchorage Alaska includes the most culturally diverse zip code in the US, and over 100 languages are spoken in the Anchorage School District. The Anchorage Literacy Collaborative (TAHLC) engages diverse organizations and individuals to promote health literacy to limited English proficient students at the Alaska Literacy Program (ALP) and to immigrant and refugee communities throughout Anchorage, Alaska.

Innovation: In 2008, TAHLC’s Peer Language Navigator (PLN) model began with breast and cervical cancer workshops and screenings with the goal to provide culturally appropriate and comprehensible health information to ALP students. The approach included recruiting and educating PLNs, training health providers, and building support for breast and cervical cancer screenings and follow-ups. In 2013, the PLN model was expanded through National Library of Medicine (NLM) funding with the goals to train and support PLNs to find reliable online health resources and to conduct community outreach. The approach included recruiting PLNs, developing training sessions on health information, computer basics, and online resources, and creating an outreach plan to share health knowledge with community members.

Evaluation/Impact: The outcomes of the initial breast and cervical cancer screening projects included an increase in participants’ health knowledge, identification of abnormalities from screenings, and successful referrals. The objectives of the NLM projects were also met and exceeded: 2 cohorts of PLNs (4 PLNs per cohort) were able to identify many different attributes of reliable online health resources and all 8 PLNs reported increased confidence accessing and sharing health information online. All of the PLNs who have completed the program feel proud of their work and have expressed an interest in continuing to expand their health communication roles in the community.

Discussion/Implications: PLNs serve a crucial ‘cultural broker’ role in improving health communication and health status for vulnerable refugee and immigrant populations. Collaboration of health and academic organizations with (and within) the existing adult literacy programs has provided unique opportunity to foster health literacy. Knowledge and skills acquired and practiced through this program helps build community capacity and provide increased cross-cultural understanding.

Patient Safety

A conceptual model for engaging parents in patient safety within the Neonatal Intensive Care Unit

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Introduction/ Objectives: A positive culture of patient safety within neonatal intensive care units (NICU) can decrease threats to patient safety. Parents are an integral part of the NICU culture, yet little is known about their perceptions of patient safety or the roles they would find meaningful and appropriate for engaging in safety promotion activities. The purpose of this study was to determine how neonatal parents conceptualize patient safety and perceive their role in the NICU.

Methods: Using a focused, medically-applied ethnographic approach, semi-structured interviews and field observations of parent interactions within the NICU were conducted from January to November 2014.

We interviewed a purposive, ethnically diverse sample of twenty-two neonatal parents with infants both currently admitted and recently discharged from a large tertiary NICU. We conducted field observations across multiple days, shifts, and weekends. We coded the interview and field observation data and conducted a content analysis to identify themes that were then verified through peer debriefing.

Results: We developed a conceptual model of parent involvement in NICU patient safety. Neonatal parents reported that care was safe when clinicians and staff were present, intentional and respectful when adhering to security and infection control procedures, interacting with their baby, and communicating with parents. Parents identified their roles as advocates, caregivers, decision-makers, learners, and guardians in partnership with bedside clinicians to promote safe care.

Discussion/Implications: Communication with clinicians is critical to parents’ perceptions of safe care and to their role as decision-maker. Promoting a culture of partnership between clinicians and parents is integral to communication and to parents engaging in actions to promote safe care for their infants. Assessing parents’ views of patient safety could improve measures of safety culture within the NICU.
Improving Patient Safety: Changing Culture Through Disclosure Communication Training

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Introduction with institutional context and educational objectives: Training the next generation of physicians to be leaders in patient safety and communication is essential. As part of a comprehensive Patient Safety curriculum of four Colorado residency programs, residents participate in disclosure communication training to disclose medical errors to standardized patients (SPs). The goal of the exercise is to educate residents on what patients expect from providers when things do not go as planned and how these events should be handled from a humanistic, patient-centered standpoint.

Instructional and/or assessment methods: Residents come to the Center for Advancing Professional Excellence, (CAPE) the University of Colorado School of Medicine’s simulation and standardized patient training center. Residents complete two disclosure cases, based on real situations, so that a baseline of skills is established and an opportunity to learn occurs. Residents are rated by the SPs on several elements: empathy, apology, accountability, structuring the interaction, relationship building, closing the session, trust, openness, and honesty. Resident disclosure encounters are videotaped so residents can review their encounters with their residency program advisor.

Program evaluation results: Debrief is an essential part of the experience, underscoring that developing disclosure skills is a lifelong process and practicing communication skills in a safe environment, is an essential element of patient care. Learners have expressed, “Very realistic, very educational,” “It was challenging to address the emotions of the patients,” “It is always hard to deal with an angry patient, so this is a useful exercise.”

Discussion/Implications: Our experience indicates that when residents are part of a culture of reporting and discussing errors, the fear of negative effects often associated with admitting or reporting a mistake is reduced. With opportunities to practice and develop disclosure communication skills, the residents are better prepared to handle adverse events with patients, families and other professionals.

Communication to care

Author: Belinda Dewar, University of the West of Scotland

Introduction: Compassionate caring is a key priority for policy, practice and research worldwide, being central to the quality of care for patients and families, and job satisfaction for staff. Therapeutic relationships are essential to achieving excellence in care but little is known about how to develop and sustain such relationships in a culture that increasingly focuses on throughput and rapid turnover. Key objectives of the study were: to develop an understanding of the concept of compassionate relationship-centered care within the practice setting; to develop, implement and evaluate strategies that promote this concept; and to examine the processes that need to be put in place to enable sustainability of these strategies.

Methods: Appreciative action research was employed to explore when compassionate care works well and to identify and further test out strategies to support staff to enable this to happen more of the time. This was carried out in an acute health care setting caring for older people. Data were generated through interviews and observations with 34 staff, 12 patients and 10 relatives. The data were analysed using immersion/crystallization technique and the findings results were feedback to study participants for validation and review.

Results: The results showed that the key ingredient to compassionate caring was caring conversations. From the 240 hours of observations and the 56 stories a framework of caring conversations was developed that comprised: being courageous, connecting emotionally, being curious, considering other perspectives, collaborating, compromising and celebrating. This framework enabled people to know who people were and what mattered to them; understand how they felt, and to work with each other to shape the way things were done.

Discussion: The study demonstrates that engaging in caring conversations promotes compassionate, relationship-centered care but that these conversations involve practitioners taking risks. Such ‘relational practices’ must therefore be valued and accorded status. Staff require appropriate support, facilitation and strong leadership if these practices are to flourish.

Paediatric Early Warning Systems - A common language, open communication and situational awareness - A systematic review to support development of National Clinical Guideline

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Introduction/objectives: Paediatric Early Warning Systems (PEWS) are bedside tools which help alert staff to clinically deteriorating children by periodic observation of physiological parameters and predetermined criteria for escalating urgent assistance. In 2014, a priority of the Irish Health Service Executive’s National Clinical Programme for Paediatrics was the implementation of a National PEWS. This systematic review assessed the evidence on the use, validation, education and cost-effectiveness of PEWS used in acute paediatric healthcare settings for detection and/or timely identification of child (0-16 years) deterioration.
Parent Medication Dosing Errors: Role of Medication Beliefs

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Introduction/Objective: Children are more sensitive than adults to adverse events from improperly dosed medications, and dosing errors are frequent among parents administering liquid formulations. There is limited knowledge of modifiable factors that influence pediatric liquid medication dosing errors. Beliefs about medications are known to be associated with patient behavior and outcomes in adult populations. We aimed to examine the association between parent beliefs about child medication use and liquid medication dosing errors.

Methods: English- and Spanish-speaking parents of children ≤8y (n=1,041) were recruited in a multisite randomized controlled experiment aimed at improving administration of pediatric liquid medications. Dosing errors were defined as ≥20% deviation from the reference weight in each of 9 trials per parent. Medication beliefs were measured with the overuse and harm scales (range=4-20) from the Beliefs about Medication Questionnaire (BMQ; 5 point Likert: 1=strongly disagree to 5=strongly agree). Using generalized estimating equations, the relationship between each BMQ scale and the likelihood of making a dosing error was assessed, adjusted for trial arm, trial type, study site, language, and health literacy. Results: Parents’ mean (SD) age was 29.4 (7.4) years; 89% were mothers, 31% had <HS education, 54% were Hispanic, 38% had low health literacy, and 45% had limited English proficiency. Overall, mean (SD) errors/parent=2.3 (2). Stronger beliefs about medication harms were associated with greater dosing errors (OR: 1.06, 95% CI: 1.02-1.09). A larger proportion of dosing errors were above (68%), rather than below, the correct weight. No association was found with beliefs about medication overuse (OR=1.02, 95% CI: 0.99-1.05).

Discussion/Implications: Parents’ beliefs about child medication harm are independently associated with increased parent dosing errors with liquid medication, even after controlling for other factors. Sensitivity to parent health beliefs and culture is necessary to ensure safe and appropriate medication administration for children.

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Emergency Medicine

A multidisciplinary exploration of misunderstanding in ad hoc interpreter mediated Emergency Department consultations

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Introduction/objectives: Emergency medicine is a predominantly oral activity in which medical errors often result from poor communication. Despite the fact that Emergency Departments (EDs) are becoming increasingly linguistically diverse, professional interpreters remain underused. Hospital staff mainly rely on ad hoc interpreters who tend to make more errors than professional interpreters do. So far, the literature on language barriers in the ED has mainly focused on health outcomes in the presence of language barriers, and the impact of interventions such as interpreting on these outcomes. This study aims to contribute to the existing knowledge by analysing the process underlying these outcomes with a view to identifying targeted communication strategies that can be integrated in clinician training programs.

Methods: We audio-recorded ad hoc mediated consultations in a linguistically diverse ED and collected the corresponding contextual information via ethnographic participant observation (including note taking and after action interviews with clinicians). The consultations were transcribed, translated, and analysed by a multidisciplinary research team of applied linguists and clinicians. In a first phase, linguists analysed the causes of misunderstandings. In a second phase, clinicians assessed the misunderstandings with regard to their clinical relevance. In a third phase, we played back our analysis to the clinicians in question with the purpose of member checking and eliciting feedback.

Results: We identified a set of recurrent communication patterns that lead to misunderstanding. Based on these, we developed a taxonomy of the causes of misunderstandings in translations and role confusions between the clinician, patient, and ad hoc interpreter that lead to communication problems of clinical significance.
**A Responsibility to Reach Everyone: The Impact of Language Barriers on Emergency Medical Services**

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**Introduction:** Emergency medical services (EMS) rely on accurate and efficient communication. Globally, EMS agencies serve increasingly multicultural communities yet little is known about how language barriers impact EMS care. The objectives of this study are to describe the strategies used by EMS providers to overcome language barriers and the impact language barriers have on their decision-making.

**Methods:** As part of an international, multisite mixed methods study, semi-structured qualitative interviews were conducted with 27 EMS providers in three EMS agencies in the Western Cape province of South Africa and in the State of New Mexico in the United States. Interviews were audio recorded, transcribed verbatim, and iteratively coded for themes related to strategies used by EMS providers to overcome language barriers and changes in decision-making when confronted with language barriers. Interviews were discontinued upon achieving thematic exhaustion.

**Results:** Every EMS provider described patient encounters featuring language barriers. EMS providers express a sense of responsibility to treat all patients, regardless of their language. Common strategies for coping with language barriers include relying on bystanders as informal interpreters, multilingual coworkers, and non-verbal communication techniques. Strategies used in these encounters are informal and, although often effective, limited by concerns of associated time delays, inaccuracies, and risks to patient confidentiality. Major themes related to decision-making were heightened diagnostic uncertainty, an attitude of self-reliance, and increased stress for both patients and providers.

**Discussion:** EMS providers work in dynamic and challenging conditions and have few resources for addressing language barriers. In this study, EMS providers in different agencies and different countries report similar experiences with language barriers. Further research on the impact of language barriers on patient outcomes and the adaptability of language-assistance tools to the EMS environment is needed, with the goal of enabling EMS to provide the best possible care for multilingual communities.

**Associations between health literacy/numeracy and mortality in emergency department patients**

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**Introduction/Objectives:** The relationships between numeracy and health literacy with mortality after an emergency department visit have not been studied.

**Methods:** We assembled a prospective cohort of 300 adult patients with hypertension who had an emergency department encounter at an academic medical center. At enrollment, demographics and clinical characteristics were recorded; subjects completed measures of numeracy (Subjective Numeracy Scale [SNS]; range 8-48, higher indicating better numeracy; low numeracy [LN]: SNS<=20) and health literacy (Brief Health Literacy Survey [BHLS]; range 3-15, higher indicating better health literacy, low health literacy [LHL]: BHLS<=9). Multiple Cox regression evaluated relationships of low numeracy and low health literacy with mortality, adjusting for age, sex, race, insurance, education level and the comorbidities diabetes, renal insufficiency, and atrial fibrillation.

**Results:** Mean age was 59.1 years (standard deviation [sd] 11.2), 138 (46%) were male, 148 (49.3%) had completed high school, 124 (41.3%) had private insurance, and 187 (62.3%) were White. Patients were followed for a median of 437 days (IQR 377,488). Median BHLS was 15 (IQR 12-15; 35 (11.7%) with LHL). Twelve patients did not complete the SNS; of those who did, median SNS was 33 (IQR 26-38; 31 (11%) with LN). Mean baseline SBP was 136.6 mmHg (sd 24.2 mmHg); 18 (6.0%) died (33.3% LHL and 35.3% LN). Unadjusted hazard for death among patients with LHL was 4.11 (95% CI 1.55-10.96) and for LN 5.28 (95% CI 1.36-20.54). Adjusted hazard ratio (aHR) for LH was 6.92 (95% CI 1.35-35.53) and for LN 5.28 (95% CI 1.36-20.54).

**Discussion/Implications:** In this prospective cohort, low health literacy and low numeracy were independently associated with increased risk of mortality after an ED visit among patients with hypertension. Additional research is needed to better understand how literacy/numerator may be linked to morality to guide future interventions.
Implementation of an Interprofessional Simulation Training & Experiential Program (InSTEP) and its Impact on Sepsis Management in the Pediatric Emergency Department

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Background: Sepsis is a leading cause of death in children worldwide. In the fast-paced environment of the pediatric emergency department, effective team dynamics can positively impact patient outcomes for children experiencing sepsis.

Purpose: To develop, implement, and evaluate an interprofessional simulation training and experiential program (InSTEP) within a pediatric ED using Green and Glasgow’s (2006) RE-AIM as a program evaluation framework.

Methods: Baseline testing was conducted to assess participants’ readiness for interprofessional learning. Four interprofessional simulation sessions were conducted over a three-month period with two simulation scenarios designed to include process measures specific to the study institution’s pediatric sepsis management protocol executed at each session. Teamwork and communication were also measured during each session. Follow-up testing was subsequently conducted to assess for change in participants’ readiness for interprofessional learning.

Results: Both baseline and follow-up testing indicated that participants were ready to pursue interprofessional learning in their clinical setting. When knowledge was assessed on the institution’s pediatric sepsis management protocol, participants scored significantly higher (t = 4.7, p < .000) following attendance at an InSTEP simulation session. Mortality by health literacy level and numeracy level are shown in the figure.

Mortality by Health Literacy Level
Mortality by Numeracy Level

Figure: Mortality, by low health literacy and low numeracy.

Conclusion: Early successes demonstrated during InSTEP’s pilot testing indicate staff readiness for ongoing interprofessional learning. Key stakeholders should explore additional incentives and opportunities for healthcare professionals to attend future interprofessional learning activities.

When Electronic Medical Records (EMRs) Go Bad: Lessons Learned from a Botched EMR Installation in a For-Profit Community Hospital’s Emergency Department

Author: Barbara Cook Overton, Louisiana State University

Objectives: The Health Information Technology for Economic and Clinical Health Act (HITECH) was passed in 2009 and was fueled in part by reports from the Institute of Medicine and the World Health Organization suggesting medical errors could be reduced by up to 80% with development and widespread use of health information technology. Despite preliminary research and promises of improved patient safety and operational efficiency, EMR adoption rates have remained low and up to 80% of installations fail. Many studies have identified barriers to adoption, namely EMRs are expensive, difficult to use, time consuming, interfere with the physician-patient relationship, and disrupt workflow. Few studies to date have examined the long-term process of adoption and implementation of an EMR from start to finish, making this study both unique and valuable.

Methods: Qualitative data collected over 18 months consist of observation notes and interview transcripts with 37 nurses, physicians, and other healthcare workers in an Emergency Department (140-bed hospital).

Results: This study finds forced adoption of an EMR decreased provider agency and job satisfaction. Face-to-face interactions, particularly between physicians and nurses, declined following the EMR implementation. With respect to effective patient care, this has obvious repercussions; the Dallas Ebola crisis was ignited in large part because nurses and physicians accessed different portions of the patient’s electronic medical record without discussing, face-to-face, the patient’s symptoms and travel history. Other pertinent findings from this study relate to: role reversal/conflict and cognitive dissonance during EMR training, reactance amid forced adoption, burnout, staff turnovers, job dissatisfaction, organized provider resistance, uncompensated work/wage theft, staff redundancies, and unintended consequences.

Discussion: This study contributes to the existing EMR literature by filling gaps in qualitative emergency room analysis. Forced EMR adoption and poor implementation practices are timely and relevant topics with important clinical, interpersonal, and organizational implications.

Figure: Mortality by low health literacy and low numeracy.
Patient and Family Engagement

Developing a Roadmap for Patient and Family Engagement in Healthcare Practice and Research

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Introduction/Context: Growing evidence suggests that patient and family engagement can help achieve healthcare’s “Triple Aim”: improving health outcomes and patient experiences of care while reducing costs. Advancing the field requires a unified vision that reflects existing evidence, highlights emerging innovations and pathways by which engagement leads to improved outcomes, and addresses gaps in research and practice. The Gordon and Betty Moore Foundation funded the American Institutes for Research to develop a roadmap for patient and family engagement that presents a strategic vision for unifying research and that facilitates the translation of effective engagement strategies into widespread routine practice.

Description of Policy or Practice Innovation: To develop the Roadmap, we gathered a diverse group of over 70 stakeholders in a two-day convening, asking participants to work collaboratively to identify ways to push the field forward, identify areas where engagement can affect outcomes, and brainstorm action-oriented strategies to drive progress toward key outcomes.

Evaluation/Impact: The Roadmap defines eight change strategies that reflect priority areas for action and research, concrete examples of how to implement each, and associated outcomes:

1. Patient and family preparation
2. Clinician and leadership preparation
3. Care and system redesign
4. Organizational partnership
5. Measurement and research
6. Transparency and accountability
7. Legislation and regulation
8. Partnership in public policy

The strategies are executable for practitioners, health system leaders, patients and families, researchers and funders alike. While the change strategies are long-term approaches to creating a more patient-centered health system, the Roadmap also highlights specific “simple actions” each group of stakeholders can start today.

Discussion/Implications: The roadmap unites the wide array of engagement-related work currently being conducted across the healthcare spectrum under a single umbrella, allowing the identification of connections and synergies, and creating a unified path forward toward achieving the goals of the triple aim.

Measuring organizational readiness for patient engagement (MORE): An international online Delphi consensus study

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Introduction: While patient engagement in health care is promoted and recognized worldwide, health care organizations and clinical teams are slow to adopt it in routine care. Multiple barriers to patient engagement have been identified at the organizations’ macro- and micro-levels. Our aim was to develop a measure of organizational readiness for patient engagement.

Methods: The development of the MORE (Measuring Organizational Readiness for patient Engagement) scale was guided by Weiner’s theory of organizational readiness for change. A first prototype was developed using a literature search and critical appraisal of pre-existing tools. We subsequently invited multi-disciplinary stakeholders to participate in a two-round online Delphi survey. Respondents were asked to rate the importance of each proposed item, and to comment on the domains and items. Second round participants received feedback from the first round and were asked to re-rate the importance of the revised, new and unchanged items, and to provide comments.

Results: The first version of the scale contained 51 items divided into three domains, aligned with Weiner’s theory of organizational readiness for change: (1)respondents’ characteristics; (2)the organization’s willingness to implement patient engagement; and (3) the organization’s ability to implement patient engagement. The first survey was completed by 131 respondents from 16 countries (health care managers, policy makers, clinicians, patients and patient representatives, researchers, and other stakeholders). Seventy-two completed the second survey. During the Delphi process, 34 items were reworded, 8 new items were added, 5 items were removed, and 18 were combined. The final version of MORE totaled 38 items.

Discussion/Implications: The Delphi technique was successfully used to refine the scale’s instructions, domains and items, using input from a broad range of international stakeholders, including patients and patient representatives, aiming to develop a scale that can be applied in a variety of healthcare contexts worldwide. Further assessment is needed to assess the psychometric properties of the scale.

Keywords: patient engagement; implementation; organizational readiness; willingness; ability; scale development; Delphi consensus procedure
The lived stigma experiences of families living with epilepsy: Implications for familial engagement in dialogue surrounding the condition

Objective: On receiving a diagnosis of childhood epilepsy, families must not only contend with the medical aspects but also with the impact the condition has on psychosocial wellbeing and remnants of epilepsy-related stigma that still persist. Although epilepsy-related stigma is often reported as having more negative implications for families living with epilepsy than seizures themselves, little research exists that examines the extent and ramifications of stigma experiences for children with epilepsy (CWE) and their parents. This presentation highlights findings pertaining to the lived stigma experiences of CWE and their parents.

Methods: Data in this presentation emerged from a larger programme of research, the “Talking about Epilepsy” study, comprising two mixed-method studies. For the qualitative phases, in total, 117 interviews were conducted with CWE and their parents. For the quantitative phases, cross-sectional surveys were conducted with 60 parents and 40 CWE, examining the relationship between child and parent stigma perceptions and other variables (including quality of life, disclosure and family communication).

Results: Findings revealed that epilepsy-related stigma remains rife in modern day society. Experiences of both felt and enacted stigma emerged. Such experiences were highlighted not only by child and parent reports of exclusion, discrimination and prejudice, but also by the unwillingness of families to engage in dialogue surrounding the condition within the family context, and to be open and honest about the condition with others.

Conclusion: This study presents a unique insight into the difficulties faced by families living with epilepsy as a result of epilepsy-related stigma. In order to improve the psychosocial wellbeing of CWE and their parents, healthcare professionals should take an active role in attempting to eradicate epilepsy-related stigma. Furthermore, they should be cognizant of facilitating an environment in which families living with epilepsy feel comfortable communicating about epilepsy, both within and external to the family context.

The (side) effects of patient empowerment on medication adherence: A systematic review

Introduction: The vision of an empowered patient emphasizing the need for egalitarian doctor-patient relationship has received lots of attention in health policy. The relationship between patient empowerment and medication adherence has been widely investigated, but a systematic review is missing. The aim of this paper is to disentangle the role of empowerment and other related constructs (such as self-efficacy and health locus of control) in medication adherence. Special attention has been given to the ambiguities in the conceptualization of patient empowerment and medication adherence.

Methods: Relevant studies were retrieved through a comprehensive search of Medline and PsychINFO databases. In total, 4807 publications were identified. After applying an inclusion and exclusion criteria, 176 articles have been considered to be relevant. An appropriate level of interrater reliability has been established throughout the data extraction and quality assessment phases.

Results: The relationship between empowerment and medication adherence has been found to be predominantly positive across the literature. On the other hand, there are studies reporting no or even a negative association between empowerment and medication adherence. Firstly, the interplay between health locus of control and adherence outcomes seems to be very complex. Secondly, a considerable amount of studies call into question the unequivocally positive effect of self-efficacy on adherence. The results underline the complexity of the relationship between empowerment and adherence as well as the importance of taking into consideration other exogenous factors, such as disease characteristics or health literacy.

Discussion: This review summarizes the state of knowledge of the relationship between patient empowerment and medication adherence. The results point out the heterogeneity of the conceptualization of these constructs and its implication when comparing outcomes across empirical studies. The authors also highlight the importance of incorporating other factors into the model explaining medication adherence.
Communicative processes in medical decision making and patient recall in specialty care: Physician centered communication predominates

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Objectives: Shared clinical decision making requires that patients accurately remember information and recommendations provided by their physicians. Studies have found that patients typically remember about half of key information from routine visits. Certain communication strategies are commonly recommended to improve patient engagement and recall.

Methods: Observational study of audio-recorded outpatient cardiology and nephrology visits. In telephone interviews 4-7 days later, patients were asked to recall medical decisions from the visit; the interviewer probed for items not spontaneously recalled. Visit transcripts were analyzed using the CASES and GMIAS systems which isolate decision making processes, classify decisions, and characterize interaction process. OPTION coding for elements of shared decision making was applied.

Results: 89 coded visits included a total of 474 medical treatment decisions or recommendations with available follow-up data. Of these 190 (40%) were freely recalled with good accuracy. 183 (38.6%) were accurately recalled after prompting; it is unclear if patients might have remembered these later without prompting. 101 (21.3%) were recalled inaccurately or not at all. Physician behaviors of interest were rare. Within decision making processes, the ratio of provider to patient speech acts was 2.48. Only 6 medical decision making processes (7%) included a single provider open question, and 3 (3.5%) included a “teach back.” Based on OPTION coding, physicians stated the existence of more than 1 option for 37% of decisions, but discussed pros and cons of more than 1 option for only 3.4% of decisions. Other OPTION codes were similarly rare.

Discussion: We found a higher percentage of decisions recalled accurately than previous studies, perhaps because we prompted patients who failed to recall spontaneously. Physician communicative behaviors thought to be associated with better recall and shared decisions were very rare; it was not possible to test their effectiveness. In this sample, physician-dominated decision making was overwhelmingly the norm.

Emotional Expression and Support

Emotional Experiences among Siblings of Children with Rare Disorders

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Abstract: Previous literature reveals that having a sibling with a rare disorder represents a risk to the emotional health of children. Information about what characterizes the experiences of siblings is important in health practitioners’ encounters with siblings of children with rare disorder, or when communicating with children as carers more in general. Knowledge about the emotional aspects of the siblings’ situation is also crucial when planning and conducting interventions targeted at these groups of children. The present study aimed to provide new knowledge about the emotional experiences of siblings of children with rare disorders as expressed through participation in support groups. Qualitative thematic analysis was conducted based on videotapes of 11 support groups for 58 siblings aged 7-17 years (M _age = 11.4 years, SD = 2.4) of children with rare disorders. Participants described contradictory emotions in three main contexts: (1) implications of the disorder (knowledge, medical issues, prognosis); (2) consequences for family life (practical implications, limitations of the child with disorder, perspectives on the sibling relationship); and (3) consequences for social life (reflections about (ab) normality, reactions from others). Passive coping strategies were frequently described relative to active coping strategies. An emerging dilemma for participants was hiding versus sharing emotional experiences.

Conclusions and implications: This study revealed that siblings’ emotional experiences are characterized by diverse and contradictory feelings. Interventions to promote emotional health in siblings of children with rare disorders should address this complexity. Practitioners should provide space for emotional content, facilitate emotional expression and validate and normalize the experience of contradictory and mixed feelings. Further, interventions should address communication about feelings, as concealing emotions seemed to be a common coping strategy among the participants.
Do multimorbidity and deprivation influence patients’ emotional expressions and doctors’ responses in primary care consultations? - An exploratory study using multilevel analysis

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Objective: To explore whether and how patient multimorbidity and socio-economic deprivation conditions might influence patients’ emotional expressions and doctors’ management of patients’ emotional expressions in the general practice (GP) consultations.

Methods: Video recordings of 107 consultations (eight GPs) were coded with the Verona Coding Definitions of Emotional Sequences (VR-CoDES). Multilevel logistic regressions modelled the probability of GP providing space response, considering patient multimorbidity, deprivation conditions and other contextual factors. Further multinomial regressions explored the possible impact of multimorbidity and deprivation on patients’ expression of emotional distress and GPs’ specific responses to patients’ emotional distress.

Results: GPs were more likely to provide space for disclosure of emotional distress at the initials stage of the consultation. As the consultation proceeded, the tendency to provide space for emotional disclosure weakened until closer to the end of the consultation when this tendency started to stabilize. Patients with multimorbidity were less likely to express emotional distress in an explicit form. GPs were more likely to provide acknowledgement to emotions expressed by patients from more deprived areas.

Discussion: Multimorbidity and deprivation may influence the dynamics of the GP consultations in specific ways. Rigorous methodologies using larger samples are required to explore further how these two variables relate to each other and influence cue expression, provider response and subsequent patient outcomes.

Implications: Understanding how multimorbidity and deprivation impact on GP consultations may help inform future service improvement programmes.

Interprofessional Clinicians’ Strategies for Managing Emotions during Difficult Healthcare Conversations

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Introduction/Objectives: To examine the strategies used by interprofessional clinicians to manage their own emotions when holding difficult healthcare conversations.

Methods: Self-report questionnaires from interprofessional learners from a range of experience levels and specialties were collected during simulation-based Program to Enhance Relational and Communication Skills (PERCS) workshops for healthcare professionals. The following open-ended prompt asked clinicians to qualitatively describe the strategies they currently employ to manage their emotions during difficult healthcare conversations: Please share what strategies/approaches/advice you use, if any, to help manage your own emotions when having difficult healthcare conversations.

Results: 126 participants from six different PERCS workshops completed questionnaires. Respondents included physicians, nurses, psychosocial professionals, and medical interpreters. Professional experience of respondents ranged from 0-36 years. Respondents identified 1-4 strategies for managing their emotions. Typically, respondents identified two strategies. Five primary types of strategies were identified: Self-Care Strategies; Preparatory Activities; Remain Empathetic; Utilize Team Approach; and Maintain Professionalism. Self-care strategies were most commonly reported. Half of respondents reported use of self-care strategies such as: deep breathing; reflecting; journaling; exercising; and talking with family members. Illustrative, descriptive responses for each strategy will be presented.

Discussion/Implications: Across disciplines and years of experience, clinicians reported a similar range of strategies for managing emotions when holding difficult healthcare conversations. The findings from this study can inform the development and refinement of educational initiatives to support clinicians’ awareness of and skills for effective emotional management. Improvement of how clinicians manage their emotions when holding difficult healthcare conversations has the potential to enhance their confidence and capability when engaging in these critical conversations with patients and their families.
Do support groups act supportive? Emotional dialogue in support groups for siblings of children with rare disorders

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Introduction/objectives: Support groups are arranged for children in difficult life circumstances to help them express emotion, share experiences and gain support from peers. Research indicates that support groups may increase psychological wellbeing, but research describing the communication in the groups is lacking. We do not know how children share emotional experiences or support each other. This study aims to provide this new knowledge and answer the following research questions: a) What are the immediate responses following expressions of negative emotions in group sessions? b) Is it possible to identify prominent communication patterns in dialogues following expressions of negative emotion?

Method: 17 support group sessions with 30 siblings of children with rare disorders aged 11 to 16 were videotaped and analyzed with VR-Codes to identify expression of emotion and immediate response. The communication sequences following the emotional expressions were transcribed and content analysis applied to identify prominent patterns in communication.

Results: 117 emotional sequences, 59.8% initiated by a cue and 40.2% by a concern, were identified. Immediate responses were most often providing space for further disclosure of the emotional experience (67.6%). Plural immediate responses were rare but tended to be of similar nature. Children rarely provided immediate responses. Eight prominent communication patterns were identified based on communication style: Adult centered exploring-, avoidant- or informative and child centered dyad-, exploring-, consensus-, diversity- or self-referring. Seven prominent communication patterns were based on affective response: Positive cheerful or re-defining and emotional empathic-, talkative-, advisory- or avoidant.

Discussion/implication: Children rarely respond immediately to an expression of emotion in a support group session. Communication that follows may take many forms and some patterns seem more supportive than others. This finding forms the basis for a study exploring which communicative patterns children find supportive. Such knowledge may guide education programs for group leaders.

Two Approaches to the Analysis of Health Providers’ Response to Patients’ Emotional Concerns

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Introduction: Recognizing and responding to patients’ negative emotions and concerns are recognized as important tools in patient-centered medical consultations. A number of methods have been developed to study how health providers (HP) recognize and respond to patients’ expressions of their emotional concerns. In the present study two methods of analysing physicians’ responses to expression of cues and concerns are compared.

Objectives: To investigate how quantitative and qualitative approaches to emotional communication may complement one another.

Methods: Six videotaped hospital consultations were coded using Verona Coding Definitions of Emotional Sequences (VR-CoDES) and independently analyzed in accordance with a discourse analytic (DA) framework. One consultation was chosen for more detailed analysis.

Results: We analyzed each identified HP response by VR-CoDES to see if similar observations about the extent to which the HP provided space for further disclosure were included in DA or not. In some of the same or overlapping interaction sequences, similar conceptualizations of the HP responses were applied. On the other hand, we also found interaction sequences in which the two different methods represented a different understanding of the same HP responses. Each example will be documented in detail.

Discussion: This study demonstrates that HPs’ responses to patients’ expressions of concerns can be successfully studied by employing a combination of methods, which includes a quantitative approach as well as inductive qualitative discourse analysis. The VR-CoDES gives a precise description of HP’s immediate responses to the patient’s identified concerns in a certain sequence, but is limited to code individual utterances. The analysis may therefore fail to grasp the social meaning and functions of these responses. DA complements, and in some instances questions, the VR-CoDES findings with its emphasis on sequences rather than single responses.
Limited English Proficiency

Patient-centeredness in interpreter medicated consultations—An interdisciplinary investigation of responsibility distribution

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Introduction: Patient-centred communication is widely practiced in medical consultations. Assuming and attributing responsibilities of managing clinical and communicative tasks is a significant component of patient-centredness. However, this process is complicated when communication is mediated by an interpreter. Our research investigates responsibility distribution in mediated consultations, and its effect on patient-centredness.

Methods: Data consist of 26 video-recorded consultations with qualified professional interpreters in general practices in the UK and hospitals in Belgium. Languages spoken by participants include Russian, Turkish, Punjabi Mirpuri and Czech. The analysis draws on Conversation Analysis and Goffman’s Participation Framework.

Results: We identified two main responsibilities distributed among the participants—clinical responsibilities (ClRs) and communicative responsibilities (CoRs). Interpreters were found to be taking the speaker roles of principal, author and animator either in turns or at the same time, depending on the CoRs they assume, or are attributed by others. This led to alterations to other parties’ assumptions of the ClRs, which sometimes caused the doctor or patient failing to undertake the desired ClRs. The same effects occurred to CoRs, which was mainly associated with the sequential organisations of turn-taking. There was a tendency in the data for the doctor’s voices to be prioritised over those of the patient, leading to the loss of the patient’s voice.

Discussion: While acknowledging professional interpreters’ significant contribution to doctor-patient communication, there is still much to do in the cause of achieving patient-centred communication in interpreter-mediated consultations. A better understanding of responsibility distribution may be one of the heuristics for training both clinicians and interpreters to improve their interactions. Skills to identify and manage clinical and communicative responsibility distribution in partnership should be incorporated in training programmes for both professionals.

Lack of medical interpreters during clinical interactions: Privacy and disclosure dilemmas

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Introduction/objectives: Language barriers continue to pervade medical interactions. Though existing literature documents the use of medical interpreters in bridging the gap, the provision of such services is unavailable in certain countries. Hence, physicians must rely on family, friends, and ad hoc personnel to help with interpretation, which poses enormous challenges. This study utilized Communication Privacy Management (Petronio, 2002) theory to examine how the use of untrained interpreters affects patient disclosure patterns.

Methods: Participants were identified through purposeful sampling. A qualitative data collection method was utilized. Twelve patients engaged in focus group discussions (six per group) and ten physicians participated in semi-structured interviews. With participants consent, focus groups and interviews were audio-recorded. The analysis included coding, categorization, and generation of themes.

Results: The results highlighted privacy and disclosure concerns. Participants stated that due to the lack of formal interpreter services and unavailable procedures on who qualifies to facilitate communication on behalf of a patient, serious concerns exist about privacy. For example, patients are insecure about the confidentiality of information that they convey through the interpreter given that no clear guidelines pertain to the process. Moreover, patients seemed reluctant to share, or struggled with the presentation of conditions which bothered on sex, genitals, or stigmatizing disease such as HIV/AIDS. Consequently, physicians argued that patients’ reluctance to provide adequate information impacted diagnosis and treatment regimen.

Discussion/implications: The Communication Privacy Management theory posits that in health care situations, a patient’s decision to disclose will also depend on the nature of a person’s illness, cultural values, gender, and the potential risks or benefits associated with disclosing. As evident from this study, patients experienced a high level of discomfort sharing their intimate health information with untrained interpreters. Findings suggest a policy framework for medical interpreting and the need to protect patient privacy.

Standardizing the Way Clinicians Report their Non-English Language Proficiency Levels

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Background: There is currently no standard for clinician self-report of their non-English language (NEL) skills. The purpose of this study
was to test the reliability of a self-reporting scale of clinician language proficiency and explore characteristics associated with accuracy in self-reporting.

**Methods:** Primary care providers (PCPs) who reported using NEL skills to communicate with patients were recruited. PCPs used the Interagency Language Roundtable (ILR) Scale to self-assess proficiency, consisting of five levels: excellent, very good, good, fair, and poor. They then completed the Clinician Cultural and Linguistic Assessment (CCLA), a validated oral-proficiency exam (passing score=80/100). Percentage pass-rates for each ILR-category were estimated. The difference between each participant’s CCLA score and the average CCLA score in their ILR category was calculated.

**Results:** Ninety-eight PCPs participated in this study. The majority were women (75.5%), identified as White/Caucasian (62.2%), with Spanish (81.6%) as their NEL. The average CCLA score was 78/100 and 69 (70%) participants passed the CCLA. Participants who self-reported as “good” (45%) had an average CCLA score of 79.3. All participants who self-reported as “fair” and “poor” failed the CCLA (0% pass-rate), while all who reported “excellent” passed (100% pass-rate). There was a strong correlation between the ILR and the CCLA (.512; p<.0001). Spanish-speaking clinicians were significantly more likely to underestimate their NEL skills compared to clinicians who spoke other languages. Non-Whites and males had a non-significant trend towards overestimating their NEL skills.

**Conclusions:** Self-reporting of NEL proficiency using the ILR correlated to tested language proficiency, especially for clinicians who reported “excellent” or “poor/fair” skills. Spanish-speaking clinicians underestimated their skills but it is unclear if other characteristics are associated with over- or underestimation of language skills. Future research should explore the impact of NEL proficiency on patient outcomes and establish standards for the use of non-fluent language skills with LEP patients.

**Training interpreter-minded doctors and doctor-minded interpreters**

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**Institutional context/ Educational objectives:** Medical curricula on clinical communication skills have been focusing on monolingual doctor-patient communication. Similarly, interpreter training has not been paying enough attention to doctors’ specific communicative goals. Yet, the increasing need for interpreters in the consultation requires the above curricula to be revisited.

Research has provided ample evidence of doctors’ unfamiliarity with interactional patterns inherent in interpreter-mediated consultations, which might result in poor communication outcomes, despite overcoming the language barrier. There is also evidence of interpreters’ unawareness of doctors’ communicative goals within the framework of patient-centered communication.

Against this backdrop we introduced a series of joint practice sessions between medical students and student interpreters at Ghent University. Our objective was to acquaint medical students with the complexities of interpreter-mediated consultations and to allow student interpreters to practice in a more authentic setting.

**Instructional/ assessment methods:** Both student groups received separate theoretical training on doctors’ and interpreters’ communicative goals and practical aspects of interpreter-mediated consultations. During practical exercises 369 3rd and 4th-year medical students conducted 123 simulated consultations with patients speaking 7 different languages interpreted by 35 student interpreters (masters). Feedback focused on the structure of the consultation, the doctor-patient relationship, communication techniques and interpreter performance. For the evaluation of the sessions we employed self-efficacy scales (questionnaires) and focus group interviews. Trainers from both fields re-assessed the learning outcomes based on the students’ performance.

**Program evaluation results:** The joint practice sessions were well received by both student groups, whose needs and learning outcomes differed significantly. The medical students experienced difficulties in maintaining the structure of the consultation, projecting empathy and managing non-verbal cues. The student interpreters struggled with terminology, turn management and the signaling of dyadic interactions.

**Discussion/ Implications:** Further preparation is required for both groups prior to practice sessions. Theoretical and practical aspects, which will be incorporated in future joint sessions, were identified.

**Association of Health Literacy and English Proficiency with Medication Beliefs**

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**Introduction/Objective:** Perceptions about medications influence patient behavior, decision-making, and outcomes in adult populations. Health literacy (HL) and limited English proficiency (LEP) are known to shape these beliefs. Knowledge of these relationships is limited for young children, whose care relies upon parental decisions. We aimed to examine the association between parent HL and LEP and beliefs about child medication overdose and harm.

**Methods:** English- and Spanish-speaking parents of children ≤8y were recruited from 3 urban pediatric clinics (n=1,041). Medication beliefs were measured using the overuse and harm scales (range=4-20) from the Beliefs about Medication Questionnaire (BMQ; 5 point Likert: 1=strongly disagree to 5=strongly agree). HL was measured using the Newest Vital Sign (0-1=low, 2-3=marginal, 4-6=adequate). Confounders were identified using chi-square and ANOVA tests. Using linear regression, BMQ scales were regressed on HL and LEP, adjusted for study site, race/ethnicity, and education.

**Results:** Parents’ mean (SD) age was 29.4 (7.4); 89% were mothers, 31% had <HS education, 54% were Hispanic, 45% indicated LEP, 38% had low HL and 41% had marginal HL. After adjustment, lower HL was associated with stronger beliefs that medications are harmful (low: beta=0.81, p=0.0006; marginal: beta=0.55, p=0.009),
Breast Cancer

A community-based participatory approach to developing a Picture Option Grid for women of low socioeconomic status diagnosed with early stage breast cancer

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Introduction/Objectives: Systematic review evidence suggests that decision aids can benefit underserved patients, especially when tailored to their needs. Our aim was to develop a picture-based, encounter decision aid (Picture Option Grid) designed for women of low socioeconomic status (SES) with early stage breast cancer, facing a treatment decision between mastectomy and breast conserving surgery.

Methods: We used a Community Based Participatory Research (CBPR) approach. We primarily targeted women over 40 years of age, of lower SES, regardless of breast cancer history recruited in community settings. Convenience samples of academics and clinicians were also invited to participate. The pictorial decision aid was derived from an evidence-based table comparing treatment options for breast cancer (www.optiongrid.org). We initially developed a black and white picture-based prototype, depicting a clinician and a patient discussing options. Subsequent prototypes were developed using iterative cycles and tested in the community using “think aloud” protocols.

Results: After initial testing of the prototype (A 1.0) with academics and clinicians, a new prototype (A 2.0) was developed and pilot-tested with 50 lay individuals in community settings. Acceptability was high. In response to feedback indicating that the use of cartoon characters was patronizing and insensitive in the context of breast cancer decisions, an additional version (B 1.0) was developed to address this concern, and only included images and text. The final prototypes will be included in a pilot study evaluating the informational and decisional support needs of women of low SES recently diagnosed with early stage breast cancer.

Discussion/Implications: In adjusted analyses, low HL, but not LEP, was independently associated with parents’ perceptions about harm from child medication use. HL may explain much of the known association between LEP and medication beliefs. Additional research is needed to determine if low-literacy interventions to improve medication labeling can modify parents’ beliefs about child medication use. R01 HD070864 (SAFE-Rx for Kids Study)
Information needs and preferences regarding the dissemination method for care-relevant information from breast cancer patients in the course of the disease

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Introduction: According to a report by the World Health Organization (WHO), breast cancer is the most common form of cancer in women, accounting for 28% of the total cases of cancer in Europe. In Germany about 200 women receive a diagnosis of breast cancer every day. In addition to guideline-based health care, additional efforts are needed to satisfy patient-centred requirements.

Methods: Our analysis is part of the prospective multicentre follow-up PIAT study (breast cancer patients’ information and training needs). The study examined the information needs, the patients’ dissemination methods and health literacy of breast cancer patients. The data is based on a standardized postal questionnaires administered at three different assessment points (T1 = post-operatively, T2 = 10 weeks and T3 = 40 weeks after diagnosis). Descriptive and multivariate analyses will be used for analyses.

Results: Our sample consisted of 1359 breast cancer patients at T1; 1248 at T2 and 1202 participants at T3. The participants were recruited from 60 German breast cancer centres. The most frequently identified unmet information needs relate to ‘supplementary naturopathy’, ‘nutrition’ and ‘health-promotion’. In the course of the disease, topics such as ‘follow-ups after acute treatment’ and ‘coping with long-term side effects’ become more prevalent. The most frequently mentioned dissemination methods are ‘conversation with a health professional’ and ‘information flyer’. In the survey period, the patients’ level of health literacy changed little.

Discussion: Patients with breast cancer are often provided with large amounts of information during the course of their disease. The results indicate that the use of individualised information at different treatment times seems desirable. As a result of the PIAT Study, a patient question prompt sheet was developed to address these information needs. The questions are arranged by the different stage of treatment and by topic. The prompt sheet should serve as a conversation aid between patient and physician to help patients ask the questions important to them.

Impact of family member presence on decision discussions in metastatic breast cancer oncology visits

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Introduction/objectives: Women who have metastatic breast cancer face a number of decisions related to their quality of life, including treatment, symptom management and side effect mitigation. However, little is known about how these topics are discussed and how engaged patients and family members are in decision making.

Methods: As part of a randomized controlled trial to test a strategy to increase patient engagement in decision making against usual care, medical encounters between women and their medical oncologists were video recorded. Two coders used the DEEP-SDM coding scheme using Noldus ObserverXT. Two cancer centers in the southern US enrolled patients into the study. Each coder viewed the video recordings independently with 20% doubled coded. Discrepancies were discussed with and resolved by the PI.

Results: Thirty-nine visits had complete audio or audio and video available for analysis. Of these, in 14 visits the patient is alone, while she is accompanied in 25 visits. The amount of time spent discussing decisions in visits differed between visits with (mean=11.6 min) and without a family member (6.0 min). Similarly, more decisions were made in visits with a family member (mean=4.6) than without (3.4). In visits without a family member, physicians initiated decision making segments 78% of the time, while in accompanied visits, physicians initiated decision making segments 69% of the time. In visits with family members, patients and family members initiated roughly equal numbers of decision making segments.

Discussion/implications: The presence of a family member fundamentally changes the patient-medical oncologist dynamic. In this sample, patients with a family member experienced more time discussing decisions and had more decisions in the visit. Similar to other research on three-party visits, family members and patients seem to work in partnership by sharing the amount of discussion.
The Perceived Persuasiveness of Arguments Supporting the Age-Thresholds for Breast Cancer Screening: Studying the Impact of Micro-Cultural Differences among Young Swiss Women

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Introduction Breast cancer is the most common cancer and the leading cause of death in women worldwide. To reduce breast cancer mortality rates, many countries have implemented early detection programs using systematic mammographic screening for women aged 50-69. These age-thresholds are not arbitrary. Breast cancer risk has been shown to increase significantly with age, rendering screening beneficial. Among younger women, studies show that the benefits of screening do not outweigh the associated risks and costs. However, in spite of this, young women often advocate their right to program inclusion.

Objectives Health educators thus face a challenge convincing young women to accept the screening guidelines. This study aims to assess the relative persuasiveness of various arguments against systematic breast cancer screening among women aged 30-49 in Switzerland. Furthermore, it investigates possible micro-cultural differences in perceived argument persuasiveness and young women’s position towards early detection programs.

Methods An online survey, across the three Swiss language-regions (n = 961), including validated measures assessing young women’s attitudes and opinions concerning early detection programs as well as argument persuasiveness.

Results Micro-cultural factors appear to have a significant impact on the perceived persuasiveness of arguments dissuading young women to engage in mammographic screening, as well as on their position towards early detection programs. Generally, young Swiss-German women seem more easily convinced by fact-driven arguments than Swiss-Italian and Swiss-French women, who demonstrate higher emotional involvement with mammographic screening.

Discussion/Implications This study builds on previous studies in Switzerland that demonstrate the importance of micro-cultural factors in the context of health behaviors. The present results are relevant for the design and implementation of health education interventions to increase compliance with breast cancer screening recommendations and to reduce overuse of mammography as a service. Thereby, this study contributes to an intensifying scientific and public debate - both in Switzerland and globally.

Professionalism and Humanism

A randomized trial of online expressive writing for stress management in post-radiation cancer survivors using psychoneuroimmunology based outcome measures

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Introduction/Objectives: Patients in the oncology-care setting who are transitioning from completing their cancer treatments to survivorship are particularly at risk for experiencing psychosocial stress. Chronic stress poses serious negative consequences for neuro-hormonal and immune function in cancer survivors (CS) such as increased susceptibility to infections. Yet, the IOM has identified a paucity of theory-driven interventions for managing psychosocial stress in CS.

Methods: We conducted an RCT of an online expressive writing intervention for CS. Eligible participants had a cancer diagnosis, were; over 21 years of age, within 2 - 12 months of completing radiation, English speakers who could provide informed consent. Intervention arm participants wrote their thoughts and feelings regarding their cancer via an online survey, while control arm participants wrote about mundane matters. Measures were collected at baseline, 24 hours and 6 weeks post-intervention and included a) physiological outcomes assessed in salivary specimens, e.g. cortisol, and b) psychosocial outcomes collected online using validated questionnaires, e.g., fear of cancer recurrence.

Results: CS in this study (N=40) were predominantly white women with an early stage breast cancer diagnosis. Results showed that online expressive writing was effective in regulating stress in our sample of CS as indicated by lower levels of salivary cortisol (U=94, p<.05) and reduced fear of cancer recurrence (F (1, 38)=9.65, p<.05) over a period of six weeks.

Discussion/Implications: Online expressive writing is a low-cost and convenient approach for delivering psychosocial care for CS during survivorship which has potential to help CS manage psychosocial stress and regulate neuro-endocrine response. Future research is warranted to explore these initial findings in a larger, more generalizable sample that utilizes the full range of PNI outcomes over the course of longitudinal data collection.
Breathing New Life into an Old Tradition: Teaching professionalism at the bedside

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Introduction/Objectives: We prepared attending physicians, house staff and students for bedside presentations of patients newly admitted to the General Medicine and Geriatric Services at Wake Forest Baptist Medical Center, an 865-bed tertiary care and teaching hospital. Bedside patient presentations (BSPPs) are a unique venue for attending physicians and their teams to practice professional interactions with patients and families in “real time”. BSPPs provide opportunities for teaching and assessing patient-centered communication skills and have the potential to improve the patient’s experience of care.

Instructional and Assessment Methods: The curriculum on BSPPs spans the educational continuum from the Clinical Skills Seminars for first and second-year medical students, the third-year Internal Medicine clerkship, Internal Medicine residency seminars on communication challenges and faculty development workshops on professionalism and bedside teaching. The curriculum emphasizes communication approaches such as PEARLS and NURS that convey interest and respect for patients as unique human beings. All sessions incorporate skills practice. Learners and faculty assessed the project through surveys, narratives and the Modified Humanistic Teaching Practices Effectiveness questionnaire (M-HTPE). Patients assessed the professionalism of their medical teams with the modified CARE questionnaire.

Program Evaluation: The culture for morning rounds changed dramatically on the intervention services with BSPPS becoming the norm rather than the exception. Learner acceptance was high. On the M-HTPE, medical students (n=139) and house staff (n=73) rated BSPPS highest for “illustrating patient-centered care”, “use personal and social information about patients in their care” and “providing role models for how to build strong relationships with patients”. Attending assessment (n=36) of the educational value of BSPPS was overwhelmingly positive. Patient responses to the CARE survey were more favorable on 8 of 10 measures for patients with BSPPS (n=291) as compared to those without (n=262).

Discussion/Implications: Training all members of the medical team in BSPPs changed the practice and teaching culture on the General Medicine and Geriatric teaching services at an academic medical center. The patient’s bedside became the preferred venue in “real time” for teaching patient-centered care and communication.

Transforming Learning Environments: A Faculty Education Fellowship in Medical Humanism and Professionalism

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Introduction, Context and Objectives: Learning environments significantly influence professional identity formation of trainees. Branch et al. [1], developed a multi-institutional faculty development project* to train physician education leaders to promote more humanistic teaching. Boston Children’s Hospital (BCH) is one of 10 US institutions, and the first pediatric site, selected to implement this curricula.

Objectives: to successfully implement and sustain the curriculum at BCH, adapt it for pediatrics, and expand its focus on values and skilled communication; to develop faculty committed to promoting humanistic values in teaching/learning environments.

Description of Innovation/ Methods: To achieve faculty buy-in and long-term sustainability, we created a unique 1-year fellowship for faculty, rather than a course: the Faculty Education Fellowship in Medical Humanism and Professionalism [2]. Faculty Fellows participate in 1 ½-hour, twice-monthly small-group sessions. Curriculum topics include: communicating caring attitudes, reflective teaching, narratives, appreciative inquiry, interprofessional teams, and others. We developed new curricula on values and skilled communication based on the International Charter for Human Values in Healthcare [3].

To increase institutional impact, we sought collaborators. The Fellowship is sponsored by the Institute for Professionalism and Ethical Practice. Co-sponsors include the Offices of Faculty Development and Graduate Medical Education, and The Academy for Innovation in Education at BCH.

Evaluation/Impact: Twice as many faculty applied as positions available. The first cohort included 10 physician faculty from across BCH, many in educational leadership roles. Fellows have implemented teaching and workshops modeled after program curricula. The Fellows have continued to meet quarterly following the fellowship, and are developing a project to promote humanistic values across the institution. We are selecting a second cohort.

Discussion/Implications: We developed and implemented the Faculty Education Fellowship in Medical Humanism and Professionalism. Existing curriculum was adapted for pediatrics; new curricula were created on values and skilled communication. The Fellowship provides opportunities for faculty to enhance their reflective capacities, teaching skills and role modeling in humanism/professionalism, and to work together to promote humanistic values and teaching environments.

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How do Swedish and foreign doctors show empathy to their patients?

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Introduction/objectives: Successful communication between doctors and patients is important for quality of care. When doctor and patient have different cultural backgrounds, communication often becomes more complicated.

Swedish is a multicultural society. In 2013, about 56% of all doctors who were granted medical licenses had been educated outside Sweden [1]. At this moment, few scientific studies have yet reported on foreign doctors and their communication with patients.

Empathy is considered to be an essential element in doctors’ behavior for developing positive contact and trust with patients [2]. This paper describes and analyzes how the Swedish and foreign doctors respond to “the empathic opportunities” defined as “a clear and direct statement of emotion, progress, or challenge by the patient” [3].

Methods: Analysis is based on 63 transcriptions of video-recordings of consultations between Swedish and foreign doctors and their Swedish patients. Verbal and bodily communication is analyzed using activity based communication analysis and discourse analysis in combination with Empathic Communication Coding System (ECCS) [3].

Results: The results show both similarities and differences in empathic communication between foreign and Swedish doctors. Keeping direct eye contact with patients, using empathetic tone of voice, verbal feedback and nods are common strategies. In some cases, doctors use self-disclosure and touch. Language problems and cultural differences complicate the foreign doctors’ recognition of empathic opportunities, which might result in not responding to them.

Discussion/implications: The study contributes to better understanding of empathetic communication in intercultural medical encounters.

Doulas as cultural brokers: Exploring the doula’s role in improving patient-provider communication for Medicaid-enrolled pregnant women

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Introduction/objectives: Despite major advances in medical care and technology, disparities in birth outcomes persist throughout the U.S. The etiology of these disparities is multi-factorial and includes complex interactions between social factors and healthcare delivery. Patient-provider communication plays an important role in the provision of care, but little is known about the role doulas (trained maternal support professionals) may play in facilitating positive patient-provider communication. The objective of this study was to describe the role doulas might play in patient-provider communication for women who are at risk for poor birth outcomes.

Methods: A qualitative study design incorporating, semi-structured focus group discussions (n=13) with Medicaid-enrolled, racially diverse pregnant women and semi-structured interviews with certified doulas (n=7) who primarily serve Medicaid-eligible women. A selective coding scheme was created based on Lyerly’s “Good Birth” framework (agency, personal security, connectedness, respect, and knowledge). A co-analysis method was used.

Results: Doulas help to bridge the knowledge gap around pregnancy and childbirth. Doulas who attended prenatal care visits often described experiences with “translating things into layman’s terms” for clients. Pregnant women without a doula present at prenatal appointments report communicating with their doulas afterwards for clarification. A doula’s presence at prenatal appointments may lessen judgmental attitudes and foster a lengthier and more pleasant patient-provider encounter. Doulas sometimes see themselves as “cultural brokers”—bridging the gap between patient and provider in a way that respects the patient’s culture.

Discussion/implications: Results of this analysis indicate that the presence of a doula during prenatal care may support the patient-provider relationship. It further suggests that doulas are “cultural brokers”; this concept deserves greater attention in clinical practice and future research, which can help to elucidate how doulas can improve the prenatal care experience, particularly for low-income women. While further studies are necessary to replicate and generalize these findings, these results suggest a need for greater integration of doula services in health-care settings and an expansion of culturally relevant community doula programs.

Establishing Communication Skills Training in a Post-Communist Country

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Objective: The aim of this research is to gain more insight in establishing proper physician-patient communication in countries that belong to the post-communist sphere.

Methods: The research was based on literature review with the use of online resources and preliminary reports from teachers and students.

Results: Findings reveal specific differences in doctor-patient communication in post-communist countries as a consequence of differences in trust and ambivalent relationship toward authority.

Trust towards doctors’ authority levels in western countries for some age groups tend to exceed 70% whereas in post-communist countries trust is at the level of 21-22%.

Patients manifest ambivalence towards the authority when getting a prescription, a drug or a recommendation of a certain change in behavior. Sometimes they do not even confess that they have a problem not to be adherent.

Conclusions: Specific for post-communist countries, ambivalent attitude towards authority means that on one hand one has to obey authority, and on the other, there is no trust in authority doing any good. In this regard, the basic ambivalence towards any kind of authority relates to the typical authoritarian figure, a doctor; then this ambivalence would come into play in physician-patient relationship. Thus, patients would, on one hand, bow their neck and pretend that they do what is recommended and on the other pretend they do not believe that what is done, is done in their best interest. Adherence might as well be a huge problem. This substantially means we have to assume that social desirability is an even bigger problem in post-communist countries than in western countries. Preliminary data reveals problems students have with receiving or giving feedback. Instilled ambivalence toward authority plays a crucial role in the way students are willing to accept feedback from seniors, who are authority. And this way they seem unable and not willing to give feedback to each other.

We are planning to investigate these hypotheses with a questionnaire that we developed according to these findings

Practical implications: It is recommended to use a culturally sensitive approach, to establish proper physician-patient communication skills training, in countries that belong to the post-communist sphere.
Problematizing discourse of communication in Speech-Language Therapy

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Introduction: Communicative competence of Speech-Language Therapists is not a well-researched phenomenon in the field of Speech-Language Pathology, especially within the context of post-colonial, post-apartheid South Africa. Globally, the communicative competence of clients is more commonly researched. There appears to be reluctance for Speech-Language Therapists to reflect on their own communication, especially in view of contexts where diversity in language, culture and background is common. The healthcare work context demands that graduates are well-equipped for the workplace. Communicative competence has been cited as one of the most important competencies that graduates should possess, especially when a country like South Africa is attempting to address the disparities and injustices of the past through effective service delivery in underserved and previously marginalized communities. This article will be a critical document review of the current literature, prioritizing the focus on the communication of Speech-Language Therapists. The Communication Accommodation Theory and the Problematic Integration Theory provide the theoretical framing for the article.

Methodology: The literature reviewed included published studies, reviews and books using the appropriate search terms. The databases searched included Ebscohost (CINAHL), Science Direct, PubMed and Google Scholar in the time period between 1999 and 2015. Seventeen literary sources met the inclusion criteria for the review.

Results and Discussion: The results of the review suggest that communicative competence remains an area of particular importance in the field of Speech-Language Pathology as we need to understand the ways Speech-Language Therapists interact with their clients as these interactions are shaped by the intrinsic asymmetry in the access to language itself, since the clients have communication disabilities. It has been suggested that if we can validly ascertain key competences in clinical interactions, then we will have more grounded ways of sign-posting students’ development of communicative competence. Without effective communication skills on the part of the Speech-Language Therapist, client situations will not be appreciated, client desires will not be understood; common ground with the client and families about priority issues will not be reached and shared decision-making about best courses of action will not occur. This will inadvertently impact on diagnosis and treatment outcomes for clients and their families. We, in South Africa may excuse this as being attributable to the legacy of apartheid; however, what of other countries, as this is a global concern?

Implications: There is a lack of literature across the board, even in the other countries that we are so reliant on for direction and professional literature. The article concludes with the focus on the direction for future research in the field and an alternative understanding and view of communicative competence in Speech-Language Pathology.

Health Literacy and Numeracy

Associations of Health literacy, ethnicity, communication quality and beliefs about medicines in rheumatoid arthritis

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Objective: Disparities in vulnerable populations with rheumatoid arthritis (RA) may result from limited health literacy (LHL), cultural barriers, or mood disorders leading to negative beliefs about medications and poorer adherence. RA patients with LHL report suboptimal patient-provider communication, suggesting missed opportunities to address negative beliefs. Our objective was to examine associations of literacy, communication and mood, with beliefs about medicine in RA.

Methods: Data were derived from an observational RA cohort. Subjects completed a telephone interview in English or Spanish that included measures of patient-provider communication, literacy, depressive symptoms (PHQ), demographics and the Beliefs about Medicine Questionnaire (BMQ). Linear regression was performed to identify correlates of two BMQ subscales: necessity, which assesses beliefs about necessity of medicines; and concerns, beliefs about potential adverse and long-term effects.

Results: Of 438 patients, 88% were female, 29% were Latino, and 30% had LHL. Mean age was 61 years. Subjects with LHL were more likely to be female, Latino, and depressed mood. More than half with adequate health literacy reported their doctor “always” spent enough time with them (63%) compared to 48% with LHL (p=0.006). Subjects with LHL had more concerns about medicines compared to those with adequate literacy (p=0.001), as did those who did not report their doctor spent enough time with them (p=0.001). In multivariate regression, LHL, depression, Latino ethnicity, and reports that the doctor did not spend enough time were associated with stronger concerns about medicines; and concerns, beliefs about potential adverse and long-term effects.

Discussion: Among a diverse cohort of adults with RA, LHL, Latino ethnicity, depressed mood and lower perceived quality of communication with the doctor were associated with stronger concerns about medicines, which may be associated with poorer adherence and poorer outcomes. Future research should focus on knowledge transfer and promotion of patient engagement to reduce disparities.
Cancer Health Literacy, Culture and Language Barriers among Immigrant Latinos in Louisiana

Author: Margarita Echeverri, Xavier University of Louisiana

Background: Although Latinos are the largest and fastest growing minority group in USA and cancer is the Latinos' leading cause of death, studies examining Latinos cancer literacy levels are missing in the literature.

Methodology: Exploratory cross-sectional study of immigrant Latinos living in Louisiana and who completed the Spanish version of the Cancer Health Literacy Test (CHLT-30). Frequencies, means, and analyses of variance were determined to test for significant differences by CHLT-30 scores, gender, age, and education.

A total of 400 Latino immigrants (50% women) completed the questionnaire. Age ranged between 25-40 years (41%), 41-55 (30%) and older than 56 years (29%). While 24% of participants had primary school or less, 37% had some high school or high school diploma, 26% some college or vocational studies, and 13% hold a bachelor or advanced degree.

Objectives: Examine the cancer health literacy level among immigrant Latinos in Louisiana.

Results: Based on total CHLT-30 scores, three main groups were identified: 17.5% of participants were classified in the low cancer literacy level (score of 10 or lower), 73.8% in the intermediate level (scores 11 to 26), and 8.8% in the high level (score 27 to 30). Although not significant differences were found by gender and age, mean differences were significant among participants with primary education or less, some high school, and HS diploma, but not among participants with some college, bachelor degree and/or advanced degree. Most of participants did not speak English (66%), have never had a professional interpreter (79.5%) or telephone interpretation services (80.3%), and preferred a doctor who speaks Spanish (59.8%). Although 80% agree that cancer screenings help to save lives, 59.5% do not know if they need the tests, and 46.5% do not feel comfortable making health decisions by themselves.

Implications: Low level of health literacy combined with limited English skills and lack of professional interpreter services may affect Latinos communication with healthcare providers, understanding of medical instructions, as well as their decisions about cancer screening and healthcare.

Examination of the integrated model of health literacy in women with breast cancer

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Introduction/objectives: The integrated model of health literacy was proposed based on the synthesis of existing definitions and concepts regarding health literacy by the European Health Literacy Survey Consortium. The model indicates that an individual's environmental and personal determinants could predict his/her health literacy and thereby influence the participation in health management and health outcomes. However, the mechanisms underlying the relationships among these determinants and consequences of health literacy have not been examined. This study aimed to examine the integrated model of health literacy using structural equation modeling (SEM) with a sample of women with breast cancer to investigate the mechanisms of health literacy.

Methods: We prospectively collected information on participants’ demographics (age, education and urbanization level of residence), health literacy (the 47-item European Health Literacy Survey Questionnaire), participation in health management (the 9-item Shared Decision Making Questionnaire), and self-rated health (the EuroQol visual analogue scale). An SEM was conducted to test the relationships among the variables on the basis of the integrated model of health literacy.

Results: A total of 405 women with breast cancer participated in this study. The SEM showed good fit between the model and data ($\chi^2=43.13$, df =19, RMSEA=0.06, CFI=0.98, SRMR=0.04, NNFI=0.97). Health literacy had direct effects on participation in health management and self-rated health ($r=0.21$ and 0.22, respectively). Age and education significantly predicted health literacy ($r=-0.23$ and 0.36, respectively). No significant relationship was observed between residence and health literacy.

Discussion/implications: Our results supported the plausibility of the integrated model of health literacy. The model demonstrated that the personal determinants indirectly affected participants’ participation in health management and self-rated health through their health literacy. These findings suggest that to enhance breast cancer survivors’ participation and health outcomes, interventions for increasing their health literacy are needed. Furthermore, the intervention of health literacy should be tailored to their personal determinants.
Factorial validity of the European Health Literacy Survey Questionnaire in women with breast cancer

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Introduction/objectives: Adequate health literacy is a prerequisite for breast cancer survivors’ effective participation in the intervention and self-management. The European Health Literacy Survey Questionnaire (HLS-EU-Q) comprises 47 items assessing an individual’s ability to access, understand, appraise and apply health information in the domain of health care (HC), disease prevention (DP) and health promotion (HP). The HLS-EU-Q was recommended for its theoretical basis, and comprehensive coverage of multiple conceptual dimensions of health literacy. However, the factorial validity of the HLS-EU-Q in women with breast cancer was unknown. Thus, we aimed to examine the factorial validity of the HLS-EU-Q in women with breast cancer.

Methods: Prospective confirmatory factor analyses (CFA) were conducted to test the factorial validity. We first performed a first-order CFA to verify the 12-subdomain measurement structure of the HLS-EU-Q. A second-order CFA was then carried out to investigate whether the 12 subdomains reflected HC, DP and HP domains correspondingly.

Results: A total of 405 women with an average age of 56.4 years participated in this study. The first-order measurement model showed a reasonable model fit with the data of the HLS-EU-Q containing 47 items ($x^2=2602.01, df=968$, RMSEA=0.07, CFI=0.89, SRMR=0.08). However, two items had unacceptably small loading on their corresponding subdomains (0.49 and -0.03, respectively) and were deleted. The modified first-order measurement model adequately fitted the data of the HLS-EU-Q with 45 items ($x^2=2282.57, df=879$, RMSEA=0.06, CFI=0.91, SRMR=0.06). The second-order CFA model acceptably fitted with the data ($x^2=2553.93, df=929$, RMSEA=0.07, CFI=0.89, SRMR=0.07).

Discussion/implications: Our results supported the factorial validity of the 12-subdomain HLS-EU-Q with 45 items (2 items removed), and the 12 subdomains were justified to be constructed as HC, DP and HP domains. Thus, the HLS-EU-Q with 45 items was recommended for use in capturing the diverse health literacy competencies in different health management fields of women with breast cancer.

Has lay-friendliness improved? A comparative analysis of EU patients information leaflets from 2000-2012

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Introduction/objective: Since the patient information leaflet (PIL) became mandatory and harmonized in the EU in 1992, the genre has been heavily criticised for failing to provide easily understandable information. The literature is very critical of the genre and the underlying EU template and many attempts have been made to improve the European PIL. This study examines whether the lay-friendliness of Danish PILs (as representatives of the standardized EU PIL) has improved from 2000 to 2012 from the perspective of the Danish consumers and discusses the success and suitability of the PIL as a health communication genre.

Methods: In 2000 we carried out a quantitative (with qualitative elements) questionnaire study (688 respondents) for the Danish Ministry of Health. We asked 13 questions about the consumer’s use of the PIL and views on its lay-friendliness. This study was reproduced in 2012 (669 respondents) and compared to the 2000 survey.

Results: In spite of all improvement efforts, Danes (and by extension Europeans, we hypothesize) are less inclined to read the PIL in 2012 compared to 2000 and the general interest in the PIL as a source of information has decreased. At the same time the number of respondents who deem the PIL easy to read has gone down. According to Danish consumers, the lay-friendliness of PILs has not improved from 2000 to 2012, and based on the qualitative comments we suggest that the PIL genre has become far too regulated, long and complex to live up to its original intentions.

Discussion/implications: The genre has failed and needs to be reinvented. On the basis of our empirical results we suggest a practice change, namely a summary of the most vital information in the beginning of the PIL or a PIL which only consists of the summary with a longer version available on request.

Health literacy and diabetes knowledge in a French therapeutic patient education program for patients with type 2 diabetes

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Context: Currently, health literacy (HL) is not evaluated in therapeutic patient education (TPE) programs in France.

Objectives: The purpose of this study was to explore the relationship between HL, diabetes knowledge and other covariates among adults with type 2 diabetes.

Methods: This study is part of a TPE program intended for patients with type 2 diabetes living in a rural area: Breval, Yvelines, France (DIABREVAL a program supported by the Agence Régionale de Santé). The Literacy instrument was the Newest Vital Sign questionnaire (NVS), translated and adapted to the French public for this study. NVS was self-administered prior to completing the Diabetes Health Belief Model (DHBM) scale and Diabetes Knowledge Test (DKT). Socioeconomic status was evaluated with the EPICES Score (Evaluation of Precarity and Inequalities in Health Examination Centers score). Perceptions of medical treatment were assessed
using the beliefs about medicines questionnaire specific scale (BMQ-Specific). Multivariable linear regression was used to assess the association between NVS score, DKT score, DHBM scale score, BMQ-Specific score.

112 subjects with type 2 diabetes were screened and 73 completed at least one questionnaire. Mean age was 64.7 (31-85) and 37% of the participants were women. Sixty two (85%) participants answered to the NVS and 31 (50%) participants had a NVS score of 3 to 6. HL was associated with age, DKT and DHBM results. No association was found between HL and gender, EPICES Score, or BMQ-Specific score.

Implications: This study is the first to use a French version of the NVS in France. We found a significant association between NVS score and Diabetes knowledge in a French population of patients with type 2 diabetes.

Implementation Science and Knowledge Translation in Health Communication

Psychometric Properties of the Communication Skills Attitudes Scale (CSAS) among Portuguese undergraduate students in Allied Health Sciences

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Introduction/objectives: Communication in health has attracted increasing interest in recent decades, revealing the need for appropriate research tools. The study of the psychometric properties of instruments and the confirmation of their structure is crucial for the reliability and validity of the overall results of scientific work. Repeated analyses of these dimensions over time are important because it allows us to identify changes that result from social and cultural changes. This study aims to assess the reliability, factor structure, and construct validity of the Communication Skills Attitudes Scale (CSAS; Rees, Sheard, & Davies, 2002, Loureiro & Soares, 2011 - Portuguese research version).

Methods: The CSAS consists of 26 items measured on a 5-point Likert-type scale, from 1, “strongly disagree” to 5, “strongly agree”. This instrument was applied to 801, 1st- to 4th-year undergraduate students from 12 Allied Health Technologies programmes, such as Cardiopneumology, Neurophysiology, Occupational Therapy, Physiotherapy, Radiology, Radiotherapy and Speech Therapy, at different Portuguese Schools of Allied Health Sciences. Statistical procedures to assess the psychometric properties of the instrument included exploratory and confirmatory factor analysis. Reliability was assessed using Cronbach’s alpha.

Results: The factors resulting from the principal component analysis (PCA) of the scores are presented and analyzed. Cronbach’s α for the positive attitudes scale (PAS) and for the negative attitudes scale (NAS) reflects the scales’ internal consistency and are also presented.

Discussion/implications: The results allow a critical analysis of the structure found on the Portuguese adaptation of the CSAS (Loureiro & Soares, 2011), with implications for its adequacy to the population of Portuguese higher-education students, particularly those pursuing careers in Allied Health Technologies.

Other Communication-related Topics

An evidence-based online content to inform the public on cancer risks linked to exposure to environmental factors

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Background: Cancer risks associated with environmental, occupational exposures and nutritional factors represent a growing concern for the public, cancer patients and health professionals. The Comprehensive Cancer Centre Léon Bérard has developed an evidence-based online content to improve access to up-to-date reliable information and recommendations regarding cancer risk and environmental factors. Such a website does not exist in France to date.

Methods: The website www.cancer-environnement.fr uses as primary information sources the best scientific evidence available on environmental, occupational or nutritional factors and cancer risks, which is adapted in plain language by an interdisciplinary working group including users. A literature monitoring is performed on each theme of the website by the editorial board, and allows regular updating based on available data. This website benefits from partnerships with the International Agency for Research on Cancer (IARC) and French oncology research network.

Findings: The website was certified HONcode by the Heath On the Net Foundation, in partnership with the National Health Authority since its launch in October 2010. Nowadays, more than 160 fact-sheets have been published into the five main sections of the website: general information (classifications, regulations...), cancers, environmental exposure, occupational exposure, nutrition and physical activity. French translations of summaries of evaluations of human carcinogens by IARC are available exclusively on this website. The number of visits is 201 787 in 2014. In 2014, fact-sheets on ‘e-cigarette’ and ‘endocrine disruptors’ were the most viewed topics of interest.

Discussions: This unique evidence-based online content allows different target user groups to access to up-to-date and good-quality information on cancer risks linked to environmental factors. A national online survey will enable to characterize information seek-
Anxiety is Related to Patient Self-Efficacy and Treatment Adherence in Type II Diabetes: A Pilot Study

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Introduction: Although anxiety symptoms are common in patients with Type II diabetes, few studies have investigated their effect on patients’ self-efficacy and adherence to treatment recommendations. This study evaluated the impact of anxiety on patients’ self-efficacy for exercise, information finding, and communication with providers, and treatment adherence.

Methods: Seventeen patients with type II diabetes completed measures that included portions of the Chronic Disease Self-Efficacy Scale (CDSS), the Anxiety Sensitivity Index-3 (ASI-3), that yields subscales for cognitive, social, and physical aspects of anxiety, and self-report measures of adherence to medication, diet, and exercise. Regression models evaluated the relation of ASI-3 subscales to self-efficacy and treatment adherence after taking age, gender, race, and education into account.

Results: Analyses showed that although no demographic variables were related to communication self-efficacy, the ASI-3 cognitive scale was inversely related (R square for demographics only model = 0.10 which increased to 0.45 with the addition of the ASI scale; change in F = 7.06 [1, 11], p = 0.02). Cognitive symptoms were also inversely related to self-efficacy for information finding (p = 0.01) and exercise self-efficacy (p = 0.049). Social anxiety symptoms were inversely related to medication adherence at a level that approached significance (p = 0.06), and cognitive symptoms were related to diet adherence (also p = 0.06), while no ASI-3 scale was related to exercise adherence. The CSDD communication self-efficacy scale was positively related to medication and dietary adherence (p = 0.007 and p = 0.01).

Discussion: This pilot study suggests that anxiety may have a negative impact on self-efficacy and treatment adherence in persons with Type II diabetes. Our small sample size limits conclusions, but anxiety had a negative impact on self-efficacy while higher levels of self-efficacy were related to better treatment adherence. Additional research on anxiety and its impact in type II diabetes is needed.

Central aspects of telephone advice nursing as experienced by elderly callers

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Introduction: Telephone advice nursing is expanding worldwide. For many patients, this service can be the first contact with the healthcare system. Despite increasing healthcare needs, older people seek telephone advice nursing services in Sweden less than expected given their proportion in the population. Therefore, exploration of facilitators and barriers for elderly callers use and access to telephone advice nursing is needed.

Aim: The aim of this paper was to explore elderly callers’ experiences of telephone advice nursing at primary healthcare centres in Sweden.

Methods: This study has a descriptive design with a qualitative inductive approach. Qualitative interviews were used for data gathering, and a strategic sample of 10 elderly callers participated. Data was analysed using qualitative content analysis.

Results: To be the focus of attention during calls was experienced as important by the elderly callers and the communication was found to be crucial to build a mutual understanding of the problem. Elderly callers’ satisfaction related to the patient-friendly aspects of telephone advice nursing. The telephone system that is used for contact with the nurse could be both an asset and obstacle. Elderly callers’ had a strong confidence in the telenurses’ competence and they experienced access as mostly good.

Discussion/implications: The study contributes to increased awareness of the advantages and disadvantages of the telephone system as experienced by elderly callers.

The communicative competence of telephone nurses is essential to assess elderly patients’ health concerns and to refer patients to the proper care. In addition, a person-centred approach is important to provide the best patient care in telephone advice nursing. These aspects should be highlighted in nursing education, as well as clinical practice.
Comparing the perceptions of attending and trainees on physician attributes and feedback in a multicultural academic medical institute in Qatar

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Background: Hamad Medical Corporation in Qatar has recently received the Accreditation Council for Graduate Medical Education-International (ACGME-I). Considering professionalism as a core competency, it became strategically very important to navigate and compare the attendings’ and trainees’ perceptions about professionalism to inform the planning of any further faculty development, training or assessments.

Objectives: The purpose of this study was to describe and compare the perceptions of attending physicians and trainees on professionalism in a multicultural highly diverse medical academic institution in Qatar.

Methods: 575 trainees and 135 faculties were surveyed about their perceptions on professionalism at Hamad Medical Corporation-Qatar during the academic years 2012-2014. Participants from 17 disciplines (i.e., medicine, surgery and its subspecialties, pediatrics, obstetrics and gynecology, anesthesia, ophthalmology, orthopedics, psychiatry, family medicine, emergency medicine and radiology) were enrolled. An 11-question survey was offered before they attended professionalism faculty development activities. The survey contained 5-Likert scale and open-ended questions. All analyses were performed with SPSS version 20.0. Chi-square and Fischer’s exact test were used to drive p-values.

Results: A total of 459 trainees (56% males) and 100 (77% males) attendings (from >27 different nationalities and >28 different medical schools) completed the survey; response rates were 80% and 74%, respectively. Both trainees and attendings agreed that responsibility, respect, honesty and patient confidentiality were the most important physician attribute at work place compared to compassion, empathy and interpersonal competence (p>0.05). Team work and altruism were perceived as highly important professionalism characteristics by attendings compared to trainees (p<0.01). Attendings would like to learn more about conflict of interest when compared with trainees (55% vs. 7%, respectively, p=0.001). Attendings (78%) and trainees (76%) agreed that the single most important component of learning professionalism was clinical interactions and positive role modeling (p<0.05). The current evaluation systems were considered by both groups as the least effective. The strongest curricular recommendations included regular: a) courses and workshops, and b) adequate feedback. In the qualitative data gathered, the importance of role modeling was again emphasized and strong interest to know how to report lapses and breaches were highlighted.

Conclusion: Although Attendings and trainees agreed on the importance of the physician attributes, however, there were some differences for some of them. Positive role models in the training and work environment was emphasized as the most important way to teach professionalism. Skills and training on giving feedback on professionalism lapses were needed. The medical education leaders need to work on refining the skills on giving feedback and other supporting skills through faculty development programs and in clinical milieus where training occurs.

Keywords: Physician attributes, professionalism, role modeling, medical education, Qatar

Early introduction of clinical reasoning has no negative impact on medical and physician assistant student performance on communication skills

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Background: Since clinical reasoning (CR) guides and is guided by information collected from the medical interview through effective communication, we introduced a program integrating history taking and CR early into our medical/physician assistant (PA) curriculum. Our concern was whether early integration of CR into history taking could negatively impact students’ communication skills (CS).

Methods: Early in the second semester of their first year, 177 students conducted one-on-one interviews with simulated patients (SP) focused on demonstration of effective CS.

Students then participated in 3 activities of increasing complexity, where they interviewed SPs in pairs or groups and took timed breaks during the interview to perform CR by analyzing the information collected, developing/refining a differential diagnosis and deciding what additional information to obtain.

Finally, students conducted another one-on-one interview with SPs, where they had to demonstrate effective CS and perform CR.

SPs provided students with feedback on their CS after each activity and completed a survey after both one-on-one interviews, rating the students’ performance on key CS (establishing rapport, empathy, use of summaries, adequate transitions, and quality of questions asked). For each item on the survey, SPs placed students in one of the following categories: “not yet”, “emerging”, “developing”, “effective”, and “strong”. A grade of 0, 0.5, 0.7, 0.9 or 1 point was assigned to each category respectively. Student performance on the 2 interviews was compared using chi-square and t-tests.

Results: No change in overall student performance and in performance on the key CS was seen between the 2 one-on-one interviews (overall class average 87.3% and 87.7% respectively, p-value 0.5). Students appreciated the introduction of CR into the interview process and felt it reflected real-world situations and made them better appreciate the importance of effective communication.

Discussion: CR can be introduced early into the medical interview without negative impact on students’ CS.
Is analogue patients’ recall of cancer related information associated with their arousal (psychophysiological as well as emotional) as provoked by bad news?

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Introduction: Cancer patients forget on average 50% of information presented during physician-patient consultations, which leads to uncertainty and impairs patients’ ability to make well informed decisions. During bad news consultations, patients’ emotional distress and accompanying physiological responses may produce an attentional narrowing that result in a hyper-attention to the bad news and a relative inattention to, and limited recall of, additional information. Our primary objective was to test these associations in a video-vignette study using analogue patients (APs). Our main research question was: are APs’ psychophysiological and self-reported emotional arousal in response to bad news associated with their information recall?

Methods: APs were instructed to imagine themselves in the video-patient’s situation while watching a scripted video-vignette of an oncologist discussing with a patient the cancer diagnosis and the treatment thereof. APs’ psychophysiological responses were assessed continuously: electrodermal activity (skin conductance level and responses) and cardiovascular activity (blood pressure, heart rate and cardiac output). Moreover, we assessed emotional distress, using the STAI-State short form for anxiety and 8 Visual Analogue Scales (0-100) for other emotional states. Recall of information provided in the video-consultation was assessed one day later, using a structured telephone interview.

Results: We included 181 healthy participants (age 18-40 years). Preliminary results from repeated measures MANOVA’s showed that APs’ arousal was significantly increased during watching the video-vignette, for both the psychophysiological measures (F(12, 132)= 24.16, p < .001, partial eta squared= .69) and the emotional distress measures (F(8, 136)= 20.58, p < .001, partial eta squared= .55). Currently, using multiple regression analyses, we are analyzing the hypothesized relationships between APs’ arousal and their information recall. The results thereof will be presented.

Discussion/Implications: By unravelling the mechanisms which lead to limited recall, we may try to intervene, for example by guiding physician-patient communication, and improve patients’ recall, thereby reducing their uncertainty and supporting autonomous decision making.

Older Patients’ and Providers’ Perspectives on Asthma Management: A Qualitative Investigation

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Background: Multimorbidity challenges asthma management among older adults. We sought to understand older patient and provider perspectives on the difficulty of managing asthma in order to inform future health system responses.

Methods: We conducted 6 patient (n=31) and 5 clinician (n=25) focus groups with participants from academic and community-based practices in New York City, NY. English and Spanish speaking patients ages ≥50 with an asthma diagnosis were recruited, as well as practicing clinicians at participating sites. We explored patients’ experiences with asthma and their self-management strategies, and clinicians’ approaches for managing this population. Three trained investigators used content and constant comparative analysis to analyze transcripts.

Results: Patients often reported good asthma control, yet also using rescue inhalers daily (indicating poor asthma control), a contradiction suggesting patients misperceive their level of asthma control. Patients also reported uncertainty if shortness of breath, fatigue and cough were due to asthma or their other chronic illnesses. Common problems of self-care strategies included misunderstanding and misuse of controller medications, and a lower expectation of attainable health. For their part, clinicians stated asthma was low on their priority list because other chronic illnesses took precedence. Clinicians also questioned whether patients’ symptoms were attributable to asthma or to other conditions, like heart disease, yet they consistently relied on self-report rather than objective measures to confirm a diagnosis.

Conclusions: Older adults with asthma may misattribute asthma symptoms and misperceive the severity of their asthma. In turn, physicians often rely on patients’ self-reports of asthma activity rather than using objective assessments, a management approach which may lead to perpetuation of poor asthma control in this population. Education that aims to enable patients to better understand their asthma and more accurately report to clinicians, combined with physician support that promotes objective asthma assessments may enhance illness-related communication between physicians and older adults with asthma.
Patient Medical Education Training: A Pilot Test of the AGENDA Curriculum

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Introduction/objectives: Medical training programs address physicians' communication skills, but few institutions have proposed how to improve the communication skills of patients. The purpose of this research was to conduct a feasibility study of our AGENDA curriculum for teaching patients communication skills geared for medical encounters. The AGENDA curriculum was first described in Patient Education and Counseling (Arnold, Coran, & Hagen, 2012) and includes: (1) Agenda setting; (2) Goals for health; (3) Expressing concerns, questions, and negotiations; (4) Navigating health literacy; (5) Disclosing detailed information; and (6) Active listening.

Methods: One hour workshops were conducted with four groups of 10 to 20 volunteers between January 2015 and April 2015. Workshop participants received four 15 minute teaching sessions on agenda setting, listening, and technological approaches to improving health literacy and medication compliance. A pre- and post-test survey methodology was implemented to test the feasibility of AGENDA workshops and to assess perceptions of curriculum improvement and satisfaction.

Results: A total of 55 patients participated in the communication workshop (69% female, 31% male, age range 19-65+). Educational attainment ranged from some high school to post-graduate degrees, with the largest patient segment reporting some college education (44%). Paired t-tests revealed that participants considered the workshop significantly helpful for improving their future communication interactions with their physicians (p<.001). Further, patients believed that the medical workshop will significantly enhance satisfaction with future interactions with their physicians (p<.001). Two sample t-tests revealed that females believed that medical training was very useful for their future interactions with physicians (p =.05). Patterns that emerged from the data included: pre-training scores were higher for older patients (50-65+) than younger patients (<50), but post-training average scores were higher for younger participants.

Discussion/implications: Results strongly suggest that providing patients with communication skills training is an effective and inexpensive way to enhance physician-patient encounters.

Physician liking, patient affect, patient-centeredness, and gender differences

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Introduction: Physicians’ liking of their patients has been reported to be associated with the gender of the physician as well as of the patient. It has also been shown to be associated with the patient’s affective state and satisfaction after the visit. Previous studies have been performed in primary care in established physician-patient relationships, and based on questionnaires only.

Material and Methods: We used questionnaire data from 497 hospital encounters with 71 physicians, of which all had been coded for physician patient-centeredness, and 210 had been rated with global affect scores for physicians and patients. Patient questionnaires comprised a 25-item Positive Affect Negative Affect Scale (PANAS) before and after the visit, reports of global satisfaction, physician patient-centeredness, communication and information quality, and assessment of prior knowledge of the physician on a 3-point scale. Physicians assessed their expectations about the visit and their liking of the patient.

Using structural equation modelling, we proposed that patient emotions before the visit would influence observed affect in the encounter and physician liking. Further, we proposed that prior knowledge and physician expectations would influence physician liking. We also proposed that physician liking would influence observed physician negative and positive affect and observed patient-centeredness. Finally, we proposed that observed patient-centeredness would influence patient-reported outcomes and post-visit emotions, and that there would be gender differences.

Results: Three proposals were not met: Physician liking did not influence observed negative physician affect. Patient-centeredness did not influence post-visit emotions. Patient gender differences were not observed.

There were considerable physician gender differences; while physician liking increased patient-centeredness for both genders, observed patient negative affect was strongly associated with more patient-centeredness only for male physicians. Male physicians liked patients with negative affect less. Prior knowledge increased liking only for female physicians.

Conclusion: Male physicians compensate for less liking with more patient-centeredness.

Prognosis Discussion in End of Life Care: The Role of Physician Burnout, Relational Attachment and Gender

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Objective: The purpose of this presentation is to examine factors associated with the depth of prognosis discussions between physician and patient at end of life.

Methods: We conducted a study with Standardized Patients (SPs) to examine physician responses to the consistent stimulus of an actor trained to portray an advanced cancer patient. We obtained 40
recordings for analysis. Physician talk about prognosis was coded and scored using a prognosis communication coding system (PTCC). The prognosis talk score took into account the depth of prognosis topics discussed such as: curability, survival time, future quality of life, advancement of disease, advanced directives, patients understanding of prognosis, patient’s desire to know prognosis, and palliative care. Physicians completed questionnaires about burnout, empathy, and attachment style, as well as demographics.

**Results:** The average prognosis score was 5.1 (SD=3.6). Scores ranged from 0 - 14. We found that higher physician burnout, secure attachment style, and male gender were associated with more prognosis talk. Secure attachment style is unrelated to gender but is negatively related to burnout. Burnout is inversely correlated with secure attachment. We will present qualitative data comparing prognosis talk used by high burnout physicians versus high secure attachment physicians.

**Discussion:** Attachment theory posits that securely attached physicians are more comfortable with emotion and may be better prepared to manage the emotions in themselves and their patients when discussing prognosis. We are unsure why male physicians talked more to patients about prognosis, however, during recruitment many male physicians emphasized that they tell patients their prognosis. Finally, physicians with higher burnout may less attune to patients reticence to discuss prognosis and charge ahead oblivious to patient cues. Another explanation is the association between the physician burnout and the secondary trauma that may result from discussing terminal prognosis with patients on a regular basis in a physician’s practice.

**Quality of support from hospital to home: Role of readiness ratings by patient and nurse**

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**Introduction/objectives:** Patient- and nurse-reported measures are being adopted as means of identifying those at risk for poor outcomes after hospital discharge. However, it is not well understood how these measures are influenced by patient characteristics, or are related over time. As such, the objective of this study was to explore the association between patient and nurse-assessed readiness for hospital discharge, and patient-reported coping difficulties and quality of preparation for post-hospital care post-discharge.

**Methods:** A non-experimental, prospective, correlational pilot study was conducted with a sample of 70 Veterans admitted to medical and surgical units between February 2014 and June 2014. Demographic characteristics, health literacy, and patient- and nurse-completed Readiness for Hospital Discharge (Pt-RHDS, RN-RHDS) surveys were administered on the day of discharge. Post-Discharge Coping Difficulty Scale (PDCDS) and 15-item Care Transitions Measure (CTM) were administered 2 weeks post-discharge.

**Results:** PDCS scores were approximately 20 points lower for higher levels of education (p=.02) compared to less than high school. The discordance (Pt-RHDS minus RN-RHDS) between patient and nurse ratings moderated the relationship between PDCDS and Pt-RHDS. The model explained 37% variance in PDCDS. Lower CTM scores were associated with greater discordance between Pt-RHDS and RN-RHDS ratings (b=-0.16, p=.05). The number of people living with patients moderated the relationship between CTM and Pt-RHDS. The model explained 30% variance in CTM.

**Implications:** Patient-reported outcomes are influenced by personal characteristics and self-assessed readiness for discharge. The discordance between patient- and RN-readiness for discharge ratings influenced patient outcomes, suggesting that patient-RN relationships at discharge may be an important determinant of patient experiences during transitions from hospital to home.

**Recognizing Subtleties of Messages Connected to Patient Care: A Qualitative Analysis of Family Medicine Residents’ Reflections about Communication**

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**Abstract:** Patients share straightforward statements with physicians such as fears about their diagnosis. Physician reflection can sharpen awareness to implicit, indirect, subtle communication messages that contextualize patients’ illness experiences. Reflective learning in medicine can shift the lens of seeing through internally examining a trigger experience or exploring an issue of concern, creating or clarifying meaning and changing conceptual perspective. This project examines physicians’ written reflections that offer insight into their interpretation of both the stated and the tacit aspects of their observations about communication, their resulting responses, and their intended actions.

Tufts University Family medicine residents (N= 33) of the Tufts Family Medicine Cambridge Health Alliance completed three reflective exercises each week over the course of one year (N=756 reflective entries). An interdisciplinary research team identified communication-related concepts within the reflections. Identified themes include: 1) physicians recognizing interdependence and collaborative interplay about how communication predicts patient disclosure, 2) physicians paying attention to subtleties of patient behavior as indicative of a fuller picture of patients’ lives and their coping with illness, and 3) physician images of growth and awareness about communication indicative of their potential for growth/improvement. Results provide qualitative empirical evidence for reflection about communication enhancing attentiveness to relational components of clinical practice and fostering physicians’ abilities to acknowledge, identify, and express their human capacities.

This project allows for medical educators, communication scholars, and practitioners to identify competencies for reflection about com-
munication to use extend theory and application for communication and medical education. Building on interpersonal communication processes and challenges of interdisciplinary and translational research, results illustrate the development of attitudes coincident with medicine, including ability to critically assess communication and improve patient care. The representative sample of medical students, comprehensive analysis, inclusion of a year of reflections, and cohesive interdisciplinary analysis high validity in identified communication processes.

Teach the teachers: An e-learning course for professionals working with pupils with NF1

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Context and objectives: The goal of this project was to create, execute, and evaluate an e-learning course in order to find out if e-learning is experienced as a good method for professionals to learn about Neurofibromatosis type 1 (NF 1).

NF1 is a rare disorder associated with learning difficulties and attention- and behavior challenges. Parents report that little is known about the diagnosis among professionals and that it is difficult to get adequate help for their children in school.

The e-learning course created was aimed at counselors, teachers and assistants who teach pupils with NF1 in primary and secondary school.

Methods: The participants completed six modules, which included medical information, potential learning challenges and how to facilitate teaching. The course content was developed using existing scientific studies, experiences from professionals, parents and young adults living with NF1.

The course included text, videos, quiz, short written assignments and opportunities for dialogue in a closed, invitational only, designated Facebook group.

All these elements were implemented into a nano-learning platform, which allows series of short lessons delivered to participant email addresses. 125 professionals and parents participated in the course.

Descriptive methods were used to evaluate the course. It consisted of an online questionnaire that was sent to all participants, and semi-structured interviews were conducted to elaborate on the results from the questionnaires. A content analysis was conducted of the interviews.

Evaluation: The evaluation results from both the online questionnaire and the interviews were categorized.

63 persons participated in the evaluation including the four in depth interviews. The participants reported great satisfaction with the course’s usability and content.

Conclusion: The results from the evaluation indicate that this e-learning model can be an effective way to teach professionals about rare disorders and its implications in the future.

What patient communications do inpatient oncology nurses perceive as cues to emotional distress?

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Introduction/objectives: Effective patient-provider communication is necessary to identify and manage psychosocial needs of patients with cancer. Nurses working in an inpatient oncology setting, with extended time for patient observation and interaction are uniquely positioned to recognize various types of patient cues to emotional distress. The objective of this research was to explore what communications inpatient oncology nurses perceive as cues to emotional distress in cancer patients.

Methods: Data for this study was drawn from a larger qualitative study that investigated the cognitive strategies oncology nurses use when making psychosocial assessments. A convenience sample of 16 nurses working on inpatient oncology units at two Midwestern institutions participated in semi-structured interviews. Two coders conducted a content analysis, first reading whole transcripts, and then analyzing them for and extracting text segments relevant to “cue recognition”. Like text segments were sorted into categories and labeled until consensus was reached.

Results: Inpatient oncology nurses report perceiving four categories of cues to emotional distress: (a) body language (looking away, being withdrawn, “deer in the headlights look”); (b) verbal cues (questioning everything, crying, cursing); (c) exerting control (refusing therapies, refusing daily activities like eating, showering, or exercising); and (d) environmental factors (lights out, door shut, no visitors).

Discussion/implications: Inpatient oncology nurses, with patient-centric training, observational skills, and extended time with patients, offer a valuable perspective for the psychosocial assessment of distress. Nurses in this setting can provide a close and nuanced psychosocial assessment of distress and could enhance the oncology teams’ continued evaluation and treatment of patients with cancer.
Evidence-based Health Education in Asthma
- No short-term Effects on Health-related Quality of Life and Satisfaction with Programme but Higher Patient Perceived Trainer Skills

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Aims: We hypothesize an evidence-based patient education programme targeted at adult asthma patients in medical rehabilitation based on the theoretical domains framework for use in behaviour change and criteria for good educational practice will enhance asthma control. We expect the programme to be effective via enhancement of patient’s asthma-related health literacy. However, effective patient education is said to be demanding for patients. This may reduce acceptance and satisfaction with the programme.

Methods: We conduct a prospective single-centre controlled trial in an inpatient medical rehabilitation centre (duration: 3 weeks). Target group: Adult asthma patients (18-65 years). Intervention: modified patient education programme (MPEP). Comparator: usual education programme. Timeline: Apr 2013-Nov 2013: recruitment of control group (CC; n=200), Dec 2013 until Feb 2014: Implementation of MPEP, Apr 2014-Nov 2014: recruitment of intervention group (IG; n=200). Time points of measurement: At the beginning (T0) and the end of inpatient treatment (T1), 6 (T2) and 12 (T3) months after discharge. Instruments: a.o. Comprehensibility and impact of patient education (COHEP; heiQ, at T1 only) disease specific health related quality of life (St. George’s Respiratory Questionnaire (SGRQ), sociodemographics. We calculated mean scores for COHEP and heiQ at T0 and mean differences in change scores T0-T1 for SGRQ-Scales. We tested statistical significance with the T-Test and analysis of covariance.

Results: 424 patients completed questionnaires at T1 (IG: 185, CC: 192, mean age 50.6 yrs., 75.1% females, living a mean of 22.7 years with asthma). We observed no statistical significant differences in any of the background variable between IG and CC. With regard to health-related quality of life, we noted no differences in mean change scores (T0-T1) in any subscales of SGRQ. The intervention group rated trainer skills an average 3 points better than the control group (p=0.005), transferability, type and amount of (medical) information was rated no different by treatment group. Luckily, health-related quality of life improved in both groups during rehabilitation substantially, but not different by treatment (fig. 1).

Conclusion: The MPEP increased patient perceived trainer skills and with no side effects on programme acceptance or health-related quality of life.
Health Information Seeking Behavior among Adults in the United States—Does Having a Cancer Diagnosis Matter?

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Introduction/objectives: Several studies have investigated information seeking among cancer patients, but none have explored potential differences in predictors of information seeking between cancer and non-cancer patients on a national scale. The objective of this study was to examine if predictors of information seeking are different among cancer vs. non-cancer patients.

Methods: Data from the Health Information National Trends Survey 4 Cycles 1-3 (October 2011 to November 2013) were analyzed for 10,774 survey participants aged 18 years and older. Binary logistic regression was used to examine the effect of socio-demographic variables on the decision to seek health information.

Results: There were differences in the magnitude of the health seeking predictors between cancer and non-cancer patients. Among those aged between 50-64 years old, individuals with cancer diagnosis were 4.95 times more likely to seek health information (95% CI: 1.25 - 19.68) whereas the same age group among non-cancer diagnosis individuals was not statistically significant. Among individuals without a regular healthcare provider, those with cancer diagnosis were 59% less likely to seek health information (95% CI: 0.24 - 0.73), while individuals without cancer diagnosis were 27% less likely to seek health information (95% CI: 0.56 - 0.96). Furthermore, education was an important predictor of health seeking behavior for both individuals with cancer diagnosis and those without. We found that the likelihood of seeking health information declined steadily across education levels, and was significantly worst for those without high school diploma (OR=0.14, 95% CI: 0.05 - 0.38) for those with cancer diagnosis, and (OR=0.42, 95% CI: 0.14 - 0.32) for those without cancer diagnosis.

Discussion/implications: Age, educational levels, and having a regular healthcare provider are predictors of health seeking behavior. Future health communication interventions targeted at cancer patients and the general public must consider these predictors so that interventions are tailored specifically to achieve optimal result.

Innovation: How to Increase Training in Mental Health

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Background: Mental disorders are the most common, most disabling of all health conditions, but >85% of patients receive substandard care from untrained medical physicians. While the IOM recommends greatly increased training in all years of education, educators may not know how to implement this large increase because of the dearth of psychiatrists and skilled others to teach.

Innovation: We propose a national “train-the-trainer” program where a cadre of national outreach trainers (psychiatry and medical mental health experts) would train 10-20 medical faculty at every teaching institution. Newly trained local medical faculty would then train their students and residents. Teaching would extend to all years of formal education and address common, difficult mental problems in all medical settings (e.g., chronic illness, chronic pain, geriatrics, palliative care) in addition to psychiatric disorders.

Evaluation: This plan requires rigorous research guidance in 3 areas. 1) Our earlier research identified an evidence-based care model for medical physicians that improved patient outcomes. 2) Next, our research now is developing a train-the-trainer model to demonstrate that local faculty we trained can teach the care model to residents. 3) Finally, more difficult, research must demonstrate that this train-the-trainer model can be disseminated on a wide scale basis. Research would identify a few institutions willing to experiment with this approach, and a small group of national experts would pilot test its feasibility with these programs. Next, the expert outreach faculty would conduct training at a few other interested institutions to further verify that the training programs improved patient outcomes, quality of care, and cost. With such robust research support, this would open the door for national dissemination and implementation.

Discussion: With no competing ideas, the research proposed is a fresh, feasible educational perspective with the potential to improve care for the most common, most disabling health conditions.
Pilot and Feasibility Testing of an Integrative Chinese Medicine/Biomedicine Diet for Chinese Americans with Type 2 Diabetes

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Introduction/objectives: Many Chinese Americans (CAs), particularly first-generation immigrants, follow diets consistent with Chinese medicinal principles. For those with diabetes (T2DM), these principles may conflict with Western principles for appropriate diabetes diets. We therefore created and pilot-tested a Chinese language integrative diet guide for T2DM, bringing together nutrition guidelines consistent with both Western diabetes principles and Chinese medicine principles.

Methods: We piloted the integrative diet in two-hour classes (n=2) providing copies of the guide and oral instruction in its use. Participants (n=9) were Cantonese-speaking CAs with T2DM who used Chinese medicine in the previous year. All participants met with a licensed acupuncturist for a one-hour interview to determine their Chinese medicine diagnosis. Diagnoses corresponded to specific diabetes-appropriate diets in the integrative diet guide and were reviewed during the classes taught by a bilingual/bicultural registered dietician. Participants completed surveys at baseline. Four weeks later, they completed a follow-up survey and interview.

Results: All participants (n=9) reported that they knew what a diabetic diet was and needed this diet. However, 77.8% also preferred eating traditional Chinese foods and felt this made it difficult to follow Western diabetes diets. Immediate post-class surveys indicated that participants “learned something new about diabetes and diet” and that the skills learned “will improve my diabetes diet.” From interviews, participants reported satisfaction with the guide’s familiar foods, portion sizing/bowl proportion, and the opportunity to meet with a Chinese medicine provider. Many reported new positive attitudes toward diabetes self-management and positive changes in eating habits. Even participants who did not use their Chinese medicine diagnosis adjusted their diet in response to the education.

Discussion/implications: For CAs using traditional Chinese medicine, an integrative diabetes diet may be more culturally appropriate. More research is necessary to determine what parts of the integrative diet are most effective and if behavioral changes are significant.

Psychological factors influencing medications’ adherence in patients suffering from anxiety disorders: The role of mental health literacy, health locus of control, self-efficacy and clinical insight

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Introduction/objectives: Anxiety disorders (ADs) are common, distressing, and impairing psychiatric conditions. Data suggests that medications’ non-adherence rates in ADs are high and comparable to those of patients with other long-term conditions. This study investigates the role of psychological factors in influencing intentional non-adherence to prescribed psychopharmacological therapies. It focuses on the role of “having control” or “the perception of having control over one’s health”, which has been linked to psychiatric patients’ functioning and quality of life. The main aim is to gain insights on the role of patient’s health locus of control and self-efficacy, which are the two psychological dimensions traditionally related to the individual’s sense of control, in influencing intention to adhere and intentional medications’ non-adherence. Clinical insight and mental health literacy are also investigated.

Methods: A survey was developed through the collaboration of six psychiatrists having a strong background in ADs. It assesses patient’s intention to adhere, attitude toward his/her illness, expectancies regarding medications (necessity, efficacy, safety) and mental health literacy. The health locus of control, general self-efficacy, and clinical insight are measured using validated self-reports. Four psychiatric departments (Lombardia, Italy) collaborate in the recruitment phase, which is still in progress. 400 ADs patients, according to DSM-IV criteria, will compose the final sample.

Results: Detailed data on medications’ adherence in ADs will be provided, taking into account differences across diagnostic categories and medications’ class. Final data and the interactions between medications’ non-adherence and the psychological factors will be analyzed using a structural modeling approach.

Discussion/implications: Few experimental studies conducted to identify risk factors for non-adherence in ADs are available, highlighting that research in this field represents a big challenge for psychiatry and health psychology. This study, may inform healthcare providers and institutions who may in turn incorporate results into research projects and interventions, which aim to increase the rates of intentional adherence across ADs patients.
Risk Communication and Medical Decision-making

Communication about late effects during routine follow-up consultations between paediatric oncologists and adolescents: A video-based, observational study

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Introduction: Information about late effects is a prerequisite for survivors of childhood cancers to engage in self-management of their health, yet many lack such knowledge. We investigated to what extent: 1) potential late effects were discussed with adolescent survivors, and 2) information about late effects was provided by the paediatric oncologists (P.O.s) during routine follow-up consultations.

Methods: We video-recorded consultations with 10 P.O.s and 66 adolescents, aged 12-20 years, treated for leukemia (72.7%), lymphoma (21.2%) or received hematopoietic stem-cell transplantation for a benign disease (7.6%). We identified and coded discussions of potential late effects and then categorized the amount of information about late effects provided into three levels: none, basic and extended information.

Results: Potential late effects were discussed in 85% of the consultations. Of these, 71% were P.O. initiated, and 60% concerned existing health problems. The P.O.s provided none, basic and extended information about late effects in 41%, 30% and 29% of these discussions. Patient’s age, time since treatment and risk of late effect were not associated with amount of information about late effects provided, whilst consultation length, type of potential late effect (physical vs. patient-reported and current vs. future risk), and P.O were.

Implications: Although potential late effects were frequently discussed, the opportunity to provide information about late effects was often missed. Survivors of childhood cancer should be informed about late effects and their risk for these. The observed variability in providing information about such late effects indicates a need for standardization of survivor information practices.

How do general practitioners conceptualise advance care planning in their practice? A qualitative study

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Introduction/objectives: Although general practitioners (GPs) are well placed to initiate advance care planning (ACP) in a timely manner, many find it difficult. Training programmes can improve their skills in performing this task but need to draw on GPs’ previous knowledge and experience to be effective. The objective of this study is to explore how GPs conceptualise ACP, based on their experiences with ACP in their practice.

Methods: This study, using a qualitative study design, was conducted with GPs in Belgium. Five focus groups were held with 36 GPs. Discussions were analysed using a constant comparative method.

Results: With regard to content of discussions, ACP was conceptualised as the organisation of professional care required to meet patients’ needs, bad news conversations, choices of treatment and types of care for the patient, and the completion of documents. With regard to tasks for the GP, ACP was considered in terms of exploring patients’ vague preferences, coordinating care to address patients’ and families’ needs, actively initiating ACP and providing comfort when discussing palliative care with terminal patients. These conceptualisations could occur simultaneously in the narrative of a GP, however some only used one of the conceptualisations to present ACP.

Discussion/implications: This study illustrates that GPs have varying conceptualisations of ACP, of which some are more limited to specific aspects of ACP. Training efforts building further on GPs’ conceptualisation of ACP could improve their skills and knowledge of the ACP process, and lead to a better uptake of all the important elements of ACP discussions.
Patient needs and doctor support in patient’s accepting treatment risks

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Objectives: This study examined patients’ understanding of treatment risks and how doctors can support patient decision-making.

Methods: We used an online survey of patients with cancer and rheumatoid arthritis (RA). Questions spanned different phases of treatment, from understanding risks and making treatment decisions, to reflecting on their decisions. A Likert scale measured respondents’ attitudes, and a 1-10 scale measured expectations and experiences with doctors.

Results: Seven hundred questionnaires (51%) were completed, split equally between the diagnoses. Of these, 66% of respondents with cancer and 57% of those with RA stated they received explanations of treatment risks. 45% of cancer patients thought their doctor explained risks clearly, but 21% felt they received less clear descriptions, whereas for RA patients, the breakdown was 37% and 33%, respectively. To understand risks, more than half of respondents conducted Internet and literature research, and about 40% of all respondents expected to have active involvement, such as asking questions, rather than passive involvement, like listening to doctors’ explanations. When asked how best to avoid regretting one’s decision, about 50% said, “nothing special,” about 20% understanding risks, and 17% obtaining a second opinion. We found significant differences between patients’ expectations and experiences with doctor support throughout their treatment (p<0.01).

Discussion: In this study, acute- and chronically ill patients viewed risks similarly. Even after receiving understandable explanations, however, many were still unclear as to the risks involved and steps needed to treat their condition. To avoid regret, respondents noted the importance of understanding risks, obtaining a second opinion, and being actively involved in decision-making, but did not know how to do it. Within the time available, doctors should keep pace with patients and their understanding, and make every effort to ensure that they have both questioned about and clearly understood the information provided to make informed decisions.

Tanning stories: A narrative Examination of indoor tanning

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Abstract: Indoor tanning is a 5 billion dollar industry. In the medical community indoor tanning is recognized as dangerous, a leading cause of melanoma and other skin cancers. Despite widespread acknowledgment of the dangers, the individuals and organizations who are part of the indoor tanning industry promote indoor tanning as a healthy natural activity. What other behavior, so clearly detrimental to health, has been marketed as healthy? Not since the 1950s when tobacco companies employed physicians to convince the public that smoking cigarettes was good for such things as digestion, weight loss, and fitness, has a health-jeopardizing behavior been touted as good for consumers. This is an examination of the conflicting organizational narratives regarding indoor tanning. These organizational narratives inform and influence public policy and personal behaviors. Through interviews and marketing materials, conflicting narrative claims are examined. Because stories provide meaning and cohesion for tellers and hearers, the narratives of physicians and patients are vital. Included here are the stories of physicians working on two fronts—medically, by treating patients suffering from illness and injuries caused by tanning bed exposure, and legislatively by working at state and local levels to restrict access to tanning by minors. Patient stories, told through interviews, describe the experiences of women who are former tanners. Once they believed tanning was healthy, now, as cancer patients, the debate has ceased to be theoretical. This author believes that the stories of physicians and melanoma patients, told together, can become a powerful rhetorical tool for shaping the national and international discussions about indoor tanning. Hopefully, there will come a time when claims of tanning as “healthy” will be viewed as preposterous as the 1950 cigarette ads that claimed, “More doctors smoke Camels.”

Testing large-scale disclosure language and communication methods through an experimental online vignette survey

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Objective: The Veterans Health Administration (VA) mandates disclosure of large-scale adverse events (LSAEs) to patients, because LSAEs may require patients to undergo bloodborne pathogen testing. Through lessons learned from our studies of VA and non-VA disclosures, we aimed to develop new disclosure language and communication strategies using an innovative study design. The objective of this study was to ascertain optimal communication strategies when disclosing LSAEs.

Methods: We created six hypothetical vignettes of a colonoscopy LSAE, varying the exposure from low risk (LR) to high risk (HR). Participants were randomly assigned to an Internet-based vignette, and communication within the vignettes varied by disclosure strategy: social media, provider phone calls, and hospital letters. Before and after reading the vignettes, participants reported their perceived risk of HIV/hepatitis infection, their willingness to undergo HIV/hepatitis testing, and trust in their provider and healthcare system. Two qualitative questions to assess what participants liked and
I don’t think he wanted last resort life status.

Discussion: Whether LSAEs are framed as low or high risk has implications for patients’ testing behavior following disclosure. The experimental vignette methodology was successful in identifying patient-preferred communication strategies following a LSAE.

Turning Chance into Choice: BRCA-positive Patients’ Uncertain Health Experiences influence on Decision-Making in Clinical Encounters

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Introduction/Objectives: Women with a harmful mutation in the BRCA gene are at significantly increased risk of developing cancer during their lifetime (i.e., 40-87% breast and 22-65% ovarian for BRCA1 carriers; 18-87% breast and 10-35% ovarian for BRCA2 carriers, Mavaddat et al., 2013), compared to those without a harmful BRCA mutation (i.e., 12% breast and 1% ovarian, NCI, 2011). Because of their high risk, such individuals experience fear and uncertainty in anticipation of the likelihood they will develop cancer. Thus, the purpose of this paper was to analyze how BRCA-positive patients’ uncertainties influence their health decisions.

Methods: Qualitative, semi-structured interviews were conducted with BRCA-positive patients. Participants were recruited through Facing Our Risk of Cancer Empowered’s (FORCE) social media pages. The final sample—contingent upon thematic saturation—included 34 female patients. Interviews were recorded and transcribed. The transcripts were analyzed using the constant comparison method of grounded theory whereby open coding, axial coding, and selective coding were completed (Lindlof & Taylor, 2011).

Results: After testing positive for BRCA, there are three main health options for BRCA-positive patients—doing nothing, increasing surveillance (e.g., increased mammography, breast MRI, CA-125 blood measurements), and undergoing preventive surgery such as a prophylactic bilateral mastectomy (i.e., having both breasts removed) and/or a prophylactic bilateral oophorectomy (i.e., having both ovaries removed). Analysis revealed that the following factors contribute to patients’ health decisions: 1) an individual’s risk perception of developing cancer, 2) personal scares of potential cancer, 3) traumatic cancer family experiences especially death, and 4) current life status.

Discussion/Implications: Overall, the most common health choice was prophylactic bilateral mastectomies because patients believed it reduced their cancer risk the most. The findings demonstrate uncertainty’s immense power on BRCA-positive patient’s lives and highlight the need for clinicians to assist their patients in making the best health decision for them.

“You have to be sure before someone cuts on your baby:” Parent perspectives on decision-making and communication for adenotonsillectomy in children who snore

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Introduction/objectives: Sleep-disordered breathing (SDB) affects up to 20% of children, and adenotonsillectomy (AT) is the primary treatment option. However there is concern for unexplained variation (both underuse and overuse) which may be reduced by improving physician-patient communication and decision quality for this elective procedure. This study aimed to understand how parents communicate and make decisions about surgery.

Methods: Parents of children who have been treated for SDB participated in semi-structured, audio-recorded interviews. Parents were asked open-ended questions regarding experiences of having a child with SDB and seeking evaluation/treatment; information provided about options for treatment; communication with physicians; and experiences with AT surgery. Recordings were transcribed and analyzed for emergent themes using a grounded theory methodology.

Results: Parents described an urgency which led them to seek treatment, most commonly concern for fear of child stopping breathing during sleep and for behavioral or cognitive delays. Parents often viewed surgery as a “last resort” and had explored alternate therapies prior to seeing the surgeon. Nearly all parents feared anesthesia more than the AT surgery itself, though some were influenced by negatively publicized AT events in the media. They described trust, respect, and satisfaction for physicians who provided them with options, who engaged their child in conversation (“Let’s figure this out together”), who depicted SDB visually, and who were responsive to questions and were easily accessible (“I have his cell phone number”). Parents also described negative experiences with physician arrogance (“Felt a little judged by him”) and sometimes suspected physicians were withholding information (“I don’t think he wanted to give me too much information because he didn’t want me to worry”).

Discussion/implications: This analysis exploring parent perspectives will help to advise future communication strategies for physicians treating children with SDB. This study provides a unique contribution to inform development of a family-centered communication approach.
Shared Decision-making and Patient/Family Engagement

A data-driven critique on the future of electronic health records in the UK

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Introduction/context: Patient controlled electronic health records (PCEHRs) have existed for many years. They enable patients to access and manage personal clinical information that is made available to them by their doctors. In the UK, the process for obtaining paper records still generally involves making a specific request.

Description of policy or practice innovation: However, there is greater aspiration afoot. Not only has the National Information Board (NIB), a policy-making body set up under the auspices of the Department of Health, raised the bar to 100% of patients having full record access by March 2018, but also recommends moving beyond primary care to include the entire health service. Clearly expectations and aspirations for PCEHRs are high, but a healthy dose of caution is also in order. Here, we strategically critique the NIB strategy pertaining to PCEHRs.

Evaluation/impact: Using publically available data from PCEHR providers at primary care practices, we find that the NIB’s goal is more realistic to be achieved with an exponential growth model. Currently, only 4.46% of practices have the functionality of patient access enabled. Using linear regression, 11.37% of practices are expected have full patient access enabled from March 2018 compared to 79.4% with exponential growth.

However, we need to consider that the goal is 100% of patients must be enabled, rather than 100% of practices must offer the functionality. Currently, 5.06% of patients have the functionality to access their record enabled. Using linear regression, we predict 12.67%, and exponentially we predict 72.56% of patients could have full functionality enabled from March 2018.

Discussion/implications: As numbers grow, sustaining the exponential growth rate will be increasingly difficult. We discuss the research that must be carried out into what actions can be taken to encourage and support the growth of PCEHRs.

Can All Doctors Be Like This? Seven Stories of Communication Transformation by Physicians Rated Highest By Their Patients

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Introduction/objectives: Researchers have consistently found the top predictors of overall patient satisfaction are quality of the physician-patient relationship and contributing communications. There is limited understanding, however, if these behaviors are only innate or if physicians can transform their communication behaviors and how they can accomplish that.

Methods: A standardized six-question set was posed, in semi-structured, 60-minute interviews, to 77 of the highest-performing Kaiser Permanente physicians on a validated patient survey of physician communication, from Los Angeles, Honolulu, Portland and Oakland, which represented 16 disciplines. These interviews were audio taped with permission, transcribed and coded for patterns.

Results: Seven areas of transformation in communication were described by these physicians, including: 1. Communication medical education: “Using a listening technique allowed me to hear the patient’s story.” 2. Group Class Experience: “My experience that’s not about me, it’s about them, was a real shift in the way I saw myself.” 3. Beyond Clinical Focus: “Ten years ago, I would have said it’s all about making good diagnosis, but now I see my patients as complete human beings.” 4. Personal Epiphany: “What made the difference for me was a conscious decision that I wanted to be there to try and do something positive for my patients.” 5. Doctor as Patient: “I learned how frustrating it can be as a patient to not know how much your doctor knows about you in the moment.” 6. Technology: “I started to write down personal patient notes and over time noticed I was sharing these personal moments and stories with my patients.” 7. Mentor Advice: “Being emotionally engaged with your patients doesn’t have to burn you out; it can be nourishing.”

Discussion/implications: These stories exemplify that improvement in communication skills can be learned through various activities and experiences transforming physicians into those who highly satisfy their patients.

Connecting provider communication and delivery expectations: A qualitative study of mothers’ prenatal care and delivery experiences

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Introduction: Given medical advancements, childbirth should carry minimal risk of adverse outcomes in the developed world; however, childbirth is fundamentally unpredictable. Prenatal care providers play a significant role in preparing women for the complexities of birth. The goal of this study was to draw connections between provider communication and women’s delivery expectations to enhance prenatal care.

Methods: Interviews were conducted with recently-delivered mothers (n=36) at a metropolitan hospital. Transcripts were systematically analyzed to investigate how participants perceived provider prenatal communication and how they described their expectations of the birth experience.
Results: Five themes emerged, aligned with prenatal interpersonal processes of care: empowerment/self-care; explanation of processes of care; emotional support and respectfulness; patient-centered decision making; and elicitation of and responsiveness to patient problems and concerns. A sixth theme, provider continuity, also emerged. Although not a communication behavior, mothers described continuity as a direct influence on communication. Three factors from the expectant mothers’ information environment also shaped expectations: prior birth experience; social norms; and information sources such as birth classes and websites.

When prenatal providers used positive communication behaviors, it helped women create flexible expectations for the delivery experience. Women with flexible expectations were informed patients who understood that childbirth is unpredictable. They were willing to be flexible with birth plans when medically necessary. When providers did not enact positive communication behaviors, women tended to have fixed expectations. They had specific birth plans and were less willing or prepared to deviate from them. Setting flexible expectations for childbirth is important because fixed expectations may lead to confusion or interpersonal conflict during delivery when unforeseen events occur.

Discussion: In the complex information environment of prenatal care, mothers rely on providers as partners in their healthcare. Although providers may not have power to influence continuity of care, providers can use patient-centered communication to prepare women for the unpredictability of birth.

Health literacy in pregnant women and their intention to use a patient decision aid in the context of prenatal screening for Trisomy 21

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Introduction: Pregnant women have to choose whether or not to take the prenatal screening test for Trisomy 21 (T21). The shared decision making (SDM) process and use of a patient decision aids (PtDA) could facilitate a decision based on women’s own values. However the relevance of the PtDA may depend on the patient’s health literacy. Health literacy has been identified as a factor influencing the process of SDM at various levels. A better understanding of the relationship between health literacy levels among pregnant women and their intention to use PtDA could enhance its use, as the knowledge will enable the development of PtDAs that better meet the needs and expectations of patients.

Objective: To measure the association between the health literacy levels of pregnant women and their intention to use a PtDA in the context of prenatal screening for T21.

Method: We produced a questionnaire identifying women’s salient beliefs about the use of PtDA in the context of prenatal screening for T21 and measured their intention to use it. These beliefs were identified through semi-structured individual interviews with 45 pregnant women recruited in Quebec City who were attended by midwives, obstetrician-gynecologists or family physicians (15 women per category). We validated the retained items with 45 new pregnant women (15 per category) using a test-retest consisting of closed questions scored on the Likert scale. Literacy levels were also measured using three validated scales. All retained items will be included in a questionnaire for a survey of 350 pregnant women. Our data will be analyzed using descriptive statistics and association between literacy and intention to use PtDA will be measured.

Conclusion: The findings could help identify a new factor affecting women’s use of PtDA in the context of prenatal screening for T21.

Language use in married couples during diabetes medical appointments

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Introduction: There are approximately 29 million Americans diagnosed with Type 2 diabetes (CDC, 2014), many of whom have a spouse that is involved in treatment adherence. Language behaviors, such as first-person plural pronouns (i.e. we, our), are associated with higher marital quality, positive health outcomes for cardiac patients, and commitment to health behavior change for smokers (Lewis et al., 2006; Rohrbaugh et al., 2008; Rohrbaugh et al., 2012).

Methods: We audio recorded diabetes management appointments of 62 patients with Type 2 diabetes and their spouses and coded conversations for language behaviors such as first-person plural pronouns or speaking for the patient. Analyses were controlled patient’s use of first-person plural pronouns; spouse’s use of first-person plural pronouns, number of years diagnosed, and total income.

Results: Female patients (p < .05), and female spouses (p < .001), had higher frequencies of using first-person plural pronouns, e.g. “We”, “Us”, or “Ours”. Also, female spouses spoke for the patient at a greater frequency (p < .01).

For spouses, the longer a patient had diabetes, the higher the frequency of first-person plural pronoun (p < .01), and speaking for the patient (p < .05). Patients with higher levels of education (p < .01), had higher frequencies of using first-person plural pronouns.

Discussion: Characteristics, such as gender or length of time with disease, influence language behaviors at diabetes management appointments. Use of first-person plural pronouns and speaking for the patient may indicate joint ownership of the patients’ medical problems. When physicians witness these language patterns in their
Patient Attributes and Shared Decision Making During High Stake Medical Encounter

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Background: Engaging patients during decision making for surgical intervention represents the corner stone for physicians to demonstrate an understanding of many of the skills expected in patient-centered care. Empirical research suggests that physician attitudes towards shared decision-making vary as a function of patient demographic characteristics, risk tolerance and physician’s own attributes. We conducted a pilot experiment to evaluate the communication skills of individual physicians as they interact with different patients with similar medical problems but different risk perception and motivations.

We hypothesized that when patients’ risk perception and motivation are controlled, physicians vary in their skills to achieve shared medical decision making under dynamic conditions.

Methods: In our feasibility study, we observed 18 anesthesia residents as they obtained consent from trained actors who played the role of a parent whose child was to undergo an elective surgery. During each encounter the medical condition of the child remained the same but parent’s risk tolerance and motivation was changed. Enrolled physicians were blinded to the parent behavior traits prior to the interviews.

Results: We will present our preliminary results from the experiment. Audio-visual recordings of encounters will be evaluated by two independent trained raters using previously validated instruments. These instruments will be modified to measure pre-surgical conversation.

Patient enablement in medical consultations: An analysis of a mixed methods study through a philosophical lens

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Introduction: Martin Buber’s existentialist perspective provides an approach to considering patient-doctor relationships relevant to consultation dynamics and the outcome of patient enablement. Buber contrasts two different approaches to dialogue: the “I/It” and the “I/Thou” interaction.

Methods: Routine consultations in UK general practice were studied to develop an insight into the mechanism underlying patient enablement (measured with the Patient Enablement Instrument). 82 consultations were recorded, analyzed with RIAS for verbal interaction, and had an enablement outcome. Semi-structured interviews exploring both participants’ perspectives were carried out, using the recording as a trigger, and analyzed thematically. Triangulation of this data was viewed through the lens of Buber’s philosophy.

Results: From Buber’s perspective a “life of dialogue” is a fluid interplay moving from “I/It”, to “I/Thou” interactions which require an awareness of engaging, and being engaged, as seen in the observational study. For enabling consultations, the interchange could be distinguished here as patient-centered in terms of verbal interaction. Buber recommends a state of “open receptivity” (an enabling mindful doctor), seen in the thematic and verbal analyses where patient counseling and socio-emotional interchange was found to be important for enablement.

Enabling interaction comes from “the Between” and so is dependent on the relational aspects of the interchange between patient and doctor. For enablement in Buberian terms, each participant experiences mutual presence, reciprocity, and recognition. When both patient and doctor can mutually “turn” to each other, a “rememberable common fruitfulness” is achieved, which patients distinguish as enablement.

Implications: The pivotal role of recognizing each individual is seen in the value patients placed on personal tailoring, and the doctors on consulting with informed flexibility. This supports current ideas of optimizing patient-centered consulting, as found in Buber’s approach to dialogue.

Patients’ perspectives on antenatal group consultations: Identifying communicative strengths and weaknesses

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Introduction and objectives: The doctor-patient dyad has constituted the main paradigmatic relationship in Western medicine, and provided a central focus for health communication research and
clinical teaching endeavors. With new technologies, other constellations are enabled, such as patient-patient communication, which is increasingly taking place in online patient communities. One novel offline setting which can support patient-patient communication is the group consultation where an individual healthcare professional and a group of patients engage. The purpose of this study is to investigate how patient-patient communication unfolds in a group consultation with a midwife in order to identify its communicative strengths and weaknesses.

**Methods:** Using a sequential multi-methods design, we performed eight individual interviews with pregnant women from a Danish antenatal clinic about their experiences of two group consultations, followed by an observation study of group consultations at the same clinic.

**Results:** Analysis identified the value of placing patients together, as it helped to normalize pregnancy which otherwise can be medicalized in the healthcare setting. The sharing of personal experiences had a reassuring effect, and the power of experiential knowledge became clear when second-time pregnant women shared their experiences with women who were pregnant with their first baby, prompting new sets of questions and answers. Interviewees highlighted the fact that group composition affected their experiences of this consultation mode, and stated that further patient-patient communication could be facilitated in group consultations.

**Discussion/Implications:** Group consultations offer new possibilities in terms of patient engagement, where pregnant women not only participate in their own health and wellbeing, but also in that of others. Further research is necessary to investigate the exciting communicative potential of group consultations and to establish how they can be improved in order to facilitate greater patient involvement.

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**Teaching and Evaluating Clinical Communication Skills**

Assessing Veteran-Centered Communication Skills: Validation of a Military Focused Standardized Patient Checklist

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**Introduction:** The last decade of American history has been marked by extensive military conflict, with the deployment of troops to combat zones in Iraq, Afghanistan, and elsewhere. Now, over 2.6 million military personnel are reintegrating into civilian life and health care centers across the nation. In 2011, the Joining Forces Initiative was launched to improve the nations’ commitment to meeting the health care needs of veterans and their families. To aid in this effort, we developed two military focused standardized patient cases, post-traumatic stress disorder (PTSD) and military sexual trauma (MST) to assess trainees’ interpersonal communication skills with patients with mental health conditions (2) sensitivity and respect for patients’ behaviors and lifestyles, and (3) ability to meet the special needs of veterans.

**Description:** We used a two-stage process to development the checklist. Checklist items were evaluated for inclusion by an expert panel; while feasibility was established in a pilot study. Checklist validity was also examined during these stages. Post-program, validity was reexamined and internal reliability calculated.

**Evaluation:** The overall 36-item checklist was found to be reliable (Cronbach alpha=.83) and its’ validity supported. The 10-item communication skills subscale had an internal reliability of .58. To examine validity, scores were compared by House Officer (HO) level and both HO3s scored higher (92%±12) than both HO2s (84%±12) and HO1s (84%±13), differences were not statistically significant. However, the effect sizes (both .62) indicate practical significance. HOs performed well on communication skills; mean and SD of 86%±13 and a range of 60% to 100%. Scores were similar for both cases.

**Discussion:** These cases provide clinical supervisors with data to assess learners’ interpersonal communication skills based on direct observation. Creating a valid checklist is critical to the credibility of the assessment. The data provides learners with opportunities to address deficiencies and develop self-efficacy.
Based on a True Story: An Assessment of Re-Enacted Clinical Interactions for Training Physicians to Discuss Clinical Trials with Patients and Families

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**Objective:** Video recordings of actual clinical interactions are ideal for training oncologists, but use of these videos for training is limited by privacy concerns. Thus, most training curricula use simulated scenarios, which may not accurately reflect clinical reality. We evaluated the extent to which professional re-enactments of actual patient-oncologist interactions are perceived as appropriate for training oncologists to discuss clinical trials with a diverse population of patients and families.

**Methods:** Data were from a research-based archive of actual video recorded interactions in which oncologists discussed trials with patients and families in an outpatient setting. Following suggestions from an expert panel including medical oncologists, communication scientists and community members, brief segments of the videos were selected for re-enactment if they illustrated at least one aspect of trial-related informational or relational communication, such as discussing risks of participating or encouraging patients’ questions. The segments were transcribed verbatim, re-enacted by professional actors, and evaluated in two ways. First, we assessed oncologists’ and survivors’ perceptions of the quality of the re-enactments and of the oncologists’ trial-related communication during the re-enactments. Second, we assessed how faithfully the segments were re-enacted by comparing trained research assistants’ judgments of oncologists’ communication in the re-enactments and in the original videos.

**Results:** Oncologists’ and survivors’ perceptions of the re-enactments were favorable and did not differ significantly from each other. Research assistants rated the original videos significantly higher than the re-enactments for items reflecting relational communication, but no such differences were found for items reflecting informational communication.

**Discussion:** Re-enactments of actual patient-oncologist discussions of clinical trials are appropriate for training oncologists to discuss trials with patients and families. Future research is needed to assess the extent to which training oncologists using re-enactments improves oncologists’ communication.

Development and evaluation of a “Four-Habits”-based communication skills trainings for General Practitioners

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**Objective:** The quality of communication between general practitioners (GPs) and patients has a significant impact on treatment success and job satisfaction of GPs. The study aims to develop an effective communication skills training (CST) for GPs in Germany. This training should consider the conditions of German primary care where a high number of patients per day allows little space for long consultations. The specifically tailored CST for GPs will be based on the internationally established Four Habits Model (FHM).

**Methods:** To adapt the CST to the needs of patients and physicians in Germany, focus group discussions with both patients and general practitioners were conducted. The audio-recordings were transcribed verbatim and afterwards interpreted by content analysis. The material was discussed by a multi-professional group (general medicine, psychosomatic, sociology, patient, communication skills trainer) and a code system was determined. Two of the authors independently applied the code system to the material. The data systematization and analysis were conducted computer-assisted with MAXQDA.

Results of the content analysis were transformed into a structure which was compared with the contents of the FHM. A training program was developed based on these findings. This CST will be carried out evaluated and refined within a triple subsequent feedback process with small groups of GPs.

**Results:** Six focus group discussions with patients and seven with general practitioners were conducted all over Germany. Ten identified dimensions from the categories were compared to the content of the FHM. Most of the dimensions (1-5, 9 and 10 see Figure 1) overlapped with the FHM and were adopted for the CST. Some dimensions were complementary (6-8) to the FHM or were adjusted for the CST (3-5).

CST evaluation and adaption are in progress until August. The resulting CST-dimensions will be presented.
Direct Observation and Coaching of Physician Communication within Patient Interactions: How Satisfied Are Providers Following the Process?

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Introduction/objectives: Effective physician-patient communication is a key component in the delivery of safe, high-quality health care. Further, improved communication increases both patient satisfaction and patient outcomes. However, physician-directed interventions aimed at improving communication are few and far-between, particularly with established providers who have been in practice for five years or longer. There are perceived barriers to these efforts including provider acceptability; concerns remain regarding the comfort level of providers in regard to direct observation and coaching of communication within medical encounters. Thus, most intervention efforts have targeted physicians who are still in training.

Methods: 21 established pediatric sub-specialty practitioners (MDs) were involved in a process of shadowing their health care encounters with patients and their families (mean # of encounters observed per provider = 6). Feedback about current communication styles, as well as strategies for improved communication was provided in both verbal and written form to all participating physicians. Observations and feedback were conducted by a PhD-level clinical psychologist with expertise on communication within health care settings. A standardized provider satisfaction measure was devised and administered prior to and following the coaching intervention.

Results: Assessment of findings indicates consistent improvement in provider satisfaction. Pre- post- comparisons indicated that provider satisfaction scores (n = 21) improved significantly for all individual physicians who participated in shadowing and communication coaching (t = -2.50; p < .01).

Discussion/implications: Despite concerns about implementing an intensive process of direct observation and behavior change coaching for established providers, those who participated in a shadowing and coaching process indicated higher levels of individual role satisfaction following the completion of this process. These findings have implications for broadening the scope of communication interventions to target provider groups beyond physicians in training.

Evaluating Physician-Patient Communication at an Internal Medicine Outpatient Clinic

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Objectives: The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data show that patient satisfaction at Erie County Medical Center (ECMC) is rated below the state and national averages. This study will build upon a previous undertaking known as “Improving Patient Satisfaction with Physician Communication on Internal Medicine In-Patient Teaching Services at the Hospital of University at Buffalo” conducted at ECMC. The study used patient satisfaction surveys that rated “teams” of doctors and compared the results to physician self-evaluations. In this study, observations of “individual” physician-patient interactions will be made over the same parameters that were used in the previous study.

The study has the following aims:
1. To develop a systematic, ethnographic approach to observe physician-patient interactions
2. To identify aspects of physician-patient interactions that warrant improvement
3. To provide recommendations for improving communication skills of physicians.

Methods: The American Board of Internal Medicine (ABIM) patient survey will be modified to develop a ‘checklist’ that identifies whether or not the physicians demonstrate specific communication skills reflected in Step 2 Clinical Skills (CS) component of USMLE. Physicians at ECMC will be accompanied by an observer while interacting with patients in a Primary Care Clinic setting. The observer will complete the modified ‘checklist’ during the physicians’ interaction with patients. Each physician will be observed during multiple patient encounters. Responses in the form of binary variables (yes/no) will be recorded against each parameter on the ‘checklist.’

Results: The percentage of responses for each parameter will be calculated and compared to a reference (or benchmark). Parameters falling below benchmark values will be noted. A baseline evaluation of strengths and weaknesses related to the observed communication between physicians and patients will be used to develop tailored interventions intended to improve physician-patient outcomes.
Evaluation Approaches to a Newly Implemented Physician-Patient Communication Course

Authors: Minna Saslaw, New York Presbyterian-Columbia University Medical Center
Steven Kaplan, New York-Presbyterian Hospital
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Introduction/objectives: In October 2014 our large hospital system implemented a “Relationship Centered Patient-Provider Communication Workshop” to improve physician-patient communication. Sustainability for this major financial investment depends on early modification of course content to meet physician goals and demonstration of effectiveness. Creating a two-phase course evaluation met these dual needs.

Methods: Participant feedback on course content is through a CME-linked web-based survey sent one day post-course. The survey uses scaled questions on perceived usefulness, and solicits suggestions for content modification to meet physician goals. Assessment of course effectiveness is through a web-based retrospective pre-post tool sent 6 weeks after the course. Participants reflect back on their communication skills prior to the course, and report on current skills 6 weeks after the course. This survey type minimizes the response shift bias often associated with traditional pre- and post-surveys, and helps avoid underestimation of effectiveness. Data on self-reported behavior, attitude and knowledge is collected through simple frequencies; paired t-test will be used to test for change in individual responses following participation. Regression analysis will be used to control for confounding variables.

Results: 31 participants have completed the course. 82% completed the first survey and 29% the second survey. Of those who responded, all recommended the course to colleagues the day after the course, and there is a positive trend toward improved knowledge, skills and attitude 6 weeks later. We expect responses from an additional 100 participants by October 2015 to allow statistical analysis.

Discussion/implications: Sustainability of communication skills training at a large institution depends on offering relevant course content and demonstrating effectiveness. We present a two-stage evaluation process to achieve both goals in a hospital system offering training to all physicians. This two-phase evaluation process may be useful for institutions with similar needs.

Evaluation of medical interview training with simulated patients (SPs) by graduates of Nippon Medical School (NMS)

Author: Ryoko Aso, Nippon Medical School

Objective: Although the importance of undergraduate medical interview training with SPs is recognized, knowledge is scarce about what practical influence it may have on medical doctors in the field. This study interviewed graduates to explore the influence of such training programs.

Methods: Ten NMS-trained doctors who underwent interview training were surveyed. E-mails were sent to candidates explaining the purpose and procedure of the study. Six doctors who graduated from NMS between 1 to 7 years ago participated in a one hour semi-structured interview. Questions included impressions of medical encounter training, contents of the medical interviews, and feedback from the SPs. Interviews were recorded, transcribed, and analyzed qualitatively using the modified grounded theory approach. This research was approved by our institutional ethical committee.

Results: The following is a typical example of the graduates’ experience. Although motivated to practice medical interviews with SPs, one medical student expressed anger at SPs’ feedback (“SP warned us about dress code, which I felt was too strict.”) But on another day when the SP commented, “My relative was hospitalized,” the student re-evaluated the feedback and accepted it. This reflected good communication and the establishment of confidence between the interview-patient and doctor.

Discussion: The doctors studied found the SPs’ feedback useful and kept it in mind. Our study suggests that training to accept patient response can be valuable in post-graduate practice and that medical interview training is useful.

Learner Ratings and Evaluation of the Educating Nurses about Reproductive Health Issues in Cancer Health Care (ENRICH) Curriculum

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Introduction: Oncology nurses are in an ideal position to initiate conversations about reproductive health with Adolescent and Young Adult (AYA) cancer patients. ENRICH (Educating Nurses about Reproductive Issues in Cancer Healthcare) is a web-based 8 module curriculum based on Adult Learning Theory to train nurses to effectively communicate reproductive health topics to AYA cancer patients. The ENRICH curriculum is based on Adult Learning Theory using a problem-based and collaborative approach rather than a didactic one. Adult Learning elements specific to communication included: a case study assessment, a reflective learning assignment, and simulated case study videos. This study reports the learner feedback specific to the curriculum modules.

Methods: Nurses who participated in the 2014 ENRICH Training Program (n=77) took a program evaluation upon course completion to identify learners’ ratings regarding whether each module met learning objectives and perceived level of change with respect to: competencies, knowledge gained, and effect on patient care confidence.

Results: The majority of learners (94.8%-96.1%) rated the each module’s ability to meet objectives as either 4 (very good) or 5 (excellent). Similarly, 96.1% of learners rated the relevance of educational objectives to the curriculum as 4 or 5. The majority of learners reported their perceived level of change in patient consultation, critical thinking skills, and professional practice behaviors as a 4 or 5.
higher, 89% perceived an increase in confidence in ability to provide patient care, and 91% scored their increase in knowledge as a 4 or higher as a result of course participation.

**Conclusion:** The modules within the ENRICH curriculum was perceived as effective and relevant to training objectives. Additionally, the ENRICH curriculum improved oncology nurses’ knowledge and confidence in discussing reproductive health and fertility preservation with AYA cancer patients. Future directions include tailoring the curriculum for allied healthcare professionals.

Lessons learnt. Low patient power in a randomized controlled trial on the effectiveness of training medical specialists in communication with patients with unexplained symptoms

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**Objective:** Medically unexplained physical symptoms (MUPS) burden patients in their well-being and functioning and are among the five most expensive diagnostic categories in the Netherlands. We developed a MUPS-focused training for medical specialists which improved their communication skills. In this study we focus on the outcomes at patient level: we discuss the results and low patient power in our study on the effectiveness of this training programme on patients’ health and costs.

**Methods:** In a multi-center randomized controlled trial medical specialists and residents allocated to the intervention group received a 14-hour MUPS-focused communication training. They practiced a patient-centered approach in MUPS consultations, multi-factorial symptom exploration and explanation of MUPS with perpetuating factors. Both for pre-measurement and for post-measurement each doctor was asked to include three MUPS patients. We used a compilation of validated web-based patient questionnaires to collect data on patient-related health outcomes and costs at baseline, 3-month and 6-month follow-up.

**Results:** A sufficient number of 123 medical specialists and residents participated in the study. They included 478 MUPS patients with informed consent; 279 patients filled out web-based questionnaires at baseline, 159 patients at 3-months follow-up and 68 patients at 6-months follow-up. No significant effects were found on patients’ health and costs.

**Conclusion:** We found no significant effects of training medical specialists in MUPS communication on patients’ health and costs. The power was low, most likely due to inadequate patient information, low literacy and low motivation. To enhance patient response rates we recommend the use of a patient platform to discuss methods and implementation before and during the trial.

Online Nursing Education and SBAR Handoff Reporting: An Innovative Learning Activity

**Author:** Catie Chung, Touro University Nevada

**Abstract:** Nursing education, especially at the Bachelor of Science in Nursing (BSN) level, builds the foundation of health communication skills that students need in clinical practice. Handoff communication occurs frequently in healthcare, such as when patients are transferred to a new clinician or to a different level of care. The Joint Commission documented that 65% of sentinel events in hospitals between 1995 - 2004 were a result of handoff communication errors (DeJohn, 2009). SBAR (Situation, Background, Assessment, and Recommendation) is an evidence-based handoff communication tool that students must learn to be safe clinicians. SBAR has been proven to increase the effectiveness of communication between healthcare providers (Westwood et al., 2012), and improve patient outcomes (Townsend-Gervis, Cornell, & Vardaman, 2014).

While BSN students may practice SBAR-format reporting in clinical coursework, monitoring students’ SBAR reports for quality and consistency can be difficult in such settings as teacher:student ratios range from 1:8 – 1:12 depending on state board of nursing regulations. Further complicating the scenario is the fact that online education for non-clinical nursing courses is becoming more prevalent, and online courses may not attempt to assess communication skills. Therefore, an innovative assignment was created to assess the students’ quality and consistency of utilizing SBAR reporting in an online Professional Issues in nursing course. The assignment utilizes uses standardized unfolding case studies from the National League for Nursing’s Advancing Care Excellence for Seniors (ACES) curriculum and voice-over PowerPoint software. The assignment specifics will be demonstrated for the audience and assignment implications pertaining to effective handoff practices will be discussed.

Provider responses to patient emotional cues and SEGUE framework performance: A comparative study using VR-CoDES

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Introduction/objectives: Different instruments have been used to evaluate clinicians’ and students’ performances in medical interviews, attending to both medical and patient/relationship-centered approaches. Evaluations usually focus on general skills associated with each type of approach, not being able to discriminate and assess specific types of provider interventions, particularly in what concerns response to patient emotions. Considering clinicians and students assessment fundamental in the process of acquiring, developing, and mastering the ability to respond to emotional cues and concerns, the present work aims to identify the types of responses to patients negative emotions (VR-CoDES) used by medical students, attending to their global performance (adapted SEGUE) on a medical interview.

Methods: From 255 videotaped interviews with standardized patients conducted by 2nd year medical students as part of their final evaluation of Medical Psychology, we randomly selected 15 interviews. These interviews were then transcribed and coded using VR-CoDES. The frequency of the main categories of VR-CoDES providers responses to emotional concerns/cues was compared to students’ performance using an adapted form of SEGUE.

Results: Preliminary results suggest that higher rates in SEGUE are associated with the use of more explicit and opening responses to patients’ emotional concerns/cues. In particular, we found that the only student that used a response of affective exploration presented the highest rate on global performance. Students with lower performance rates tend to use non-explicit and reduce space responses.

Discussion/implications: Using a patient/relationship-centered approach to medical encounter implies the ability to identify and respond to emotions. Clinicians also have to elicit and deliver information, attend to the nonverbal maintaining structure and several studies suggest that time management is a common difficulty. The evaluation of different types of emotion responses, their timing, efficiency, and association with global performance maybe particularly useful to the design of under and post graduated training programs.

Tell Me a Story: Narrative Medicine in a General Medicine Practice

Authors: Natalie May, University of Virginia
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Introduction: We often overlook the story’s potential power to forge more effective relationships with our patients or to help us find creative strategies to help them be well. We developed an educational innovation designed to expose residents to the value of narrative medicine in giving care to their patients. Our goal was to study the effectiveness of “planting the seed” of narrative medicine in a clinical setting while simultaneously growing a clinic culture that appreciates the potential of patient stories to improve patient care.

Instructional Methods: We implemented the TMAS project at our general medicine teaching practice. We identified 9 firms (out of 18) to serve as the intervention firms, led by a total of 8 attendings. The TMAS team introduced the project to all faculty physicians and then held additional meetings with the intervention attendings. We developed pocket cards with story prompts and suggestions for transitioning from the story to the patient exam. We developed a narrative medicine mini-CEX. Residents who elicited a story from a patient received M&Ms and “green cards.” We asked them to share that story and their reflections on how the story changed the doctor-patient relationship and/or improved the patient’s care during a future morning report. We interviewed 10 of the 24 residents who shared stories at morning report and conducted a focus group with faculty.

Evaluation Results: Resident reflections on their experience reveal that narrative medicine does foster patient trust; helps the physician to gain insight into barriers to health; creates meaningful connections; and sometimes adds a little fun to the patient visit.

Discussion: Narrative intelligence, like emotional intelligence, can improve with experience. Physicians, even those inclined to relatively strict evidence based clinical practice, are open to stories and willing to share. Story listening can be done in a way that does not impede efficiency.

Story listening and sharing increased, lightening the mood in the workrooms, replacing much of the black humor and negative patient stories with more therapeutic stories, and shifting attention to the benefits of narrative medicine during morning report.

The communicative experience in the context of the clinical practices of medical students

Author: Claudia Villegas, Universidad Pontificia Bolivariana

Introduction/objectives: Worldwide, the need has been recognized to integrate communicative skills and development into the core curriculum of medical schools due to their relevance in formative process and the foundation of a humanized clinical relationship. This process is a complex phenomenon which relates not only to students, but also to teachers, clinical practice and health systems, constituting a key issue in medical education research. This study aims to explore and identify the personal, academic, curricular and institutional conditions that influence and enhance the communication experience of medical students at different times in their learning process.

Methods: The project has been realized in the Medical School of Universidad Pontificia Bolivariana in Medellín from a qualitative approach taking social phenomenology as a methodological perspective. The conceptual framework is based on the review of literature available in databases worldwide. Also we developed interviews...
and focus groups as techniques of data collection among students between third and sixth year, during clinical practice and internship in order to identify possible similarities or differences throughout the training process.

**Results:** Until now, we have developed the theoretical review of the worldwide literature related and fieldwork which allows us to the analysis of results, process that is taking place until now.

**Discussion/implications:** We expect to present the final result of our research work during the Conference. Also, we expect that the results will provide a deep understanding about the communicative phenomenon and development of communication and interpersonal skills in medical students during their formative and training process. It will also contribute to new strategies in curricula definition and development according to new challenges in medical education.

The Long-Term Impact of Experiential Communication and Relational Training on Radiology Fellows

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- Stephen Brown, Boston Children’s Hospital

**Introduction/background:** Since 2011, Boston Children’s Hospital (BCH) radiology fellows have been required to attend a radiology-specific communication workshop (Program to Enhance Relational and Communication Skills - PERCS-Radiology). This study aimed to:
1) assess the workshop’s long-term impact on former fellows; 2) explore the persistence of learning over time; and 3) evaluate the workshop’s perceived relevance in practice.

**Methods:** Semi-structured qualitative interviews were conducted with 10 former BCH radiology fellows (six male, four female) who attended PERCS-Radiology workshops from 2011 to 2013. Phone interviews were tape-recorded and transcribed verbatim for analysis. Data analysis followed principles of thematic analysis.

**Results:** Three main themes emerged:
1) Varied prospective expectations: Interviewees had differing expectations of what the workshop would entail, but all found the workshop beneficial. Enactments with professional actors and subsequent group debriefings were particularly memorable.
2) Differential learning: Interviewees reported that the workshop imparted skills, knowledge and conceptual learning. The balance of such learning varied among interviewees, but only one focused solely on one dimension (skills).
3) Relationship to radiologic culture and institutional support: Learning persisted into practice but depended on individuals’ personal views of their roles as radiologists and on the perceived roles of radiologists within the institutional cultures where they practiced. Themes were not differentiated by gender, current employment setting (private/academic) or length of time since training.

**Discussion/implications:** Radiologists who participated in PERCS-Radiology during their fellowship training found the communication training to be memorable and beneficial. They welcomed the opportunity to observe and participate in enactments of difficult conversations in radiology, and they carried learning from the workshops into their current practice. However, the long-term impact of PERCS-Radiology was dependent on views about the communication roles of radiologists, both among interviewees and within their current institutions.

Technology and Social Media

A digital application that helps cancer-stricken kids to learn of and cope with their condition

Authors:
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- Karina Nielsen, EAL Odense

**Abstract:** In this contribution, we present a digital application that provides knowledge about cancer in an educational and funny way. The application informs and explains issues related to cancer in a way that is comprehensible to children. Specifically, the target group of our interactive digital solution is cancer-stricken children in the age range 6-12 years.

We believe that an educational platform can help children directly, and relatives indirectly, to manage their disease by easing the psychological burden associated with it. Using the right language, audio clips, illustrations and small game-like quizzes, our application is easy to understand and helps children coping with and understanding their illness. As part of the application, we additionally provide space for the children next-of-kin, especially parents, allowing them to learn about and share their experiences with other caregivers, parents, as well as children in the same situation. We contend that such a tool has the potential to increase the awareness of the medical and psychological condition of children patient, thus ultimately resulting in more informed shared decision between medical personnel and legal guardians of the sick children.

Figure 1: screenshot of the current web application
We have created the conceptual design of the application and have developed the original idea for an existing web application. We are also in the process of exporting the existing prototype onto mobile devices.

In a perspective user study, we plan to expand the content presented in the existing prototype based on factual clinical data and clinical experience. Together with the hospital Lillebaelt, we also plan to evaluate the usability directly with children and their families in order to quantify the impact and effectiveness of our digital solution.

As far as we know, our project the only informative electronic platform specifically with children with cancer.

A path to empowerment? Patients’ recording clinical encounters

Authors: Glyn Elwyn, Dartmouth College
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Background: There are reports of patients recording clinical encounters, a behavior made easier by the availability of smartphones. This has led to clinicians voicing concerns. We could find no published data on the frequency of these behaviors or the underlying motivation for patients to record. This study addresses this gap in knowledge.

Method: We administered an online cross-sectional survey advertised on a BBC website, Twitter, and Facebook. Respondents were asked to describe their views and experiences in relation to recording clinical encounters. The survey data were analyzed using descriptive statistics. Multiple logistic regression analysis was used to identify respondent characteristics associated with a preference to record overtly or covertly. Survey respondents were invited to participate in semi-structured interviews conducted by telephone. Interviews were recorded, transcribed, and subjected to thematic analysis.

Results: A total of 168 individuals responded to the survey. Of those 130 who completed the full survey, 15% indicated having secretly recorded a clinical encounter, and 11% knew someone who had secretly recorded a clinical encounter. Nearly 71% of the sample said they would consider recording a future health care visit either secretly (35%), or with permission (34%). Of the 56 individuals agreeing to be contacted, 17 consented to phone interviews. Interviews revealed three key themes: 1) Participants establish a rationale for recording based on the benefit of being able to better understand information exchanged, 2) Recording was viewed as a way of increasing accountability on both sides of the encounter, 3) We noted a fear of the unknown, uncertainty about how clinicians might react to the purpose and future use of the recording.

Conclusion: This is the first attempt to identify the prevalence and motivations to covertly record medical encounters. Making recordings part of routine care could reduce unease among clinicians and patients and improve accountability.

Discutons Santé—Let’s Discuss Health. Implementing referral to a website to help chronic disease patients and their primary care providers engage in productive interactions

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Background: Communication interventions directed at patients, including self-learning websites, can increase patient participation within healthcare encounters (HCE). However, few patient communication educational websites are available in French. Our group developed and validated Discutons Santé, the only French language website intended to activate patients. The website provides three patient tools: 1) communication training based on Cegala’s PACE model; 2) visit preparation guide; and 3) health booklet. The aim of this project is to study the adoption and implementation of the Discutons Santé patient tools in Québec primary care clinics.

Methods/Design: Observational study. RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) is the framework that will guide both quantitative and qualitative data collection and analysis. Setting: Three Family Health Teams of the Réseau-1 Québec network. Participants: Five healthcare providers (HCP) and 50 adult patients with one or more chronic diseases from each site. Intervention: Discutons Santé patient tools (www.Discutonsante.ca). Instruments: Patient and HCP self-report questionnaires completed after the first return-visit following use of Discutons Santé tools measure perception of the usefulness of the tools and patient activation. HCP and patient focus groups will be held at each site to gain in depth understanding of the implementation and adoption of the tools in clinical routines and their perceived usefulness in the management of chronic diseases.

Results: Partial results will be available at the time of the presentation since this project has just received funding from Réseau-1 Québec. This poster will describe the research framework our project is built on and the complete study protocol.

Discussion: Helping patients adopt an active role during HCE through the use of the Discutons Santé tools may lead to patients’ activation and increased confidence in their chronic disease self-management skills, both eventually leading to improved chronic disease outcomes.
Improving communication in video counseling sessions through interactive role-play

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Introduction/objectives: The Norwegian National Advisory Unit on Rare Disorders’ main task is to ensure that people with rare disorders receive holistic and individually based care. The advisory unit practice outbound services for patients and local professionals nationwide often provided using videoconference technology (VC).

Even though technical progress might simplify the process of achieving good communication through VC, the Advisory Unit has encountered challenges in motivating employees in using VC. In order to motivate and optimize the quality of VC-counseling, potential participants need to develop practical and technical skills.

Methods: We conducted two-hour training courses where two groups were connected via VC. Each group attended one course, which comprised of two sections. The first section was a hands-on practical training using the VC equipment, and the second section included the role-play, followed up by reflections and discussions. An electronic questionnaire was sent the participants after the course was completed.

Results: Out of the 89 participants 71% answered the questionnaire. 18% of the respondents had never attended a VC before, while 23% had participated in more than 10 VC. 85% reported the practical dialing and connection procedures to be useful, and 70% said that the role-play made the training realistic.

After the two-hour course, 57% reported increased motivation for using VC in their counseling service, and 75% replied to be more conscious of how to communicate during a VC.

Discussion/implication: Practical and realistic training sessions with role-play, are a useful way to increase the empowerment and motivation for using videoconference as a medium for professional counseling in the field of rare disorders. Mastering the equipment is important in order to gain confidence and trust in a new type of communication.

We will use video clips from the training to illustrate the method.

Online debates on pediatric vaccinations: Exploring the arguments and sources of information on Italian forums through content analysis

Authors: Marta Fadda, University of Lugano
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Introduction/Objectives: Web 2.0 applications might play a special role on childhood vaccination decision-making, allowing users to interact with each other and actively propagate information. The purpose of this study was to analyze online debates on pediatric immunizations through a content analytical approach to quantitatively evaluate and summarize users’ arguments and information sources.

Methods: Threads from 3 Italian forums were extracted using the keyword vaccin* in the title, focusing on childhood vaccinations, generating at least 10 posts, and started between 2008 and June 2014. Five independent coders analyzed the posts achieving high intercoder reliability. Exploratory analysis using k-means clustering was performed to identify users’ pattern in posting arguments toward discussed vaccines and users’ cited sources of the posted arguments.

Results: 340 threads were included comprising 6544 posts and mentioning 6223 arguments about vaccines with 4067 cited sources. Total number of users was 1729 where 97.7% of them were females. The clustering based on the users' posted arguments resulted in 3 clusters/groups: (1) “general pro-vaccination” group (n=121) posting arguments supporting vaccination from multiple aspects; (2) “focused-argument pro-vaccination” group (n=59) undermining mainly the negative side effects of vaccination; (3) “anti-vaccination” group (n=156) posting negative arguments on vaccinations. The latter group generated 59.2% of the posted arguments. The clustering based on users’ cited sources resulted in 4 groups: (1) media-fans group (n=28), (2) doctors/medical practitioners-dependent group (n=45), (3) diversified-source group (n=55) and (4) own-experience group (n=85). The anti-vaccination group had 61% of the cited sources, and used media, rumors and own experience as their main sources while the other two groups depended on their own experience and more on medical professionals.

Discussion/Implications: Further research needs to be carried out on social media’s role in shaping parental vaccination sentiments while getting more insights from the ongoing online debates is essential for addressing parental concerns in a way that is suitable for the online environment.

Using Mobile Technology to Address Adolescent Depression Education

Authors: Vinay Parekh, Johns Hopkins University School of Medicine
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Introduction: Adolescent depression has significant morbidity and mortality, including risk for suicide, but early identification and effective treatment can address the risks associated with adolescent depression.
Depression. In one study of adolescents who completed suicide, fewer than 10% had received treatment and less than a quarter of young people who were aware of a suicidal peer told an adult or encouraged their friend to seek adult help. (1, 2)

Description of practice innovation: Approximately 85% of Americans have a mobile phone; cellphone users between 18-29 years old are more likely to use mobile health apps. Mobile technology may be a novel way to reach teenagers for health education.

An app was designed based on the Adolescent Depression Awareness Program (ADAP) curriculum, which educates high school students, teachers, and parents about Major Depression. The goal of ADAP is increasing adolescents’ knowledge about the illness of depression and decreasing the stigma associated with mood disorders. (3)

Evaluation and impact: An adolescent depression awareness app could also promote mental health literacy. Mental health literacy is defined as not simply having knowledge but linking that knowledge to actions that benefit one’s own mental health or the mental health of others. (4) The ADAP app has a resources section which links to a treatment locator.

This app will be evaluated as a clinical tool in primary care settings to facilitate discussion of the symptoms and diagnosis of depression and compare its use to standard health education tools such as pamphlets and other written materials. A video based mobile platform may be more engaging to adolescents.

Discussion and implications: Introducing a high quality evidence-based depression education app can help address the public health crisis of adolescent suicide as well as morbidity associated with unrecognized adolescent depression. Future directions include expanding functionality to solicit and respond to questions and broaden the audience to adults.

Underserved Populations and Health Disparities

Communication Practices in Requests for Organ Donation: A Comparison of Hispanic’s and Non-Hispanic’s Experience

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Introduction/objectives: Hispanics in the United States generally donate organs at rates significantly below that of non-Hispanics. Approximately 17% of the US population is Hispanic, and while approximately 19% of all people waiting for organs are Hispanic, only 11% of all donors are Hispanic. Continued research is needed to understand and remediate these differences. This research compares perceptions and experiences of the organ donation request process for Hispanic families to that of non-Hispanic whites.

Methods: Data were collected on requests for donation made by 271 Organ Procurement Organization (OPO) staff employed by 9 OPOs. Semi-structured telephone interviews were conducted with 1,601 family decision makers (FDM) approached about the option of organ donation to assess the quality, content, and outcomes of the donation request.

Results: Approximately 17% of the sample was Hispanic/Latino (a), over half of whom indicated Spanish as their preferred language. Overall, 1,347 FDM authorized donation (84.1%). More Hispanic FDM agreed to donate than did FDM of other ethnicities (86.7% vs. 83.6%, p=.20); more Spanish-speaking Hispanic FDM donated than did English-speaking Hispanic FDM (89.9% vs. 82.8%, p=.08). Paradoxically, Hispanic FDM provided lower ratings of the request than did non-Hispanic whites, including less care, concern and comfort with the requester, less satisfaction with the time spent discussing donation, and less comfort with the final donation decision. No differences were found in the number of donation-related topics discussed or the communication skills employed by requesters interacting with Hispanic or non-Hispanic families. However, Hispanic respondents reported significantly higher levels of pressure to donate (p=.01).

Discussion/implications: Findings from this national sample suggest Hispanic families approached about the option of posthumous organ donation authorize at rates comparable to those of non-Hispanic whites. These findings also raise the question as to whether, how and to what extent coercion plays a role in Hispanic families’ willingness to donate.

Factors Associated with Suboptimal Medication Beliefs Among Patients with Diabetes

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Introduction: Studies have demonstrated relationships between medication beliefs and medication adherence and have found that medication beliefs are associated with patient-provider communication, number of medications and comorbidities, and social support. We undertook this study to assess factors associated with medication beliefs in a cohort of patients with diabetes.

Methods: We recruited diabetic patients taking ≥1 oral hypoglycemic agent and used the Beliefs about Medicines Questionnaire (BMQ) to evaluate beliefs about diabetes medicines. The BMQ consists of 2 5-item subscales assessing perceived necessity and concerns. We created BMQ differential scores by subtracting the concerns from necessity scores. Higher BMQ differential scores indicate greater perceived necessity with low concerns while lower scores indicate lower perceived necessity with higher concerns. Descriptive and univariate analyses were used to assess factors associated with BMQ differential scores.

Proceedings from the 2015 International Conference on Communication in Healthcare
Results: Of the 78 participants recruited to date, 46 (58%) were male; 20 (25%) were white, 25 (32%) black, and 33 (42%) were of other race; 32 (41%) had a monthly income <$2000; 46 (58%) had at least one year of college; and 7 (8%) were classified as having low health literacy. Lower BMQ differential scores were associated with low health literacy (p=0.007), being poorer (p=0.025), lower educational attainment (p=0.045), and identifying as non-white (p=0.003). Patients who reported they did not understand the medical plan (p=0.040) or had a hard time telling their providers about new symptoms (p=0.036) also had lower BMQ differential scores. Neither age nor gender was associated with medication beliefs.

Discussion: Patients with diabetes who are non-white, poorer, have lower educational attainment or lower health literacy have greater medication concerns and are less likely to believe their medications are necessary. Providers should clearly communicate the necessity of diabetes medications and discuss potential concerns with their patients who are at higher risk for having suboptimal medication beliefs.

HOOTEA: Healthier Obstetrical Outcomes through Enrichment Activities

Authors: Beth Damitz, Medical College of Wisconsin
Sandra Olsen, Medical College of Wisconsin

Abstract: The USA ranks among the bottom of developed nations for infant mortality, with preterm births accounting for 35% of all U.S. spending for infant healthcare. In addition, there exists a racial healthcare disparity. In the City of Milwaukee, infant mortality for Caucasians is 6.4%, while the percentage for African Americans is 15.7%.

The overall goal of this project is to improve birth outcomes in an urban, high-risk population. To do this, 1) we created a team based, multidisciplinary approach including members of an African American service sorority, prenatal care coordinators, dieticians, and physicians, 2) explored methods to increase patient engagement, and 3) will study the effects of this new model of care on the health of high-risk mothers and their babies.

This project uses an innovative, community focused approach to improving access to prenatal care while increasing pregnancy health literacy. This is done through monthly group visits that are led by members of our team and focus on a variety of pregnancy related topics such as co-sleeping, breastfeeding, and nutrition. It also targets psychological factors that have been shown to effect infant morbidity and mortality. The literature has shown that various stressors are influential in the health of the pregnant woman and her baby. This project is meant to gain more information on the types of stress pregnant women have as well as how her stress changes through her pregnancy. This is done through a series of validated stress surveys done at each trimester and postpartum.

Early results show that our clinic preterm and low birth weight outcomes are better than the 2013 published results for the high risk zip code we serve. In addition we are analyzing the birth outcomes to the stress surveys and will have that data to share at the time of the conference.

Scalable, Technology-Enabled Behavioral Health Services that Cross the Barriers of Stigma, Time and Distance, and Cost

Authors: Kim Norman, University of California, San Francisco Medical Center
Christine Garcia, University of California, San Francisco Medical Center
Kimberlie Cerrone, Tiatros Inc.

Abstract: The UCSF Department of Psychiatry’s Young Adult & Family Center provides quality, effective mental healthcare to young people, anywhere, anytime by offering services on the Tiatros HIPAA compliant health cloud. Our virtual clinics use real time video-chat, instant messaging, text messaging, and social media postings so patients and their families can easily communicate with clinicians. Tiatros enables true care collaboration as multiple providers in multiple systems of care can literally get on the same page in caring for a patient. The Tiatros health cloud is also a powerful population health tool, as it can be leveraged to deploy highly scalable, effective therapeutics for behavioral health that have the promise of bridging health care disparities worldwide.

Our Next Mission project provides proof of concept. We teach online courses on trauma and post-traumatic growth to active duty military service members and veterans. They earn promotion points and/or University of California college credits, while acquiring the knowledge base and skill set necessary to heal from military trauma and grow from their experience while they transition to civilian life.

Our courses teach the healing power of storytelling and personal narrative, as well as the neurobiology of stress. Students watch video lectures and complete homework assignments online, coming together to discuss and practice what they are learning in a facilitated support group. All activity is behind HIPAA compliant firewalls so personal health information is privacy protected. In our ongoing studies, we achieve completion rates equal to our brick and mortar college classes, with half of our participants actively engaged in online discussions. Clinical outcomes are as good as in-person, trauma-focused psychotherapies.

The Tiatros health cloud allows us to transform behavioral health services by giving us the power of social media within the protection of HIPAA firewalls, while bypassing stigma, time and distance, and cost barriers.
Communication in Quality and Safety

Communication in healthcare: A systematic review of the literature and practical recommendations

Author: Peter Vermeir, Ghent University Hospital

Objectives: Effective and efficient communication is crucial in healthcare. Written communication remains the most prevalent form of communication between specialized and primary care. We aimed at reviewing the literature on the quality of written communication, the impact of communication inefficiencies and recommendations to improve written communication in healthcare.

Design: A systematic literature review.

Methods: A search was carried out on the databases PubMed, Web of Science and The Cochrane Library by means of the (MeSH) terms ‘communication’, ‘primary health care’, ‘correspondence’, ‘patient safety’, ‘patient handoff’ and ‘continuity of patient care’. Reviewers screened 4609 records and 462 full texts were checked against following inclusion criteria: 1) publication between January 1985 and March 2014, 2) availability as full text in English, and 3) categorization as original research, reviews, meta-analyses or letters to the editor.

Results: A total of 69 articles were included in the systematic review. It was found that poor communication can lead to various negative outcomes: discontinuity of care, compromise of patient safety, patient dissatisfaction and inefficient use of valuable resources, both in unnecessary investigations and physician worktime as well as economic consequences.

Conclusion: There is room for improvement of both content (ensuring the required items, addressal of referral questions, diagnosis and management issues) and timeliness of written communication. The delineation of ownership of the communication process should be clear. Peer review, process indicators and follow up tools are required to measure the impact of quality improvement initiatives. Finally, communication between caregivers should feature more prominently in both graduate and postgraduate training, in order to become engraved as an essential skill and quality characteristic of each caregiver.

Communication of the diagnostic of bipolar disorder: Patients’ experiences and preferences

Authors: Irene Carvalho, University of Porto
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Introduction/Objectives: This study aims to characterize the experiences patients have when receiving their bipolar disorder diagnosis, to identify their preferences in this situation and to inspect whether these preferences correspond to their experiences at the time of diagnosis communication.

Methods: Sixty-seven patients from the outpatient care in the central psychiatric hospital of a major city answered a questionnaire about their experiences at the time of the communication of their bipolar disorder diagnosis and about their preferences about this moment. The questionnaire was created with items used in research on communication of bad news and contains 37 items. Data were analysed in PASW 20.

Results: More than half of the sample reported that the aspects in the questionnaire occurred at the time of the communication of the diagnosis. Participants valued most of the aspects in the questionnaire. Significant agreement between patients’ preferences and their reported experiences during the communication of the diagnosis was observed in eight of the 37 aspects considered. No significant disagreements between experiences and preferences were observed. The time since reception of the diagnosis, context in which the diagnosis was given, marital status, and age influenced patients’ preferences.

Discussion/Implications: Research in breaking bad news with bipolar patients can help caregivers to better understand patients and to adapt communication strategies to their preferences. In this sample, importance was placed on the communication of the diagnosis in person, with consideration for individual fears and questions, giving hope and emotional support, providing information in a clear way, on the possibility of cure and on the treatment, with time, in private and checking if it was understood. The least valued aspects included communication by a team or by the senior doctor, having the company of someone close, and communication of all the details of the diagnosis.

Do providers and caregivers accurately judge patient pain? Results from two meta-analyses

Authors: Danielle Blanch-Hartigan, Bentley University
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Introduction: Uncontrolled pain in patients is a persistent problem in the healthcare system, with up to a third of adults experiencing
Innovative Teaching Strategies to Optimize Safety in Healthcare Delivery by the Novice Nurse

Authors: M’Lyn Spinks, University of West Georgia
Holly Dever, University of West Georgia

Abstract: Like no other time in history, the media has brought medical error to center stage. Reports of tragic harmful medical events in Hollywood families and political figures are presented through emotionally charged news stories and televised legislative hearings on cause-of-death statistics. Awareness of medical error is not a barrier to reducing medical error. The daunting task of selecting an effective and efficient method of change in provider behaviors and system failures that contribute to this error, however, is. Compounding the public safety issue of medical error is the high risk of error by novice nurses. Approximately half of graduate nurses will commit a medical error within their first year. Acknowledging the recommendations of the Institute of Medicine and Quality Safety Education in Nursing to incorporate safety strategies into provider education, the AHQR sought a solution. Working alongside the Department of Defense, AHRQ developed TeamSTEPPS. Consisting of a standardized set of strategies and tools, TeamSTEPPS improves communication and teamwork resulting in increased safety and quality of patient care.

Incorporating these strategies and tools into nursing education is multifaceted. First, it enhances the confidence of the novice nurses’ in the ability to organize and articulate critical patient information within an interdisciplinary team. Second, it improves the nurses’ attitudes towards teamwork that are essential to performance and provision of quality care. Integrating TeamSTEPPS within the existing curriculum enables faculty to incorporate the provided skills effectively. Adaptations of current summative assessment tools of clinical performance determine, not only, the success of mandated clinical skills performance but also the execution of the proven strategies of communication and teamwork. Through this comprehensive integration of TeamSTEPPS within nursing education, faculty will play a significant role in reducing medical error and improving the safety and quality of nursing care in the United States.

The more the merrier? - Is there a relationship between the frequency of communication and relational coordination in intensive care units?

Authors: Sandra Klingenhaeger, University of Education Weingarten
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Introduction: The specific relation between communication, relationship and work coordination has been explored only since recently. The focus lies on the coordination of interdependent tasks of inter-professional teams in high-risk work environments such as intensive care units. Here, successful coordination of work is a prerequisite to master the complexity of tasks, stressful environmental factors and to reduce the potential for errors. The frequency of communication with respect to Relational Coordination is a central factor. There is a lack of empirical evidence concerning the relationship between communication frequency and relational coordination in intensive care units.

Methods: The empirical study analyzes the relationship between communication frequency and relational coordination among the various professional groups in intensive care units. The Relational Coordination Questionnaire (Gittell, 2006) was adapted according to the research question and translated. 146 employees from different professions in the ICU of a German university hospital were surveyed. In addition, the actual communication frequency was surveyed between the professional groups in a quantitative observation.

Results: The results support the theoretical assumption that communication frequency and satisfaction with communication frequency are factors influencing relational coordination in the field of intensive care medicine.

Discussion: Consequently, further study is needed to investigate if and how frequency of communication and relational coordination influence objective indicators of organizational outcome (e.g. length of stay, mortality, turnover of staff) in intensive care units. Thus, a constant increase of efficiency and quality of patient care in intensive care units could be supported.
Diversity and Cross-cultural Communication

Patient’s Perceptions Regarding Communication Skills of their Physicians and Influence on Trust, Satisfaction, and Adherence: A Comparison of IMG and USMG Physicians

Author: Parul Jain, Ohio University

Objective: One-fourth of all physicians practicing medicine in the United States are considered international medical graduates (IMG physicians) and there is a dearth of research examining communication skills of these physicians and comparing it with their US counterparts, especially from patient perspective, and resulting influence on key medical outcomes that influence health related quality of life. Thus, the main focus of this research involves comparing patient perceptions of communication patterns of internationally trained and US trained (US Medical Graduates; USMG) physicians and how that impacts patients’ levels of trust, satisfaction and adherence to treatment. Further, a moderating role of gender and physician cultural competency would also be examined. The theoretical perspectives that guide this research are communication accommodation theory and ecological perspective.

Methods: A cross-country random sample survey (n = 400) is currently being requested. This is where I could use help from more experienced researchers in the area, especially with respect to patient recruitment. The participation criterion is patients who see physicians in an outpatient setting. Previously established scales are included in the survey. The scales measure variables such as trust, anxiety, satisfaction, communication assessment, relational history, perceived empathy, and adherence, among other things.

Results: Different statistical techniques relevant to the hypotheses such as regressions, mediation and moderation models may be employed for the analysis. Data collection is not yet complete so no concrete results could be presented as this abstract is being submitted under “Research in Progress” category.

Discussion/Implications: The proposed study would be very first to compare IMG and USMG physicians on the abovementioned variables from healthcare receiver perspective. Findings obtained from this research will be used to better understand factors that may help in patient empowerment and reducing health disparities. The findings hold potential in informing graduate medical education in the areas of communication skills training and furthering research on understanding cultural factors in medical interaction.

The role of concordance and patient participation on communication outcomes in intercultural GP settings

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Introduction/objectives: Previous research among majority populations has found positive effects of doctor-patient concordance and patient participation on communication outcomes. However, little is known about the influence of these variables on communication outcomes among ethnic minority patients. Because ethnic minority patients’ preferences as well as their communicative behavior are different from that of the majority population, effects of concordance and patient participation are assumed to differ between the patient groups. Hence, this study aimed to investigate differences between Dutch and Turkish-Dutch patients in concordance between GPs and patients (in preferred relationship and preferred level of patient involvement) and perceived patient participation on patient satisfaction, understanding of information and fulfillment of information needs.

Methods: To assess concordance between GP and patient in preferred relationship and level of patient involvement, perceived patient participation and communication outcomes, pre- and post-consultation questionnaires of 136 Dutch and 100 Turkish-Dutch patients were combined with the questionnaires of their 32 participating GPs.

Results: Among Dutch patients, concordance in preferred patient involvement positively affected satisfaction, fulfilment of information needs and understanding of information while among Turkish-Dutch patients, discordance in preferred doctor-patient relationship positively influenced fulfillment of information needs and understanding of the information. Interaction effects between concordance and perceived patient participation showed that Turkish-Dutch patients who were concordant with their GP in preferred doctor-patient relationship and reported high participation had a higher understanding of the information and better fulfilled their information needs.

Discussion/implications: The type and direction of concordance effects seem to differ across Dutch and Turkish-Dutch patients. Future studies on concordance effects should incorporate perceived patient participation and should separate ethnic groups from each other to investigate how concordance operates in the medical setting. Intercultural communication could be enhanced by adopting a more patient-centered approach to accommodate to variations in patient’s preferences, combined with stimulating patient participation.
Health Literacy and Numeracy

Providing a framework for basic health information online

Authors:
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Introduction: Over 70% of Americans search for health information online, but navigating medical content can be an intimidating maze of unstructured text, subjective opinions, sources with unclear credibility, and incomprehensible jargon. To address this, Google launched a product that provides basic health information on over 400 common conditions. This study explores how medical experts and Google users responded.

Methods: Working with over 150 medical doctors, we curated information on common conditions and then summarized that information in succinct layperson’s terms in a discrete Knowledge Graph within Google Search. This included creating 1,288 synonyms for symptoms, grouping 985 symptoms into 56 categories to ease readability, and developing accessible ways to think about prevalence, contagion, and criticality. We conducted user studies to refine these further. To gauge the product’s success, we provided a “feedback” button to learn what users thought. In addition to this anonymous feedback, we asked 88 independent doctors to give their professional opinions on select conditions.

Results: Several hundred Google users provided feedback on the product. Most found it useful and informative; however some had criticisms on wording for nuanced topics like contagion, prevalence, and treatment for specific conditions. Of the 88 doctors who reviewed the product, most commented favorably about information quality, presentation, and the prominence of important public health information on vaccines. Similar to the Google users, a few had criticisms on contagion language and the order of treatments displayed.

Discussion: These results demonstrate that it is possible to use a structured data approach to summarize complex medical information. The positive feedback indicates that this approach resulted in engaging material online that conveys valuable public health information to users of varying reading levels and backgrounds. Future versions of the product will focus on better communicating more complex concepts like contagion, prevalence, and effectively summarizing the treatments.

Humanities, Ethics, and Professionalism

A Guiding Framework to Maximize the Power of the Arts in Health Sciences Education: A Systematic Review and Synthesis of the Literature

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Introduction/Objective: A rich literature describes many innovative uses of the arts in professional education. However, arts-based teaching tends to be idiosyncratic, depending on the interests and enthusiasm of individual teachers, rather than on strategic design decisions. We therefore conducted this study to review literature on arts-based education, synthesize lessons learned, and provide a conceptual model to guide design, evaluation, and research on using the arts in medical education.

Methods: We conducted a systematic literature review using the PubMed and ERIC databases. We conducted a qualitative analysis of the content of selected articles, identifying themes and sub-themes related to educational characteristics, processes, and outcomes in arts-based education.

Results: We reviewed 922 unique articles and selected 49 for in-depth review. Four common themes emerged describing, a) unique qualities of the arts that can promote learning, b) particular ways in which learners engage with art, c) documented short- and long-term learning outcomes that arose from arts-based teaching, and d) specific pedagogical considerations for using the arts to teach in professional education contexts.

Conclusions: The arts have unique qualities, which create the conditions for novel ways to engage learners. These novel ways of engagement can foster learners discovering and creating new meanings about a variety of topics, which in turn can lead to better medical practice. At each of these steps, specific actions by the teacher can enhance the potential for learners to move to the next step. The process can be enhanced when learners participate in the context of a group, and the group itself can undergo transformative change. Future work should focus on using this model to guide process design and outcome measurement in arts-based education.
Attention without Intention: Implications for Communication from Family Medicine Residents’ Implicit Reflections

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Abstract: Reflection about communication during medical residency allows for understanding the learning process as connected to patients’ lives beyond biomedical symptoms. Promoting reflection about medical education generally involves assigning written exercises in which learners revisit an experience with the goal of gaining new perspectives and appreciations. The aim of this study was to analyze family medicine residents’ written reflections to determine how residents used the opportunities for reflection when the writing was for themselves, i.e., it was not to be submitted assessment or grading. We analyzed 767 private reflections written by 33 residents over six months using a qualitative content analysis approach to identify themes and to develop a theory to explain the reflective process as connected to communication. We identified four themes that emerged from the data to understand reflection about medical education. Two themes, “elaborated reporting” and “metacognitive monitoring” represent explicit purposeful self-analysis that typically would be characterized as reflective about the medical education process. The other two themes “simple reporting” and “goal setting” seem to signify an automatic analysis of experience that might bypass the inherent revisionism that occurs during deliberate reflection yet may still lead to increased self-awareness of learning about communication in medicine.

From this analysis, we offer the theory that addresses reflection about communication, as typically described, that requires the person to embrace a narrative self-view. We extend the concept of reflection about communication in medicine to argue that self-awareness may also come to people without realizing this narrative view of self. Our conceptualization will require a rethinking of the role of written, graded reflective exercises as a way to increase learning or to assess learners. The broader conceptualization also integrates message communicative message components as connected to learning about medicine.

Developing and Evaluating a Dynamic Clinical Ethics Curriculum for Medical Providers in Training

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Background: Competency in medical ethics is an increasingly common expectation for residents across training programs. While it is appreciated that physicians in training possess highly disparate prior exposure and expertise in ethics, the attitudes towards ethics as a discipline, preference for training and self-awareness of comfort and competency in ethical principles is not fully understood. The likely heterogeneity in background and perspective necessitates a method to gauge trainee input and dynamically adapt a curriculum for it to be maximally effective at promoting ethical competency.

Proposed Methods: This single-center, one department effort seeks to assess the needs of trainees and the progress to date of the medical ethics curriculum under development. The current curriculum takes the form of an hour-long noon case conferences every two months in the Department of Pediatrics in which residents receive formal didactic instruction in the basic principles of medical ethics, become acquainted with the “4-Topic” method to approaching and analyzing ethics cases (Jonsen et al 2006), and engage in role-playing to work through pertinent ethical principles. This study seeks to develop a comprehensive survey to gauge attitude of past and current participants to ultimately develop a feedback and evaluation metric that can allow modification of the curriculum throughout the year to meet participant needs.

Future Directions: We hope to begin collaboration with other resident training programs at our institution with the goal of allowing residents to hone in competence in their area of practice, but also benefit from further appreciation of general principles in medical ethics as incorporated across other clinical contexts. Our overarching goal is to develop a curriculum that promotes competency in ethics in a manner that is effective, minimally intrusive, and appropriate to the needs of a highly heterogeneous cohort of providers in training.

Speaking truth to power in medicine: Negotiating empathy, advocacy, and agency in professional hierarchies

Authors: Kirsten Broadfoot, University of Colorado Anschutz Medical Center
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Abstract: At the University of Colorado School of Medicine (UCSOM), professionalism is grounded in physicianship (duty, accountability, responsibility, ethical values and conduct) and humanism (compassion, respect, altruism, empathy and cultural proficiency). Over the last two years, the UCSOM has embarked on several undergraduate medical education innovations to improve relationship centered communication and care. However, the “hidden and informal curricula” role modeled and, in some cases, actively taught by fulltime and volunteer faculty often hinders the development of relationship centered care and communication, as well as institutional expectations of professional conduct (Karnielli-Miller, et al, 2010).

To prepare medical learners for clinical rotation in their third year (where they are most exposed to hidden and informal curricula), the Foundations of Doctoring Communication Curriculum created a case requiring second year medical students to advocate for a patient whose desires were being neglected by their superiors in the healthcare team. The objective of this case was to explore how preclinical learners combined relationship centered communication skills to exercise agency and advocate for patient rights while preserving
and respecting hierarchical professional relationships (Papadimos & Murray, 2008). Recordings of learner performances and their small group discussions in this case were discursively analyzed to examine discursive resources used by learners to formulate ‘speaking truth to power’. Preliminary findings suggest that preclinical learners recognize discursive tensions between agency, advocacy and hierarchy, struggles over silence and voice, and allying themselves with patients. In feedback to faculty, learners consistently reflected that their most concerning challenges lay with others further up the professional hierarchy. These challenges were echoed in advice from faculty during these sessions, as they performed the hidden curriculum in a case designed to tackle it. These study results suggest both learners and faculty require further practice with such conversations to feel confident “talking back” for patient safety.

Running an introductory experiential course on mindfulness in a UK medical school: Lessons learned

Author: Amy Spatz, St George’s, University of London

Introduction and institutional context: Mindfulness is commonly defined as ‘paying attention in a particular way: on purpose, in the present moment, and non-judgmentally’. Regular mindfulness practice is known to reduce the effects of stress. This can be important for the communication of empathy and is thought to improve performance. Previously there was no provision for learning mindfulness techniques in the present medical school. A course was designed by two internal mindfulness practitioners for piloting.

Educational objectives: The aim of the course was to provide an experiential introduction to mindfulness for medical students in order to help prepare them for communicating the concept to patients, as well as for their own personal and professional development.

Instructional methods: In order to fit into the time-table, a 3-week course was adapted from Jon Kabat-Zinn’s successful 8-week MBSR format. Ten students and 2 staff members elected to participate. Participants attended weekly 2-hour meetings where they took part in exercises and discussed their experiences. Everyone was encouraged to practice daily.

Evaluation results: Students were invited to participate in an interview or a focus group to evaluate the effects of the course. Analysis of the data is on-going. Some early emergent themes include positivity regarding the influence of mindfulness on communication, relationships, empathy skills and ability to maintain centered under stressful circumstances. Many positive statements were made regarding the format and feel of the course, although students occasionally expressed some personal preferences for a different order of exercises.

Discussion/Implications: Some participants reported more successfully fitting the daily practice in around their responsibilities than others, but finding time was a common struggle. For many, the group meetings appeared to be enjoyable for the connections made with others as well as the skills learned. A few changes could be made to the course to improve it.

Putting the Charter to Work: Enhancing Healthcare Relationships Through Core Values

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Introduction/Context: Core values and skilled communication are vital for practicing safe, compassionate, relationship-centered care. The International Charter for Human Values in Healthcare [1, 2] delineates core values fundamental to all healthcare interactions—e.g., clinician-patient, interprofessional/team, and others across healthcare systems and their stakeholders.

Objective: To describe the Charter’s further development, and progress translating core values into action.

Description of Innovation: In a 3-year effort to identify and develop a framework of core values essential for healthcare interactions, an international, interprofessional collaborative of clinicians, educators, researchers, communication specialists and linguists collected and analyzed data from multiple interprofessional groups. We used combined qualitative research methods including iterative content analysis, Delphi methodology, focus groups, and expert consensus to identify five categories of core values—Compassion, Respect, Commitment to Integrity and Ethical Practice, Commitment to Excellence, and Justice in Healthcare—and classified sub-values within each category.

Evaluation/Impact: The International Charter for Human Values in Healthcare is a major initiative of the International Research Centre for Communication in Healthcare (IRCH) [3]. The Charter’s values have been incorporated into a number of courses, including interprofessional, specialty, faculty development, and clinician training. Organizations from Hong Kong, Australia, Brazil, the Netherlands, New Zealand, United Kingdom, Uganda, United States and elsewhere have joined this international effort as Charter Partners. The National Academies of Practice (US) comprised of 14 healthcare Academies, also endorsed and became a Charter Partner. The Charter works closely with, and is a partner of, Charter for Compassion International. IRCH recently became the Asia-Pacific Healthcare Hub for Charter for Compassion International.

Discussion/Implications: The International Charter for Human Values in Healthcare developed from an interprofessional, global collaboration to restore the primacy of human values necessary for practicing compassionate, ethical, and safe healthcare. Values
What Encourages or Imposes Barriers to Humanism in Young Faculty Members

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Introduction/Objectives: Faculty members enrolled in a year-long faculty development program at 8 schools receiving a grant from the Arnold P. Gold Foundation described motivating factors and barriers to being humanistic physicians.

Methods: Sixty one faculty members wrote long paragraphs describing their personal motivators and barriers to being humanistic teachers. We are performing a quantitative analysis of this data using the constant comparative method.

Results/Major Themes: Motivating: personal goals and values, how I would like to be treated, being an example to learners, making strong connections with patients.

Barriers: Time, difficult interactions.

Illustrative sentences and phrases: Motivating: “...the core of who I am.” “I saw myself as the kind of doctor who brought comfort and was contributing to the good of world.” “...showing students the importance of families and social background.” “...humanism can bridge patients’ vulnerabilities, and fears.” “...lying on a gurney traversing these halls I had walked for decades...” “...all human beings are inherently valuable.” “I cannot imagine treating anyone different than I would want.”

Barriers: “I try to overcome this barrier by providing each patient my absolutely best care regardless of what time pressures.”, “...past a threshold of about 15 inpatients, our ability to sit down and talk with patients is limited.”, “Teaching humanism doesn’t generate income.”, “...pressures leave us stressed and make me not feel the human being I want to be.”, “A difficult patient at the end of a busy clinic can be seen as a burden.”.

Discussion: Personal values are most often cited, but numerous factors are motivators. Feeling pressured accompanies lack of time. This brings out impatience, uncertainty and intolerance, especially when encountering difficult patients. These convey the personal struggles of physicians striving to be humanistic.

Implementation Science and Knowledge Translation in Health Communication

The International Research Centre for Communication in Healthcare (IRCCH): A multicultural approach to communicate for compassionate healthcare, and mobilize values to practices

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Introduction/context: The role of communication in healthcare receives increasing attention, yet little research exists that brings together perspectives from interprofessional healthcare researchers and practitioners with linguists and communication specialists. Recognising the increasing linguistic and cultural diversity of both patients and clinicians, the International Research Centre for Communication in Healthcare (IRCCH) promotes cross-linguistic, cross-cultural and cross-national research collaborations to study the role of communication in the delivery of safe, effective and compassionate healthcare. The Centre provides a forum for internationally recognised and multidisciplinary healthcare professionals and communication experts to work together, translating research into education and practice, and improving patient safety and the quality of healthcare practices around the world.

Description of policy or practice innovation: We have initiated research collaborations and presented colloquia, workshops and papers at international conferences through the International Collaborative for Communication in Healthcare (a precursor to the Centre) since 2010. The Collaborative was officially founded at Hong Kong in March 2011.

Evaluation/ impact: It has now been 2 years since the Centre was launched in Hong Kong. The Centre, co-convened by Hong Kong Polytechnic University (PolyU) and University of Technology, Sydney...
Interprofessional Global Collaboration for Compassionate Healthcare: Mobilizing Values to Action

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Introduction/Context: Compassion, attention to core values, and skillful communication are indispensable to the practice of high quality healthcare. Attending to these significantly improves quality, outcomes and experience of care.

Description of Innovation: With over 90 members from 16 countries, the International Research Centre for Communication in Healthcare (IRCCH) serves as an expert collaborative health communication research and training hub where multidisciplinary healthcare professionals and communication experts work together, translating cutting edge communication research into best practice and training for safe, compassionate healthcare. IRCCH’s initiative, the International Charter for Human Values in Healthcare, works to promote attention to core values, including compassion, in every healthcare interaction.

Charter for Compassion International (CCI) has 1250 partners in nine sectors. CCI’s healthcare sector represents a worldwide alliance striving to instill compassion in all healthcare relationships and systems. It aims to create a significant and measurable shift in understanding between professionals, patients, insurers, and institutions, to promote compassionate, cost-effective healthcare.

Together IRCCH and CCI are working together to instill compassion and other values, informed by cutting-edge communication research, in healthcare systems worldwide.

Evaluation/Impact: IRCCH and CCI have developed a formal collaboration resulting in IRCCH as the new Asia-Pacific Healthcare Hub of Charter for Compassion International. This collaboration will be launched at the 3rd International Symposium on Healthcare Communication in June 2015. Practitioners, patients, educators, leaders, and academics will come together to share and discuss innovative practices, training and research that effectively promote compassionate care, attention to values, and skilled communication in different healthcare settings globally.

Discussion/Implications: IRCCH serves as the new Asia-Pacific Healthcare Hub of Charter for Compassion International. The collaboration brings together CCI’s worldwide alliance of healthcare partners working to instill compassion in all healthcare relationships/systems, and IRCCH’s expertise translating communication research into best practice for safe, compassionate healthcare. IRCCH and CCI are developing new clinical care projects, teaching programs and research efforts.

Translating new lung cancer screening guidelines into practice: The experience of one community hospital

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Introduction: In 2013, the United States Preventive Services Task Force issued a recommendation for lung cancer screening with annual low-dose computed tomography (LDCT), based largely on the results of the National Lung Screening Trail (NLST). The present study first assessed how new guidelines were implemented in a community hospital and the resulting radiologic findings, and second, addressed the knowledge gap of how providers deliver screening results.

Method: In this retrospective observational study, the medical records of all patients scheduled for a LDCT screening, in the radiology department of a community hospital, were reviewed. Investigators reviewed the patient record for LDCT findings, orders for additional imaging studies, resulting diagnoses, and documentation of patient notification.

Results: Throughout 2014, 149 patients received LDCT scans. Seventy-three cases met inclusion criteria; 4(5.5%) scans detected nodules >8 mm, 3(4.1%) detected nodules >6-8 mm, 9(12.3%) detected nodules >4-6 mm, and 31(42.5%) detected nodules <4 mm. Results of larger nodules prompted additional imaging, X(4,73)=21.30, p<.001. Of the studies that showed no nodules, six cases were categorized as clinically significant (other than emphysema), and seven were categorized as emphysema.

No association was detected between results and documentation of patient notification. Patients with normal results were as likely to receive notification as patients with nodule findings. Similarly, the mode of documented notification was not related to results. Across categories, patients were notified via telephone and clinic appointments.

Discussion/implications: Results showed that 64.4% of scans detected nodules. In the remaining 35.6%, half had another clinically-significant finding. This is a considerably larger proportion of actionable findings than NLST, in which 27% of participants had some abnormality identified on first screening. It is concerning that only 68.8% of patients with nodules > 4 mm have documented notification of results. Providers need training about how to discuss/document emerging guidelines and potentially uncertain results with patients.
Feasibility of implementing and studying an intervention to improve communication and decision making in the PICU

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Introduction/Objectives: Complicated decision making occurs for Pediatric Intensive Care Unit (PICU) patients. Our intervention, “PICU Supports,” uses a trained Navigator to support PICU communication and decision making by: meeting with healthcare team members and parents at enrollment (within 4 days of PICU admission) and on weekdays; organizing weekly family meetings if needed; supporting transitions out of the PICU or during death; following-up with parents post-PICU discharge; and providing families written information about the PICU. This work assesses the feasibility of studying and implementing PICU Supports and provides preliminary data about PICU Supports efficacy.

Methods: We enrolled English-speaking parents of patients with an expected PICU admission of ≥ 24 hours or a Pediatric Index of Mortality Score ≤4. Parents received PICU Supports and completed study-related surveys at: enrollment, PICU discharge (if their child survived), and 3-5 weeks post-PICU discharge. We assessed intervention fidelity using a pre-defined checklist of Navigator activities and efficacy using a survey item.

Results: We enrolled 37 parents of 30 patients, from 50 families approached (60 % participation). One parent withdrew and two patients died. Parents completed surveys at: baseline (31/37, 84%), PICU discharge (25/34, 74%), and 3-5 weeks post-PICU discharge (15/36, 42%). The Navigator met with all healthcare team members and parents of 29/30 (97%) patients upon enrollment. One family was discharged before meeting the Navigator. For 25/29 (86%) patients, the Navigator completed post-PICU discharge follow-ups. The Navigator attempted and successfully met with parents on 204/236 (86.44%) and 158/236 (66.95 %) possible weekdays, respectively. No parents wanted a family meeting. At discharge, 25/25 (100%) parents found PICU Supports “somewhat” or “extremely” helpful.

Discussion: We demonstrate the feasibility of implementing and studying PICU Supports. Parents found PICU Supports helpful. Collecting surveys after discharge was difficult. Future work will examine the impact of PICU Supports on predefined parent outcomes.

Healthcare provider (HCP) independent information services: How users of the Cancer Information Service (CIS) of the German Cancer Research Center appraise and process the information provided

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Background and purpose: Patient-centered information and communication can favorably impact quality of life and self-efficacy of cancer patients. Considering respective shortcomings, it is one goal of the German National Cancer Plan that quality information and counseling services be available for all patients as an additional cornerstone of comprehensive care. The CIS aims at filling a gap here, offering information and communication in accordance with “good health information practice” and fostering patient participation. A survey of users of the CIS telephone service looked at satisfaction with and impact of the service provided.

Methods: A total of 3658 callers, among them 1997 cancer patients, were surveyed with a mailed questionnaire that covered satisfaction with information and communication provided, self-rated impact in cognitive and emotional domains, and health information and participation preferences. The descriptive analysis presented focuses on cognitive endpoints (understanding of situation and options, orientation) and on the impact on certain affective domains (anxiety, assurance regarding medical care and health services).

Results: Information and participation preference was high among surveyed patients with 87 and 84% full agreement in the items “want all information” and “want to participate in decisions”. For comprehensibility and individual tailoring of information provided respondents rated (very) good in 85 and 67%, respectively. Over 60% stated better orientation regarding health services, understanding of options and assessment of previous information. 59% and 43%, respectively, felt more assured regarding their medical care and less anxious. Perceived high gain in orientation and knowledge translated favorably to these QoL-related domains. Also, the information provided supported doctor-patient-communication and triggered action on part of patients.

Discussion: CIS information and communication was mostly perceived helpful. Results and observed impact support that independent information services such as the CIS can effectively complement information and communication through HCP’s and other sources - provided they ensure high quality performance.
Recognition and Management of Geriatric Depression: Online, interactive modules

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Introduction/Objectives: The numbers of geriatric patients seeking care will increase dramatically over the next two decades, and providers across all specialties will need skills in diagnosis and management of common geriatric disorders. Geriatric depression is common and associated with significant morbidity. However, most psychiatry clerkships do not provide clinical experience or teaching on geriatric depression. To provide foundational knowledge on geriatric depression, we designed two online modules that could be widely used by health professional schools.

Instructional/Assessment Methods: Learning objectives and content for the modules were chosen based upon consensus from a national panel of internal medicine and psychiatry clinician-educators. The modules were developed by a clinician-educator team, including one psychiatrist, one internist, and one behavioral scientist. The modules cover recognition, use of screening tools for diagnosis, suicide assessment, patient education, and initial management. ADMSEP, the national organization of psychiatry educators, provided the platform for the curriculum. Each module is 20 minutes in length and features a multi-part video of an interaction between a clinician, standardized patient and her husband, preceded by teaching points and followed by questions, feedback and discussion.

Participants’ knowledge acquisition is assessed using a 10 question pre-test and related post-test. Following pilot-testing at our institution in July, 2015, the modules will be submitted to AAMC’s MedEdPortal, a peer reviewed medical education resource center, and promoted by ADMSEP on their website, at their national meeting and through a listserv. Use of the module will be tracked as part of the evaluation.

Evaluation Results: Results from the pilot test will be available at the time of the October meeting.

Discussion/Implications: Education regarding the care of geriatric patients is currently inadequate. Systematically developed on-line curricula, such as this one, can provide learners with pre-requisite knowledge and permit educational institutions to focus on clinical training and skills development.

Patient Education and Health Behavior Change

Don’t Tell People Smoking is Bad, Show Them: Persuasive Message Features in the Tips From Former Smokers Campaign

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Introduction/Objectives: Years of research on message design and effects provides insight regarding the most persuasive appeals. The purpose of this study was to evaluate content presented in the CDC’s Tips from Former Smokers (TIPS) campaign. TIPS was launched in 2012 and focused on increasing knowledge about the health outcomes caused by smoking. A content analysis of persuasive features was conducted to critically examine campaign content. Persuasive message design theories provide guidance regarding the most effective ways to change attitudes and behaviors. Features include: Emotional appeals, evidence type, efficacy, norms, attitude functions, message frame, and source characteristics.

Methods: Four independent coders were trained to assess design features for 122 campaign messages. The average pairwise Cohen’s kappa was 0.90 and average pairwise percent agreement was 94.78.

Results: In TIPS, 79.5% of messages included emotional appeals. Negative emotions were most common (guilt N = 47, disgust N = 30, fear N = 60). Quantitative evidence was present in 5.7% (N = 7) and qualitative evidence in 77% (N = 94). In the sample, 107 messages (87.7%) stated facts and 69 (56.6) provided visual evidence. Most messages served a knowledge function (62.3%). An ego-defensive function was present in 50.8%, a utilitarian function in 54.1%, a social identity function in 38.5%, and a value expressive function in 15.60%. Most messages were loss framed (N = 69, 56.6%) with only 13.9% (N = 17) gain frame.

Discussion/implications: Results indicate that the campaign contained more fear and guilt appeals, than other emotions. Evidence was typically presented in the form of a narrative from sources with firsthand experience. Little research has systematically evaluated the breadth of message characteristics present in behavior change initiatives. This analysis provides a complete understanding of the types of appeals being utilized. There is an opportunity for message designers to utilize persuasion and message design theory to increase message effectiveness.
Empowering Latino cancer patients on the reality of cancer pain and debunking cultural myths via an interactive pain education program

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Background: To date, limited Spanish educational materials/programs on pain management are available. In the US, pain is the most common reason individuals consult with a physician, yet for many - especially the Hispanic community - pain is a sensitive topic amongst cancer patients. The purpose of this study was to educate Spanish speaking patients/families on pain management and debunking myths about cancer pain.

Methods: Eighty-four Spanish speaking cancer patients participated in an educational intervention. Pre/post tests were collected, including one month follow-up calls and focus groups. Education was provided on: types of cancer pain, medication safety, including CAM & non-therapeutic options for pain management. Including dispelling myths/perceptions of cancer pain and taking an active role in their care by communicating their pain.

Results: Educational intervention further identified a distorted perception of pain when undergoing cancer treatment: (1) pain was not manageable, (2) part of the treatment process, (3) a way that the body gets rid of cancer. Others refused medication for fear of addiction. When asked how they dealt with pain, majority preferred to receive support from their families or other cancer patients in similar situations. Patients shared that they did not communicate their pain issues to their healthcare team, for fear of treatment delay.

Conclusion: After attending class patients are able to take more of an active role in their care. Attendees are able to communicate their pain to their health care team by using descriptive words and/or using the pain scale to rate their pain or describe it. Patients have incorporated non-drug intervention strategies to help them cope with pain (music, meditation, or attending educational classes). Power of education and knowledge was evident within a span of 2-hour class, these perceptions were quickly dispelled. Patients learned that they could go through their cancer journey pain free.

Clinical Implications: Findings from this study can guide future interventions and education to improve cancer pain perceptions amongst Latinos and patient engagement in the healthcare process. Data will be used to guide the development of future educational programs for patients and families and to explore innovative ways to deliver pain educational programs and interventions. Understanding gained from this study provides an opportunity to enhance health communication and health education strategies more effectively to benefit patients and families.

Lexical and Content Analysis of Outpatient After Visit Summaries

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Objective: To examine the content, formatting, and readability of clinical outpatient after visit summaries (AVS) and gauge physicians’ perception of their value.

Methods: We evaluated primary care AVS for readability (Flesch-Kincaid and Simple Measure of Gobbledygook [SMOG]), suitability (Suitability Assessment of Materials [SAM]), understandability and actionability (Patient Education Materials Assessment Tool [PEMAT]). We also interviewed physicians to assess their perceptions of the usefulness of the AVS in their practices.

Results: We collected data from 13 practices with 7 unique electronic health record (EHR) platforms. Physicians had mixed perceptions of the AVS; 6 of 13 found them very helpful for clarifying medication regimens while 5 of 13 found them very helpful for follow up information. The AVS tended to have small font sizes (median, 10 point) and median reading grade levels of 9 to 11. Suitability was low, with median SAM scores of 61%; understandability and actionability were fair to moderate, 65% and 78%, respectively. The inclusion and order of specific AVS content varied across the clinical practices.

Conclusion: AVS in multiple practices may often be sub-optimally designed for communicating important clinical information with patients.

Practice Implications: A patient-centered approach to designing AVS is warranted.

Measuring medications’ adherence in anxiety disorders: Patients’ vs. psychiatrists’ perspective

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Introduction/Objectives: At present, studies conducted to identify risk factors for psycho-pharmacological adherence in psychiatric populations present a lack of clear adherence’s definition and validated measuring instruments. This study focuses on adherence to the psycho-pharmacological medications in patients suffering from anxiety disorders (ADs), investigating non-adherence behaviors across ADs diagnostic categories and across SSRIs and benzodiazepines, which are the first-line medications for ADs. The study aims to provide detailed data on medications’ adherence rates in a rep-
Patient-Provider Breastfeeding Discussions in Pregnancy: Is it happening?

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Introduction: The American College of Obstetricians and Gynecologists recommends that physicians commence prenatal breastfeeding counseling with the initial prenatal visit and continue throughout pregnancy. Counseling should address benefits of exclusive breastfeeding, potential barriers, and anticipatory guidance about breast changes in preparation for breastfeeding. Whether clinicians are incorporating these recommendations, and the extent to which they are doing so, is unknown.

Methods: We surveyed 37 first-time mothers who intended to breastfeed at 2-3 days postpartum about occurrence, timing, and content of prenatal breastfeeding discussions with their obstetrical providers. The survey is part of an ongoing study tracking breastfeeding behavior through a mobile app.

Results: 84% of women reported that their prenatal care providers talked to them about breastfeeding during pregnancy. 16% reported conversations occurring more than once, with the second trimester being the most common time (46% of women). The majority of discussions consisted only of an assessment of breastfeeding intention (n=14). Nine women recalled a discussion about breastfeeding health benefits. Less frequently identified topics included specific breastfeeding plans (e.g., duration), provision of a breast pump prescription, access/referral to breastfeeding support resources, advantages of breastfeeding over formula-feeding, anticipatory guidance about milk production, and perseverance through challenges. Three women did not remember content of discussions. Most women reported obtaining breastfeeding information from sources other than clinicians (87%), including classes, online education modules, search engines/websites, mobile apps, and advice from family or friends.

Discussion: Although most clinicians are addressing breastfeeding, they are doing so in a perfunctory manner that does not meet professional standards. It is unclear if alternate sources of breastfeeding education carry the same import as a provider’s breastfeeding recommendation. Because clinician visit time is limited, future work should address supplemental or alternative strategies for provision of prenatal breastfeeding support that is accurate and resonates with women.

Self-management of complex chronic diseases: A systematic and critical review in the field of spinal cord injury

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Introduction/objectives: Self-managements of complex chronic diseases (CCDS) is linked to decision-making in several areas at the level of body functions (e.g. pain management) and activities (e.g. mobility management). In order to make these decisions, a lot of information is needed and must be processed and applied in a relatively short time. Here, there is a lack of research on how to enhance multi-domain behavior change through specific tasks that individuals with CCDS can realistically perform.

Methods: Systematic and critical review of how the literature addresses the issue of self-management in spinal cord injury unanimously recognised as one of the most difficult health condition to manage.

Results: 23 articles were included in the review which highlighted 174 different aspects to manage when people experience spinal cord injury. The critical analysis of these findings addresses the individual challenges to successfully engage in self-management habits, alongside identifying directions for the therapeutic interplay among individuals, family members and health professionals. Main focus will be on defining the domains and related tasks in the transition from a phase where the support of health professionals is needed to a phase where individuals can manage on their own. Healthcare professionals might support and help in initial behaviour changes. Yet, new behaviours are often difficult to develop and, even more, to maintain by integrating them into daily life, as they might be difficult and perceived as unpleasant.
Discussion/implications: Modern health systems emphasize the important goal of patients’ autonomy in health management from an ethical, psychological and economic perspective. This paper provides evidence on the barriers and facilitators that can influence the achievement of this management, in a context where multiple individual requirements and complex social support are needed.

Standardized Communication in the role of Post-Discharge Outreach

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Abstract: Communication, in our experience as well as in validated trials, has shown to be paramount in transitions of care. We have found that using a nurse navigator to communicate with patients post-discharge helps reduce errors in transitions of care and ease the transition from the hospital.

We have developed a unique, standardized and streamlined means of communication with a standardized template for documentation that reviews aspects of a patients care after discharge. This template and its corresponding script emphasize historical notes such as admit dates, discharge dates, attending physician name, consulting physicians, diagnoses and medical history. From a transition of care standpoint, it emphasizes home health, medication and follow-up needs. Finally, from a patient confidence perspective, the template prompts questioning into a patient’s confidence in self-managing care at home. The template also questions and ensures that patients have the contact information of their clinic providers and thoroughly understand their treatment plan. All of these questions serve as initial investigations into possible unsafe home situations or errors in transitions of care communication.

We have found that the standardization of this process helps reduce errors in communication and aids the process of discharge communication. By employing this template at specified intervals post-discharge, we are reducing our readmission rate that is secondary to errors in transitions of care. The effects are currently being measured.

Research Methodology

A novel coding system to characterize patient-clinician negotiation about opioids and chronic pain

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Introduction: Patients and clinicians both associate discussions about opioids with disagreement and difficult visits. There is little empirical data characterizing actual discussions on this topic.

Methods: We developed a coding system to characterize statements about chronic pain and opioids. Drawing on clinical experience, we developed a list of statement types hypothesized to affect patient agreement with treatment plans, clinician perception of visit difficulty, and opioid dose changes. We grouped statements into utterance-level categories and iteratively refined these categories until they could be reliably coded. For patients, major coding categories included the following: 1) requests, 2) descriptions of pain, and 3) assessments of pain treatments. For clinicians, major categories included the following: 1) patient-centered communication, 2) treatment recommendations, and 3) assessments of pain treatments. Opioid and non-opioid pain treatments were coded separately. Two coders independently coded transcripts of 45 primary care visits involving patients on opioids for chronic pain. Disagreements were resolved by discussion.

Results: Inter-coder agreement for coding subcategories varied but was moderate for most (kappa 0.4 - 0.6). Patients and clinicians made a mean 2.9 (SD 2.9) pain-related requests and 5.6 (SD 5.9) pain-related recommendations per visit, respectively. One-quarter of requests and 34% of recommendations were opioid-related. Patients expressed agreement with 63% of clinician recommendations; clinicians expressed agreement with 34% of patient requests. These proportions were similar for opioid-related versus non-opioid-related responses. Patients requested opioid dose increases in 5 visits; doctors recommended opioid dose increases in 7 visits.

Discussion: This novel coding system can be used to systematically characterize discussions about chronic pain and opioids, facilitating better understanding of communication about this important topic. In this sample, direct requests and recommendations for opioids were relatively rare, perhaps indicating that patients and clinicians tend to broach this subject indirectly due to the recognized potential for disagreement.
Patient Engagement in the Development of Measures to Assess Patient-Centered Communication in Cancer Care

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Introduction/Objectives: To develop valid and reliable survey-based measures of patient-centered communication (PCC) in cancer care that can be used for research, surveillance, and quality assessment and improvement. The measures align with six PCC functions defined in a conceptual model developed by the National Cancer Institute.

Methods: We used strategies consistent with the PCORI Patient Engagement Framework. We engaged patients and a patient stakeholder organization in the research including sharing cancer patient narratives to inform item development, input from an online patient community, and cognitive testing of survey items. A stakeholder Advisory Committee that includes patient advocates, clinicians, and experts in PCC provided input throughout the iterative measurement development process.

Results: Narratives from cancer patients’ real-world experiences helped to prioritize content areas for the measures and provided insight regarding how patients make decisions and manage clinical uncertainty. Patients’ experiences with “hard conversations” about personal and sensitive matters informed how we phrased questions. Overall, the cognitive testing participants found the measures clear, personally relevant, and easy to answer. Patients had preferences about how to refer to their cancer care team. Some had fairly strong feelings about the role clinicians should play in the emotional aspects of communication including whether or not emotions should be discussed. Based on feedback from all sources, a final version of the patient-centered communication instrument was developed for large-scale field testing.

Discussion/Implications: Involving patients and other stakeholders in the measurement development process improved the quality of the measures ensuring that they reflect the most important aspects of communication experiences. The patient stakeholder organization derived value from the process and changed how they communicate with their constituency as a result of their involvement. We will share the survey items, several lessons learned based on the engagement strategies used, and implications for the PCORI engagement framework.

Patient Satisfaction with a Patient-Centered Interaction - An Efficient Questionnaire

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Background: An evidence-based patient-centered interviewing method produced large changes in patient satisfaction and was associated with improved health outcomes. The interview satisfaction questionnaire (ISQ) we used had 25 items and four factors. We sought to reduce the number of items to make the ISQ practical for routine use.

Method: The sample comprised 12 standardized patients (SPs) who were interviewed by 105 medical residents in three 15 minute medical case scenarios (basic interview, tobacco cessation, chronic pain). Residents varied in interviewing training from considerable to none. SPs completed the ISQ after each scenario. This within-group, repeated-measures design thus included 105 residents with 315 ISQ ratings. In parallel, SPs completed the well-validated 15-item Communications Assessment Tool (CAT) to evaluate concurrent validity of the ISQ. We conducted confirmatory factor analysis (CFA) to determine which items had ample factor loadings and small residuals or error (>0.5 factor loading and <.01 error, respectively) and could be retained in the scale.

Results: On CFA, 13 items were deleted due to small factor loadings or large error, resulting in a 12-item scale (goodness of fit RMSE = .051) that confirmed (from before) this 4 factor structure: SP satisfaction with the resident’s open-endedness, empathy, and generally and SP confidence in the resident. Scale reliability of each factor was high (Cronbach’s alpha ranged from .74 to .93). All four factors of the ISQ correlated highly with the one-factor CAT (r > .7, p<.001), and the second order unidimensional ISQ scale also correlated highly with the CAT (r = .91, p < .001), demonstrating the concurrent validity of the ISQ.

Conclusion: We recommend the now efficient (12-item) ISQ as a reliable, valid instrument for evaluating an interaction. It can be used to critique patient-centered interviewing practices on 4 dimensions when it is not possible to directly rate the interviewer’s skills.
Risk Communication and Medical Decision-making

Communicating Risk about Hereditary Breast and Ovarian Cancer: A Conceptual Model for Understanding BRCA-positive Patients’ Health Experiences

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Introduction/Objectives: Individuals with a harmful mutation in the BRCA gene are at significantly increased risk of developing cancer during their lifetime (i.e., 40-87% breast and 22-65% ovarian for BRCA1 carriers; 18-87% breast and 10-35% ovarian for BRCA2 carriers, Mavaddat et al., 2013), compared to those without a harmful BRCA mutation (i.e., 12% breast and 1% ovarian, NCI, 2011). Because of their high risk, such individuals experience uncertainty in anticipation of the likelihood they will develop cancer and must make health decisions in order to protect their bodies and secure their futures. The purpose of this paper was to lay out pathways through which researchers can more effectively examine hereditary breast and ovarian cancer (HBOC) patients’ health experiences in ways that contribute to the betterment of their health, well-being, and quality of life.

Methods/Results: A representative review of the literature on HBOC reveals current research explores certain aspects of BRCA-positive patients’ lived experiences regarding the ways risk is communicated and understood, social support needs, and coping with or managing the uncertainty of having a genetic predisposition for a disease. Yet more research needs to focus on guiding such patients from genetic counseling and testing to engaging in preventative health decisions and managing treatment side effects. Therefore, we analyze HBOC risk and its harmful effects as well as present a model to assist researchers in conceptualizing communication studies and interventions for examining and improving BRCA-positive patients’ health experiences. To frame our model, we draw on Epstein and Street’s (2007) patient-centered communication functions and propose direct and indirect pathways for improving patient-provider communication about HBOC.

Discussion/Implications: This model has implications for patient-provider communication research, clinical practice, and cancer education. For example, our model provides a way for researchers to target and examine particular communication elements when considering HBOC risk for BRCA-positive patients.

eCWs Care Coordination Medical Record and Addressing Care Opportunities

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Abstract: The Care Coordination Medical Record (CCMR) is a novel analytics and care-planning platform used by the Tulane University Medical Group (TUMG) to aid in the transition to population management and value-based care. TUMG primary care physicians utilize the CCMR as a seamless product and dashboard to easily and clearly access the overall health of their patient population. The dashboard allows providers to assess their own efficacy in diabetic, hypertension and cardiovascular care amongst other disease processes. It also allows physicians to quickly and easily assess their deficits in care and which patients require further intervention and more intensive care. It also allows providers the ability to build customized care plans based on specific chronic disease guidelines to help the usability of the tool from the provider.

Furthermore, CCMR has novel systems in place for the acquisition of healthcare provided in a variety of practice settings. The CCMR tool interacts with claims data from primary insurance companies to allow Tulane to track “leakage” of patients that receive care at other facilities.

Lastly, CCMR allows TUMG as a system as well as the individual provider the ability to gain insight into their utilization with options such as the generic prescribing rate (percentage of prescriptions written as generics) or patient risk stratification (patient’s mortality risk as well as their risk for admission and re-admission). These added options help providers assess their own systemic utilization as well as the individual risk of the patient they are caring for in the clinic.

The CCMR tool serves as a central hub to ease the transition of primary care into value-based care. It has proven to be an effective agent for the delivery of primary care.
Shared Decision-making and Patient/Family Engagement

Adapting a French language decision aid in PSA screening: A transcultural study in France and Switzerland

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Background: Decisions about prostate cancer screening using blood prostate specific antigen (PSA) measurements are preference sensitive and require shared decision making.

The Collège des Médecins du Québec (CMQ) has produced a decision aid (DA) to help men share this decision with their health provider, GP or urologist.

Objective: Using a user-centered design approach, we tested the acceptability and feasibility of the DA in France and Switzerland. The data gathered will then be used to adapt the DA.

Methods: We recruited a convenience sample of family physicians, urologists, cancer patients, health volunteers and decision makers. Individual semi-structured interviews were based on a grid informed by items relating to IPDAS criteria, acceptability and feasibility, and was evaluated using 4 main topics: 1. First impressions; 2. Views regarding the tool; 3. Confidence in and transculturality of the tool; 4. Potential implementation of the tool. We conducted thematic analysis of the transcripts using N Vívo and computed the frequency of the elicited themes.

Results: 36 participants (5 French, 8 Swiss family physicians, 2 French, 3 Swiss urologists, 8 French healthy volunteers, 5 French cancer patients, 5 French decision-makers). The tool was found to be acceptable, i.e. participants’ overall responses were positive mainly due to CMQ’s scientific credibility. The DA was perceived as an indispensable mediation tool for stimulating patient-physician communication. Patients and health volunteers felt the tool should be administered mainly during consultation. Completion of the tool was found to be feasible but took too long to read. Data presentation on benefits and risks of PSA screening should be improved.

Discussion: First study to produce a transcultural French language decision aid. This DA was found to be acceptable and feasible for use in France and Switzerland, provided adaptations are made. The data gathered will be used to develop a new version adapted to the Swiss and French contexts.
Proposal to participate in a drug trial and involvement in decision-making

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Introduction/objectives: Participation in a drug trial might benefit cancer patients because of a promising experimental treatment (or state-of-the-art treatment) and because of structural effects of the consent and data collection processes. Particularly, it could facilitate patient centered care through an active engagement of the patient in treatment decision-making (TDM).

Our objective was to study the association between trial participation, doctor-patient communication and involvement in TDM.

Methods: VICAN study interviewed a French national representative sample of cancer survivors, 2 years after diagnosis. Proposal and participation in a drug trial and perceived involvement in TDM were collected. Four questions also evaluated doctor-patient communication (time to discuss, difficulties to ask questions, complexity and quantity of information).

Results: Among the 4349 participants, 7.3% reported they have been proposed to participate in a drug trial. The acceptance rate was 75.2% (5.5% of the total sample). Patients aged 65+ were less likely to receive a proposal to participate (OR=0.70, 95%CI[0.52–0.93], p=0.014) after adjustment for medical characteristics, area of residence, and psychosocial characteristics (education level, household incomes and cancer information seeking behavior).

Proposal to participate in a drug trial was positively associated with perceived involvement in TDM (72.6% vs 56.5%, p<0.001); but 27.4% of patients still felt not involved. Older patients benefited more of the trial proposal. Their perceived involvement in TDM increased from 54.3% to 79.7% (<65: from 57.9% to 70.3%, p[for interaction]=0.043, Figure).

Trial proposal (and acceptance) was not associated with different ratings of doctor-patient communication.

Discussion/implications: Two year after diagnosis, cancer survivors who were asked to participate in a drug trial, did not report better communication with their doctors but felt more involved in TDM. Promoting trial participation could be a way to increase patient centered care, particularly among older patients.

Figure: Proposal to participate in a drug trial and perceived involvement in treatment decision-making

(p-value for interaction term [age group*proposal]= 0.043)

Supporting shared decision making using an Option Grid for osteoarthritis of the knee: A stepped wedge trial

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Background: The aim of the trial was to investigate the effect of introducing encounter tools called Option Grids into a clinical practice setting to investigate the feasibility of using these tools in real world workflows.

Method: Six physiotherapists were introduced to the Option Grid that described treatments for osteoarthritis of the knee and were instructed in how to use it. Each physiotherapist was to see 6 patients in the pre-intervention phase, and 6 in the post-intervention phase, aiming for a total sample of 72 patients. The extent of SDM was measured by the Observer OPTION measure, and Decision Quality evaluated using an adapted version of a published measure.

Results: The mean Observer OPTION score was 29.40 (range 0-100, SD=12.9) in the pre-intervention phase and increased to 37.83 (SD 8.4) in the post-intervention phase, and thus the 95% confidence interval for the increase was 4.42 to 12.27, indicating statistical significance. The ICC was 0.101 which implies clustering of physiotherapists on their Observer OPTION scores. On average, the gain in knowledge of the Decision Quality measure was 0.9 points (score range 0-5, 95% CI, 0.3 to 1.5). Baseline patient education level had
no effect on theses scores. Baseline health literacy and patients’ Adjusted Index of Multiple Deprivation Quintile had no effect on the levels of SDM achieved. Increasing patient age was correlated with small increases in Observer OPTION scores ($R^2 = 0.16$), but only in in the post-intervention phase.

Conclusions: After training in how to use the knee osteoarthritis Option Grid, the extent of SDM as measured by an observer-based measure increased in the post-intervention phase of this stepped wedge trial. This significant increase in SDM was accompanied by a similar increase in the patient knowledge component of the Decision Quality measure.

The Challenge of Shared Decision Making in Pediatric Visits: Speaking Practices

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Introduction/Objectives: In adult primary care and pediatric cancer care, models of patient and family-centered communication and shared decision making emerge from years of development and evidence. Over the last decade, the majority of studies involving shared decision making in pediatrics concern in-hospital family consultation, chronic conditions, complex treatments, neonatal complications, oncology and palliative care. As an arena for shared decision making (SDM), provider-family communication in pediatric primary care receives far less attention. Fiks and Jimenez (2010) define SDM as a process in which the pediatrician explains the evidence for different options and family members discuss these options in the context of their personal values for negotiation with their provider and come to a decision. Since this definition of SDM does not focus on communication, this study examines a snapshot of the prevalence of pediatric SDM and the communication practices that characterize both best practices and areas for improvement require identification.

Methods: As part of a larger parent study that recorded 120 general primary care visits, this mixed methods study first rates SDM in 60 routine adolescent primary care visits using the OPTION Observing Patient Involvement Tool (Elwyn and colleagues, 2005). Then, discourse analysis is used to identify specific communication practices in higher and lower scoring interactions.

Results: The resulting mean scores for SDM were lower than previous published study of adults and providers in primary care (6.5 +/- 6 vs. 24 +/- 8). Discourse analysis found a pattern of variations with lower and higher SDM cores in exclusion of adolescents through positioning practices, fewer elicited choices or options, reliance on one-sided directives, and politeness strategies.

Discussion: Integration of results provides a foundation for dialogue with providers who resist the concept of SDM in general pediatrics as well as a path for intervention mapping for enhancing family participation in primary care.

The role of health values in decisions about cancer screening

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Introduction: Recent research points to the importance of eliciting patients’ values as an integral aspect of patient centered care. Health values are the intuitive, affective responses that motivate decisions toward biopsychosocial well-being. This study aims to identify health values among patients undergoing cancer screening. We examine how patient’s intuitive health values shape and reflect their illness experience and health care decisions regarding endoscopic surveillance (EGD) for Barrett’s Esophagus, a pre-cancerous lesion.

Methods: We conducted structured in-depth, qualitative interviews with BE patients in a single regional medical center. We recruited patients with a range of severity of BE who recently completed an EGD. Data collection continued until we reached thematic saturation (n=20). We applied principles of framework analysis to identify patients’ health values regarding BE and EGD.

Results: Health values expressed by the participants often corresponded with those outlined in the taxonomy, as well as what could be considered dichotomous counterparts to those values. Thus, based on our findings, we offer an expanded health values framework. We found that patient’s narratives demonstrated salience of some health values over others (self-sufficiency over dependence), negotiation of competing values (length and quality of life), shifting between two different values (passivity and engagement in care), and struggle to balance other values (minimize suffering while maximizing comfort and enjoyment). Narratives also demonstrated the intersection of multiple health values in their illness experiences.

Discussion: Health values play an important role in influencing patient’s health care decisions, and are often weighed as heavily as recommendations of health care providers. Providers should strive to elicit patients’ health values prior to making diagnostic and treatment recommendations as a way to better align recommendations with patient values. Eliciting values may improve concordance with treatment recommendations, enhance quality of life, and reduce unnecessary and costly medical procedures.

Using Option Grids: Steps towards shared decision making for neonatal circumcision

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Background: It is recognized that parental views are important when considering neonatal circumcision. The American Academy of Pediatrics states that parental views should be respected. Evidence indicates this often does not occur, suggesting a need for methods to
engage parents in shared decision making. This study compared the communication process between parents and clinicians before and after the introduction of a tool designed to facilitate shared decision making in clinical encounters.

**Methods** Using a mixed-methods design, we analyzed video recordings of clinical encounters before and after an intervention where clinicians were trained how to use Option Grids. We used Observer OPTION to measure shared decision making. Transcripts of video recordings were subjected to thematic analysis. Semi-structured interviews were conducted with the clinicians after completion of the study.

**Results** We evaluated 32 video recordings of clinical encounters. Observer OPTION scores were higher at post-intervention with a mean of 33.9 (range 0-100, SD=23.5) compared to a mean of 16.1 (SD=7.1) for pre-intervention, a significant difference of 17.8 (95% CI: 2.4 to 33.2). Encounters without the Option Grid revealed that clinicians used a consent document to frame circumcision as the assumed practice. Clinicians also used a set of rehearsed phrases they called “spiels” that limited opportunities for parents to ask questions and discouraged dialogue. Encounters with the Option Grid conferred agency to both parents and clinicians, by enabling collaboration, preference clarification and information provision. Clinician interviews confirmed that they recognized the tool’s positive effect on their communication process, and noted that integrating the tool required modification to their behaviors.

**Discussion** Tools designed to engage patients in clinical encounters, such as Option Grids, have potential to make it easier for clinicians to achieve shared decision making about procedures such as neonatal circumcision. More research is needed to test their feasibility in routine practice.

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**Teaching and Evaluating Clinical Communication Skills**

A multisite randomized comparison of interactive virtual human simulation (MPathic-VR) and standard multimedia for teaching advanced communication skills among second-year medical students

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**Introduction/ objectives:** Although verbal and nonverbal communication skills are essential in medical practice, training and assessing these skills in medical learners remains a challenging problem. This NIH-funded MPathic-VR trial was designed to compare performance of M2s exposed to a novel, computer simulation utilizing interactive virtual humans (VHs) with M2s exposed to a multimedia, computer-based learning (CBL) control module, and to compare qualitatively each group’s perceptions about their experiences.

**Methods:** During the 2014-15 academic year, we conducted a mixed-methods, randomized, blinded, control trial with M2s at three U.S. medical schools. Students received inter-professional communication training. They were randomized into two groups: an intervention group trained with the MPathic-VR module and the control group trained with the CBL module. The modules were comparable in terms of learning objectives. The primary outcome measures were performance on an advanced communication skills OSCE conducted after a delay of up to two weeks after training, and reflections about the training experiences.

**Results:** Of 421 M2s, (participation rate 87.5%) 210 were randomized to the intervention and 211 to the control module. Students taking the MPathic-VR intervention achieved a higher composite score (Mean=806, SD=.201) on the OSCE compared to control students (Mean=752, SD=.198): F(1,414) =9.04, p=.003. M2 perceptions about the MPathic-VR computer simulation were positive about learning verbal and nonverbal communications skills, immediate feedback from MPathic-VR that included video recordings of the student-VH encounter, and the overall utility of the system as preparation for patient interactions.
Behaviorally Anchored Communication Skills Checklist for Medical Student OSCE Demonstrates Reliability Utilizing Generalizability Theory Analysis

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Joseph Grochowalski, Fordham University
Sharon Parish, Weill Cornell Medical College

Discussion/Implications: These data demonstrate the successful transfer of verbal and nonverbal communication skills acquired from MPathic-VR to more realistic communication scenarios. Qualitative responses to the training experience favored VH simulated interaction over CBL. These findings suggest that virtual human simulation may offer a significant improvement over traditional means for training advanced communication skills.

Behaviorally Anchored Communication Skills Checklist for Medical Student OSCE Demonstrates Reliability Utilizing Generalizability Theory Analysis

Authors: Feise Milan, Albert Einstein College of Medicine
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Background: Communication skills checklists are an integral component of medical student OSCEs that assess overall clinical competency. Cronbach’s alpha, a standard reliability assessment for such instruments, cannot account for complex sources of error in measurement and is not generalizable. Generalizability theory, a method of psychometric analysis, estimates reliability with greater precision, as it accounts for multiple sources of error variance in complex designs (1,2). Communication skills checklists in the literature differ more on format than content, and we have not encountered many that use behaviorally anchored scales and have been evaluated using the generalizability theory analysis (2).

Methods: We developed a 12-item, 3-point, behaviorally anchored communication skills checklist for use with our end of 3rd year medical student 8-station OSCE based on the Three Function Model (3). The checklist has items on opening, information gathering, facilitation, relationship building and patient education skills. SPs are trained for one hour using frame of reference training with video clips. Using data from our 2014 OSCE we used classical item and multi-facet generalizability analyses to evaluate the items and reliability of the scores and the resulting scoring decisions.

Results: There were 182 examinees. The items are fairly uniform in difficulty with most item-total correlations around .70. The relative reliability for scores at each station ranged from .586 to .870, the estimated composite reliability of the checklist score was .820 and the reliability of passing score decision to be .904.

Conclusions: With minimal SP training and moderate number of items, when used with a medical student OSCE, the communication skills checklist, based on a well-established communication skills model, demonstrated acceptable item statistics and produced scores with high reliability.

Better communication can lead to better perceptions of providers: Evidence from VA primary care

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Abstract: Use of effective clinical communication skills varies widely across providers, and providers tend to use these skills less often with racial/ethnic minority patients, constituting a potential root cause of healthcare disparities. We developed a clinical communication skills training intervention for providers focused on 4 specific skills, “Agenda-Setting,” “Paraphrasing”, “Eliciting the Patient’s Perspective”, and “Strategic Pausing”, and we evaluated the intervention with providers and patients in 2 Department of Veterans Affairs primary care settings.

We created training videos to demonstrate each skill in action and showed the videos to providers sequentially in training sessions moderated by an expert in clinician education. Providers asked questions took notes on each skill, and the videos and notes were made available on each provider’s computer desktop throughout the study. Office visits of providers and patients were audio recorded. After each office visit, each patient completed validated scales of Provider’s Supportiveness and Provider’s Sensitivity. The office visit audio recordings were analyzed, and frequency and duration of provider use of each skill during the conversation were computed.

We used multivariate general linear modeling to predict scale scores from frequency and duration of all 4 skills in recorded conversations. Across the patient sample as a whole, duration of all 4 skills jointly was a statistically significant predictor of Provider’s Supportiveness and Provider’s Sensitivity (adjusted R^2 = .09 and .07), but for African American patients, the relationship was statistically stronger (adjusted R^2 = .15 and .13), and stronger still for Hispanic/Latino patients (adjusted R^2 = .39 and .41). All models accounted for patient and provider age, patient’s years of education completed, and provider’s years in practice.

Our findings suggest that increased use by providers of these important clinical communication skills can increase racial/ethnic minority patients’ perceptions of providers, encouraging more effective communication between parties and helping “bridge the gap” in healthcare disparities.

Examining Patient-Centeredness in Electronic Communication: An Analysis of Provider-Patient Secure Messages

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Introduction/Objectives: Patient-centered communication is critical to patient-centered care. Within the medical home model of the Veterans Health Administration (VHA), secure messaging is envisioned as a means to enhance access and strengthen Veteran and clinical team relationships. Although previous research has examined the content of electronic messages, less research has focused on the “patient-centeredness” of those messages. We analyzed secure messages to understand (1) their purpose; and (2) the extent to which they represented principles of patient-centeredness.

Methods: We coded a total of 334 secure message threads sent between Veterans and clinical team members from January-July 2013 at eight VHA facilities. We developed a coding scheme based on previous research regarding asynchronous patient-provider communication, and three investigators tested the scheme on a subset of messages. Once achieving acceptable reliability, three investigators independently coded the remaining messages.

Results: Of 711 individual messages, 53% were sent by Veterans (N=373) versus 48% sent by clinical team members (N=338). More than half of Veteran messages provided transactional/logistic information, such as information about tests, prescriptions, or appointments (63%, N=234). The majority of messages sent by clinical team members responded to Veteran questions with information of some kind (73%, N=246). Veteran messages were neutral in tone (70%, N=262) and displayed respectfulness (26%, N=96). The tone of clinical team messages was also neutral (82%, N=277) and respectful in nature (33%, N=113). Secure messages from clinical team members sometimes appeared hurried (25%, N=86) but still displayed friendliness/warmth (19%, N=64) and reassurance/encouragement (19%, N=63).

Discussion/Implications: Secure messages were exchanged by Veterans and clinical team members to share salient care management details and were largely neutral in tone. The considerable number of messages that involved transactional/logistic information underscores the role of secure messaging as a coordination tool. Incorporating principles of patient-centeredness into secure messaging can enhance personalized communication through this channel.
Faculty Development for Active Communication Skills Facilitators through Booster Courses

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Introduction: In large healthcare communication skills training programs where numerous small group facilitators are involved, it is essential to prioritize continual development. When faculty members are first trained in the skills of leading a small group, many of these skills may be new and unfamiliar. Further, faculty who are involved infrequently as trainers may need help maintaining good small group facilitation skills.

Innovation: At the Center for Professionalism and Communication in Healthcare at Hamad Medical Corporation (Doha, Qatar) we have 56 active facilitators (physicians and nurse educators) who teach our courses for physicians and nurses. In order to continually improve our facilitators through faculty development, we implemented a policy that all facilitators must attend a ½ day booster course once a year. This multi-disciplinary booster course has three primary objectives: 1) To review the steps for facilitating small group role plays; 2) To present a new framework for dealing with challenging situations during communication skills training; and 3) To provide a safe forum for discussion and questions. It is a 2.5-3 hour workshop.

Evaluation: We began the booster courses in 2015. In the first four months, 26 facilitators participated in the booster course. (By the conference, we expect to have n=40). Participants reported high satisfaction with the course (90% reporting very satisfied or satisfied). Participants reported most useful portions of the booster course included: interactions with other facilitators and discussions about how to deal with difficult situations with learners during communication skills role play. Participants also made suggestions for more frequent booster course offerings and opportunities to talk with other facilitators.

Implications: Improvements on the program have come out of these discussions including setting expectations with training groups, changing the room layout for afternoon sessions, developing facilitator consistency with groups throughout the day.

How communication skills are modeled and reinforced during early clinical experiences: Analysis of Medical and PA Student reflections

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Introduction: A first year course introduced early clinical experiences (ECE) for medical and physician assistant students to explore how communication skills taught in formal sessions are used in the context of real clinical practice. Students write formal reflections to deepen and integrate overall learning about communication skills.

Methods: Students are assigned to a clinician mentor and each clinic visit focuses on observation and application of communication skills learned in class. Student reflection after each visit centers on three questions: “What” (what happened); “So what” (what was the importance of what was described); “What now” (what are the implications for your future communication practice). Each student completed 5 sequential ECE experiences. Thematic analysis was applied to 1/3 of reflections (305/915) to identify common insights from student observations of real clinical interactions.

Results: Recurrent themes in student reflections included:
- If and how skills being formally taught were used by practicing clinicians.
- Impact of use or omission of effective skills (rapport building, open ended questions, seeking patient perspective, etc.) on the diagnostic and relationship building process.
- Insight on patient needs and experiences in healthcare encounters.
- Variable application of recommended skills depending on context (new/return patient; specialty; nature of complaint).
- Pushing students to consider the implications of what they observed resulted in self-identification of key learning points they hoped to apply to their own future practice.

Discussion: ECE utilizes “just in time” experiences to place communication skills learned from formal curriculum within the realities of actual clinical practice. Student reflections identifying the impact of variable use of these skills and the impact on patient encounters is critical in helping learners internalize core skills and anticipate challenges to their consistent application. Additional longitudinal analyses will help to determine if these insights and skills are carried forward into actual performance.

Partnering with patients and families to develop and evaluate a simulation-based program for training residents on ‘information sharing’ and ‘caring’ aspects of patient-centered communication

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Introduction/Objectives: We partnered with patients and their families to create an education program to advance patient-centered communication (PCC) skills among physicians-in-training.

Methods: We used simulation with standardized patients with follow up from preceptors and patients in clinical settings. The intervention was developed by a team of medical educators and patient representatives, reviewed by residents and patient-family advisors, and implemented in two residency programs within one academic center.
We randomized half of the residents within each program to participate in the training (N=24). We assessed participants’ satisfaction, self-efficacy, and use of skills in clinical practice. We conducted interviews to seek feedback on the intervention and explore how residents used taught skills in their clinical practice.

**Results:** Participants were highly satisfied and reported significantly higher confidence in their ability to break bad news, respond to an angry patient, and communicate about treatment options post simulation (p<0.05 for all). Three out of four participants reported using PCC skills more in their clinical practice at six months follow up. Use of various skills varied with ‘listening to patient concerns’ and ‘expressing empathy’ most consistently used, and ‘verifying patient understanding’ and ‘brainstorming and problem solving with patient’ least consistently used. Comparing the intervention to control group, the skill of ‘avoid interrupting patient talk’ showed the most difference among the groups with 21% of residents in control group reported using this skill ‘all/most of the time’ compared to 55% in the intervention group (p=0.08).

**Discussion/Implications:** Patients/families provide an important perspective in developing programs to advance PCC. Simulation training in this area is effective and well received; however, barriers exist to provision of feedback as a learning reinforcement strategy in the clinical setting. Evaluation of the impact of similar training programs on patient experience of care and outcomes is needed.

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**Persona non grata? A mixed-method study of medical students’ responses and reactions to patient emotion**

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**Introduction:** Several studies have shown that empathic handling of patients’ emotions may have a positive effect on health in both patients and physicians. Despite reports of a decline in levels of empathy in medical students, there are few in-depth studies of how medical students handle both own and patient emotion in clinical situations.

**Objectives:** In clinical encounters:
- what communicative behavior do students express towards patients in terms of responses to emotional cues and concerns and;
- Which perspectives and reflections do medical students offer as to why they respond like they do to patients’ emotional cues and concerns?

**Methods:** Eleven 3rd year medical students were instructed to conduct an anamnestic interview of a chronically ill patient but were not informed they were in fact talking to a simulated patient. In recall interviews using video sequences of emotional situations students were interviewed on their accounts of what made them respond like they did.

VR-CoDES were used to code student responses to cues and concerns and a qualitative content analysis of students’ recall interviews was completed.

**Results:** Students displayed a similar response pattern across encounters by mostly providing space for further disclosure of cues and concerns, but most often non-explicitly. Accordingly, students reported in recall interviews that they made use of communication strategies for conveying understanding to the patient. However, students varied greatly in their perspectives on what understanding means in the physician-patient relationship. Some students regarded these strategies for communicating understanding primarily as a means to seamlessly continue their own agendas of recording a medical history while others meant the conveyance of understanding should reflect own emotional reactions and would challenge both ethical and personal convictions if used without caution.

**Discussion/implications:** We suggest that communication skills training should also include reflection on how ethical and personal boundaries can be respected for both students and patients.

**Student factors that contribute to changes in patient-centered attitudes over 4 years of medical school**

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**Introduction/objectives:** The ability to provide patient-centered care (PCC) has been shown to be a crucial component of high-quality and equitable care. It is well documented that for some medical students, attitudes around patient-centeredness decline over 4 years of training. Little is known about which students are at greater risk to be impacted in this way. The objective of this research is to determine which students experience a decline in patient-centered attitudes over 4 years of training.

**Methods:** This study used data from Medical Student CHANGES, a large national longitudinal cohort study of medical students surveyed in 2010 in their first year of medical school (Y1) and 2014 in their fourth year (Y4). Patient-centeredness is assessed with the Health Beliefs Attitudes Scale (HBAS). Analyses include mixed-model regression procedures with random effects for school. Full models assess student factors that race, gender, age, socioeconomic-status (SES), political orientation, socio-political attitudes) that might contribute to attitudes towards PCC in medical students. 3,756 medical students from 49 US medical schools stratified by geographical region and public/private status into 12 strata.

**Results:** Nearly a quarter of students (24%) had a decrease in positive attitudes towards PCC over 4 years of training. Just over 30 percent had a negligible change (-.5 to +.5) and 44 percent had an increase in positive attitudes towards PCC. Age (>/24), gender (female), SES (low SES) predicted a positive increase in attitudes towards PCC. Sociopolitical orientation (increased authoritarianism and decreased egalitarianism) were significantly associated with PCC such that authoritative attitudes predict a decrease in PCC at Y4 and egalitarian attitudes, positive attitudes towards PCC.
Discussion/Implications: Medical school curricula with targeted messages about the benefits and value of PCC, framed in ways that are consistent with the beliefs and world-view of medical students and the recruitment of a diverse sample of students are vital for improved care.

Talking about Chemsex - A collaboration between medical school and hospital

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Introduction: Recreational drug use with sex, or ‘chemsex’, is increasingly reported by men who have sex with men and who access sexual health services in the UK. This rising trend of using drugs such as Crystal Methamphetamine, Mephedrone and GBL coupled with sex, is thought to be linked to rising rates of HIV and other sexually acquired infections.

In a study of gay men in south London, sexual health clinics were identified as places where men felt comfortable talking about chemsex. However, talking about chemsex is dependent not only on a patient’s willingness to disclose, but also on the attitudes and communication skills of health care professionals.

This presentation will outline a unique educational collaboration between St George’s Medical School and St George’s Hospital in London to tackle some of the clinical communication barriers to talking about chemsex.

Instructional methods: Doctors, nurses and health advisors were invited to attend an educational event designed by medical school academics and a senior sexual health doctor, which offered evidence based plenary session followed by small group work. The group work was facilitated by expert clinical communication teachers. Participants worked on patient scenarios taken from authentic clinical practice using roleplay with highly trained actors, and received feedback on their performance.

Evaluation results: This intervention received 100% positive evaluation using an anonymous questionnaire and was well received by participants. Participants wanted more and felt their communication overall had developed because of this event.

Discussion: To our knowledge, this is a unique educational event that blended didactic and experiential learning techniques in order to develop communication in chemsex consultations within the multiprofessional team of a sexual health clinical. We plan to develop the intervention and to offer it to a wider geographical audience in future to explore and address the rising health issues associated with chemsex.

The relationship between clinical experience, communication skills improvement and communication self-efficacy among practicing oncology nurses

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Introduction: Preparing oncologists to communicate with cancer patients is an important component of their training. Previous U.S. studies have shown significant skill uptake in a nationwide training. A limitation of this approach is its inattention to the hidden curriculum - the implicit learning that happens outside of a classroom through role modeling and transmission of cultural norms. It is also unclear whether skill uptake transfers to real clinical encounters. The purpose of this NIH-funded study was to evaluate a 4-year, institution-based communication training program for oncology trainees.

Method: 264 fellows and residents at Memorial Sloan Kettering Cancer Center (USA) participated in the Comskil Training Program during 2010-14. To address the hidden curriculum, instructors for the course included multi-disciplinary faculty from the training programs. Trainees were assessed through: (1) self-efficacy questions; (2) pre- and post-course video recorded consultations with SPs and real patients; and (3) pre- and post-course assessments of trainees’ communication skills by both SPs and real patients. Videos were analyzed using the Comskil Coding System, which codes for the 20 communication skills (in 5 categories) taught during the program.

Results: There were large significant differences between pre- and post-training self-efficacy ratings (p<.001). Participants increased their skill usage with SPs between pre- and post-training in 4 of 5 skill categories (p<.01); and SP ratings of trainees’ communication skills showed significant differences in 14/17 items (p<.01). Preliminary analysis of clinic consultations showed no differences; only 1/22 items on the patient survey showed a significant change.

Discussion: Our study confirms that communication training interventions for oncology trainees clearly have an impact on skills when measured in standardized settings. In clinical settings, either the differences were not sustained, or we were unable to capture them using our methods. Booster courses and coaching interventions may be necessary to produce sustained change.
The use of narrative writing to teach breaking bad news skills and protocol

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Abstract: Teaching Breaking Bad News (BBN) management includes two major components: didactic presentation of BBN protocols and role-playing practicing sessions. Given the importance of the “hidden curriculum” in the daily clinical setting, further reflection upon the knowledge and skills acquired from these experiences is essential. Reflective writing is being used as a teaching method related to professionalism, however its use in teaching BBN has been limited and its efficacy is unclear. Therefore, the purpose of this study is to explore what students learn about BBN through reflective writing.

Method: A systematic qualitative analysis of 166 randomly selected BBN reflective narratives written by 84 medical students as part of a mandatory BBN course. Three team members analyzed all narratives using the Immersion-Crystallization method in an iterative consensus building process.

Findings: The task of observing and writing narratives about BBN encounters has prompted students’ to participate in these encounters which they had previously avoided or were not invited to. Thematic analysis uncovered a variety of lessons learned about BBN, such as broader and deeper insights into the nature of BBN encounters; enhanced understanding of patients, families, physicians and students’ own needs and behaviors; reflection upon behaviors and actions they found important such as preparation before the encounter; and a better understanding of the BBN communication protocol and its appropriate and effective application.

Conclusions: This study shows how the use of narrative reflective writing related to BBN encounters enhances medical students’ sensitivity and awareness to patients’ and families’ needs, as well as their understanding of BBN encounters’ dynamics. Through this clinical experience and subsequent reflection they have deepened their insights into the BBN process and protocol -- essential elements towards coping with its complexities.

Using Examinees’ Observable Behaviors versus Raters’ Subjective Evaluations to Assess Communication Skills

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Introduction: In a high-stakes exam employing standardized patients (SPs) as raters, it is critical to minimize contributions of individual attitudes to scores. The United States Medical Licensing Examination © (USMLE®) Step 2 Clinical Skills Examination (CSE) is a performance-based exam where SPs score examinees’ communication skills. The CSE uses a scoring system noting whether clearly defined, observable behaviors occur. Emphasizing whether or not specific behaviors occur should result in a more impartial evaluation of examinees than a subjective evaluation. In this study, we predicted CSE scores would avoid the influence of ethnicity and gender to a greater extent than a subjective evaluation.

Methods: SPs from two test sites participated, N=139. Over eight weeks, half the SPs at each site completed subjective evaluations in addition to CSE scores for each examinee. For subjective evaluations, SPs rated examinee communication skills on four Likert-type items developed for this study.

We examined whether there were greater differences in SPs’ subjective evaluations of examinees versus CSE scores on gender and ethnicity. Scores were compared using t-tests to compare average ratings of examinees (across all encounters) between males and females and whites and non-whites.

Results: On the subjective measure, there were differences on both ethnicity and gender, t_{ethnicity} (N=987)=8.33, p<.05 and t_{gender} (N=1287)=2.95, p<.05, with whites and females scoring higher. On the other hand, there was no significant difference for either variable on CSE score, t_{ethnicity}(N=592)=1.69, p=.10 and t_{gender}(N=1776)=.612, p=.54.

Discussion: This study provides initial evidence that the behavior-based CSE instrument reflects fewer gender- and ethnicity-based differences in examinee score than subjective evaluations. This difference may be due to a number of variables, including contributions of individual attitudes and differences in performance that are measured by subjective evaluations but not the CSE. Future research may investigate the source and magnitude of these and other variables.

Technology and Social Media

Improving Google’s health searches with medical illustrations

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Introduction: Over 70% of Americans search for health information online. Many browse images to understand medical conditions but this can be daunting due to the graphic, technical, or complex nature of the content. To address this, we commissioned empathetic, accurate medical illustrations within a health product in Google search for over 100 common conditions. The present study describes the creation process and explores the user and expert response to these images.

Methods: We brought together licensed medical illustrators, medical doctors, and product designers to create bespoke illustrations for over 100 commonly searched conditions. We utilized a storyboard
approach to give context, provide empathy, help users understand pathophysiology, and augment the Google health product by highlighting key elements of the condition. The process was refined based on user studies while optimizing for speed of production and medical accuracy. We assessed the response through: (1) anonymous user feedback through a button in the tool and (2) review of select conditions by independent physicians.

Results: Based on user and doctor feedback, the illustrations in our product were able to effectively and emphatically demonstrate nuanced concepts like pathophysiology, causes, treatments, and preventative measures. There was also praise for diversity of subjects and settings. Through the feedback we’ve developed a framework that informs what content and technique(s) are most useful for different condition categories. Additionally we learned that including causes too explicitly can be unintentionally stigmatizing. We have learned how to approach diversity in a way that keeps the image relatable and inclusive but does not distract from the medical information presented.

Discussion: We showed that empathetic, medically accurate illustrations can help users understand and relate to a medical condition. Through the feedback cycle, we have modified our approach and built a framework for how we think about the content of each illustration. This framework has improved the quality of the illustrations and the user’s experience.

Integrating Health-related Consumer Data into Engagement Metrics Designed for Health Communication Targeting and Tailoring

Authors: Melissa Maravic, Eliza Corporation Heather Allen, Rexer Analytics Ralph Perfetto, Eliza Corporation

Introduction: Patient engagement metrics are often used for targeting and developing effective tailored health communications. These metrics can be constructed using patient self-reports, clinical utilization data and response to previous health communications. In an effort to understand and represent a more holistic notion of health engagement in such a metric, Eliza Corporation (Eliza) is revising their existing engagement measure, the Eliza Engagement Index (EEI) to incorporate health-related consumer data. The EEI is currently used for targeting and tailoring general health communications and those focused on increasing clinical gap closure and HEDIS/STAR ratings.

Description of Practice Innovation: Eliza’s Behavioral and Data Science department has examined the utility of incorporating 99 household-level, health-related consumer variables into a measure of patient health engagement. These 99 variables fell into 6 subscales (Health Product Purchasing, Health Information Seeking, Exercise Indicators, Diet Indicators, Prescription Behavior, and Appointment Activities) and an overall score.

Impact: Results show significant positive relationships between many health-related subscale and overall scores and increased clinical gap closure (p<0.05), indicating that these consumer data may contribute meaningful information to a health engagement metric. As such, Eliza has augmented their engagement measure, the EEI, to include consumer health-related data. This revised index is being used to inform message tailoring around retention and increasing HEDIS rates for diabetes, antidepressant medication adherence, and prenatal and postnatal visits. Results from outreaches will be available by September 2015.

Discussion: The ability to harness household-level, health-related consumer data for use in constructing engagement metrics would not only increase availability of data for metric construction, but would also increase the breadth and depth of usable health-related information.

Smartphone-facilitated N-of-1 Trials to Increase Patient Engagement and Shared Decision-Making in Chronic Pain

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Introduction: Chronic musculoskeletal pain affects 100 million Americans and is difficult to treat. The PREEMPT Study evaluates an innovative smartphone app (“Trialist”) that helps chronic pain patients and clinicians design and implement individually-tailored comparative effectiveness studies (n-of-1 trials). The intervention’s goal is to improve pain management and increase patient engagement and satisfaction with care.

Methods: 244 patients will be enrolled, with 122 randomized to the n-of-1 trial group and 122 to the usual care group. Intervention patients meet with their clinician during a regularly scheduled visit to set up an n-of-1 trial comparing two pain treatments. Patients use the Trialist app for daily monitoring of pain and side effects including fatigue, drowsiness and cognition, and the app manages n-of-1 trial logistics reminding patients when to switch treatments and complete questionnaires. Upon trial completion, patient and clinician review graphical output to guide treatment decision-making.

Results: To date, 109 patients have enrolled, 64 patients have been randomized, 30 n-of-1 trials have started and 14 trials have completed. Participants are 55% female, 71% married and 76% white. Experience of intervention group participants thus far is positive, with 100% rating the app as helpful in tracking pain; 90% expressing satisfaction with app reminders; 55% finding it helpful in working with their clinician to achieve treatment goals; and 73% having more confidence in pain management going forward. Patient open-ended comments evaluating Trialist reinforced themes of ease of use (n=3), value of viewing graphical output (n=3) and utility of daily reminders (n=2).
**Underserved Population and Health Disparities**

Language concordance, interpreter use, and communication quality for Latino diabetes patients during primary care encounters

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Background: Diabetes prevalence and complications are higher for Hispanic patients compared to non-Hispanic Whites. Reasons include suboptimal communication with providers particularly for limited-English proficient (LEP) patients. Interpreter use may improve communication at the point of care but less is known about the quality of such communication or the impact of interpretive services on diabetes-related outcomes.

Methods: We examined the quality of communication for English and Spanish speaking patients in four community-based clinics. Fifty encounters were audio recorded and patients provided demographics, food security & medical status (A1C, BMI), health literacy/numeracy, perceptions of provider communication, medication adherence, depressive symptoms, and self-care behaviors. Bivariate associations assessed the impact of interpreter use & communication quality on select diabetes-related outcomes for both language concordant and discordant encounters.

Results: Participants were generally female (54%) and obese (BMI 32.5 ± 6.6). Eighty percent self-identified as foreign-born Hispanics and 72% reported LEP. Average A1C was 9.1 ± 2.4. Encounters were English concordant (22%), Spanish concordant (46%), and Spanish discordant with interpreter (32%). No differences by encounter type occurred for length of visit, A1C, BMI, medication adherence, or ratings of provider interpersonal style. Hispanic patients had significantly lower subjective literacy and numeracy (p<0.001), greater depressive symptoms (p<0.02), and more food insecurity (p<0.001) compared to non-Hispanics. English concordant encounters were associated with higher reports of poor eating behaviors (p<0.01), greater use of data to modify diets (p<0.02), and notable trends towards higher communication ratings (p=0.09). Among Spanish speakers, Interpreter use was marginally associated with improved perceptions of decision making during encounters (p=0.05).

Conclusions: Spanish-speaking patients face greater socio-demographic challenges to their diabetes care. Language concordance or interpreter use may not fully protect LEP diabetes patients from communication challenges in primary care, and further research is warranted to understand better the important role of these services for Hispanics with diabetes.

LGBTQ emerging adults’ current and past experiences with healthcare providers regarding sexuality communication: A qualitative interview study

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Introduction: Physicians can play a vital role in educating adolescents about development issues like romantic interests, dating, sexuality, and safe sex. Unfortunately, conversations regarding sexuality during physician visits occur briefly, if ever. Physicians only spend about 36 seconds talking about sexuality topics with adolescent patients (Alexander et al., 2014). This is especially problematic for LGBTQ adolescents who may benefit most from talking about these issues with their physicians because they often face ridicule and rejection because of their sexual orientation (Berlan et al., 2010), leaving them susceptible to increased health risk behaviors and worse health outcomes compared to heterosexual adolescents (Coker et al., 2010). As such, improvement is needed in communication about sexuality development in primary care practices that see adolescent patients. To inform possible interventions, we sought to learn more about LGBTQ emerging adults’ current and past experiences with healthcare providers regarding sexuality communication.

Methods: We conducted 23 semi-structured interviews with LGBTQ participants between 18-22 (M = 21.4). Audio recorded interviews were transcribed and analyzed using thematic analysis.

Results: The four most salient themes that emerged were: (1) limited discussions surrounding sexuality/sexual behavior, (2) comfort of physicians and adolescents, (3) a need for privacy and confidentiality discussions, (4) a need for gender-neutral language when discussing patients/partners.

Discussion: These findings align with past quantitative research on adolescents that suggests sexuality communication rarely occurs during health visits and when it does, these are fleeting, uncomfortable mentions, instead of in-depth, informed conversations. LGBTQ adolescents and emerging adults may benefit from discussions emphasizing the confidential nature of their visits as this may lead to increased disclosure regarding their sexuality. Including gender-neutral language during healthcare visits may help reduce feelings of alienation for LGBTQ patients. Findings highlight a need for increased observational and intervention research with LGBTQ adolescents, emerging adults, and their physicians.

References
2. Berlan, E. D., Corliss, H. L., Field, A. E., Goodman, E., & Austin, S.
Silence is not golden: Avoidance of speaking, not stuttering severity, among adults who stutter is associated with decreased patient-centeredness during medical visits

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Introduction: Adults who stutter (AWS) constitute a heterogeneous population for which difficulty producing speech may lead to barriers communicating during medical visits. Prior focus groups indicated that some AWS avoided speaking about certain topics with their doctors because of their stuttering. We set out to determine how stuttering severity and speaking avoidance is associated with patient-centeredness in a sample of adults who stutter.

Methods: Adults who identified as stutterers were recruited from e-mail lists of the National Stuttering Association and the Stuttering Foundation of America. Participants completed electronic questionnaires about their demographics; self-reported health status; their stuttering severity and level of speaking avoidance, using the validated Subjective Screening of Stuttering (SSS); and their primary care experiences, using the validated Primary Care Assessment Survey (PCAS). The PCAS measures domains, including Communication and Trust, which have been used to represent Patient-Centeredness in previous literature. We used linear regression to evaluate the associations between SSS scales and PCAS Patient-Centeredness scales.

Results: A total of 191 participants completed the questionnaire. Mean age was 39.3 (SD 16.6); 111 (58%) were male, and 150 (79%) described their racial background as “White.” Ninety-one (48%) reported their health was “Excellent” or “Very Good,” and 122 (64%) reported having a primary care provider. In multivariable analysis adjusted for patient demographics, comorbid conditions, and patient-doctor relationship duration, higher Avoidance scores were significantly associated with decreased Patient-Centeredness scores in regression analyses ($r^2$ 0.04, p=0.03), while Stuttering Severity scores were not associated with Patient-Centeredness (p=0.36) scores in a separate analysis.

Discussion: Greater speaking avoidance, but not stuttering severity, was significantly associated with decreased patient-centeredness in AWS. Because speaking avoidance is often not apparent, greater attention needs to be placed on identifying AWS who are at risk of this symptom in order to provide the best high quality health care in this population.

Wordless intervention for epilepsy in learning disabilities (WIELD): A randomized controlled feasibility trial

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Introduction: Epilepsy is the most common neurological problem affecting people with intellectual disabilities. The high seizure frequency, resistance to treatments, and associated skills deficit make the management of epilepsy particularly challenging for people with intellectual disabilities. The Books Beyond Words booklet for epilepsy uses images to help people with intellectual disabilities manage their condition and improve quality of life. Our aim is to conduct a randomized controlled feasibility trial exploring key methodological, design and acceptability issues, in order to undertake a large-scale randomized controlled trial of the Books Beyond Words booklet for epilepsy.

Methods: We used a two-arm, single-center randomized controlled feasibility design, over a 20-month period, across seven epilepsy clinics in Hertfordshire, United Kingdom. We aimed to recruit 40 eligible adults with intellectual disabilities and epilepsy and will randomize them to use the Books Beyond Words booklet (intervention group) or to usual care (control group). We collected quantitative data at baseline, 4 weeks, 12 weeks and 20 weeks post randomization. This included the number of eligible participants, number of participants recruited, demographic data, discontinuation rates, variability of the primary outcome measure (quality of life), seizure severity, seizure control, intervention’s patterns of use, use of other epilepsy-related information, resource use and health outcome (using EQ-5D-5L).

Results: All 40 participants have been recruited into the study. Recruitment has been slower than expected, but is nearing 25%. There is so far less than 5% attrition and missing data. Follow-up questionnaires are returned on time and completed by the caregivers (after reminder call). Data collected so far suggests feasibility of undertaking a full-scale trial of the Books Beyond Words booklet in people with intellectual disabilities.

Discussion/implications: The findings will be used to inform the design and methodology of a definitive study, adequately powered to determine the impact of the Books Beyond Words intervention in people with intellectual disabilities.

Keywords: Decision aid standards, patient decision-making, shared decision-making, feasibility, decision support techniques
“Express Rather than Impress”: Discussing Research, Career, and Networking Challenges in a Peer-group of Early Career Researchers

Presenters:
- Tabor Flickinger, University of Virginia School of Medicine, Charlottesville, Virginia, USA
- Douglas Rupert, RTI International
- Marij Hillen, Department of Medical Psychology, Academic Medical Center, University of Amsterdam, Amsterdam, The Netherlands
- Kimberly Gudzune, Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA
- Tabor Flickinger, University of Virginia School of Medicine, Charlottesville, Virginia, USA
- Douglas Rupert, RTI International
- Marij Hillen, Department of Medical Psychology, Academic Medical Center, University of Amsterdam, Amsterdam, The Netherlands
- Kimberly Gudzune, Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA

Caring conversations to promote relationship centered practice

Presenter:
- Belinda Dewar, University of the West of Scotland

Emotions in Standardized Patient (SP) Encounters - Opportunities and Dangers

Presenters:
- Elizabeth Kachur, Medical Education Development
- Shakaib Rehman, University of Arizona College of Medicine
- Monica Harris, University of Miami School of Medicine
- Robert Lane, Leeds Institute of Medical Education, School of Medicine, University of Leeds, UK
- Elisabete Loureiro, University of Porto, Portugal

Engaging Adult, Youth, and Professional Stakeholders in Patient-Centered Outcomes Research: An Iterative Process

Presenters:
- Betty Chewning, UW-Madison School of Pharmacy
- Gwen Costa Jacobsohn, UW-Madison, School of Medicine and Public Health
- Nicky Britten, University of Exeter Medical School
- Kathryn Murphy, American Family Children’s Hospital
- Betty Kaiser, UW-Madison School of Nursing, Wisconsin Network for Research Support
- Gay Thomas, UW-Madison School of Nursing, Wisconsin Network for Research Support

Health Literacy: Enabling effective interprofessional communication with patients and families for safe, quality care

Presenters:
- Farrah Schwartz, Toronto Rehab, University Health Network
- Dean Lising, University of Toronto

Jazz and the Art of Medicine: Finding and Using Space in Medical Conversations

Presenter:
- Paul Haidet, Penn State College of Medicine

Lessons in Communication and Teamwork: Can we build a Meaningful, Longitudinal Interprofessional Experience for Health Professionals?

Presenters:
- Mrinalini Kulkarni, University of Texas Dell Medical School
- John Luk, University of Texas Dell Medical School
- Barbara Jones, University of Texas at Austin School of Social Work
- Farya Phillips, University of Texas at Austin School of Social Work
- Gayle Timmerman, The University of Texas at Austin School of Nursing
- Patrick Davis, University of Texas School of Pharmacy
- Holli Sadler, University of Texas Dell Medical School
Managing evidence on communication in healthcare: An introduction to Realist Reviews

Presenters:
Fien Mertens, Ghent University
Peter Pype, Ghent University
Myriam Deveugele, Ghent University

Medical Improvisation: A dynamic method for teaching clinical communication skills

Presenters:
Belinda Fu, University of Washington / Swedish Medical Group
Amy Windover, The Cleveland Clinic

Minimally Invasive Pedagogy: A novel technology-based approach to teaching Shared Decision Making in Medical Schools

Presenters:
Dawn Carey, Dartmouth College
Nan Cochran, Dartmouth College
Thom Walsh, Dartmouth College
Glyn Elwyn, Dartmouth College
Manish Mishra, The Dartmouth Institute for Health Policy and Clinical Practice

Navigating, evaluating and remediating professionalism lapses in multicultural health care context

Presenters:
Amal Khidir, Weill Cornell Medical College in Qatar
Ahmed Alhammadi, Hamad Medical Corporation
Magda Wagdy, Hamad Medical Corporation
Abdel-Naser Elzouki, Dept. of Medicine, Hamad Medical Corporation, Qatar
Khalid Alyafei, Hamad Medical Corporation

Patients as Peer Mentors: Training Patients to Tell Their Story

Presenters:
Jennifer St. Clair Russell, Mid-Atlantic Renal Coalition
Eileen Hanlon, FHI 360
Lisa Tensuan, FHI 360
Laura Planas, FHI 360

Physical examination – A communication skill needing new emphasis

Presenters:
Elizabete Loureiro, Faculty of Medicine of the University of Porto
Monica Broome, Miami Miller School of Medicine
Shakaib Rehman, Phoenix
Rob Lane, Leeds Institute of Medical Education, Leeds Medical School
Elizabeth Kachur, Medical Education Development, National & International Consulting

Plain Talk: Distilled Practices for Challenging Moments in Inter-Professional Teams

Presenter:
Nicole A. Steckler, Oregon Health & Science University

Speaking in Plain Language

Presenters:
Phyllis Mancini, University Health Network
Rita Kang, Toronto Western Hospital

Strategies to Make Informed Consent Truly Informed

Presenters:
Connie Arnold, LSU Health Sciences Center
Terry Davis, LSU Health Sciences Center

Teaching and using an evidence-based method for patient-centered interviewing

Presenters:
Auguste Fortin, Yale School of Medicine
Robert Smith, Michigan State University
Brenda Lepisto, Michigan State University
Richard Frankel, Indiana University School of Medicine
Ashley Hesson, Michigan State University
Francesca Dwamena, Michigan State University
Teaching Doctors to Communicate With Patients in Emotional Distress: The Expanded Four Habits Model

Presenters: Arnstein Finset, Teaching Doctors to Communicate Tonje Lundeby, Teaching Doctors to Communicate Erik Holt, Teaching Doctors to Communicate

The Introduction of the Electronic Health Record (EHR) into the Consultation: Implications for Healthcare Education

Presenters: Sally Quilligan, University of Cambridge Mandy Williams, University of Cambridge

The language of dementia: Applying socio-linguistic methods to issues in assessing and treating cognitive impairment

Presenters: Ashley Hesson, Michigan State University Heike Pichler, Newcastle University

The Listening Awareness Clinic: Skills to Strengthen the Physician/Patient Relationship

Presenter: Joan Lowery, Lowery Communications

The Missing Voice in Healthcare: Effective Communication with the Teenage Patient

Presenters: Caralyn Perlee, New York University Langone Medical Center Erin Lauinger, LCSW, New York University Langone Medical Center

The Neuroscience of Anger and the Angry Patient Encounter

Presenters: Monica Broome, University of Miami School of Medicine Elizabete Loureio, U. Porto

Using Vulnerability to Become a More Effective Leader

Presenters: Timothy Gilligan, Cleveland Clinic Kara Myers, Univ. Calif. San Francisco Calvin Chou, Univ. Calif. San Francisco

Writing the Clinician’s Tale: Sharing Stories and Publishing Your Narratives

Presenters: Elizabeth Rider, Boston Children’s Hospital, Harvard Medical School William Branch, Jr., MD, Emory University School of Medicine, Atlanta, GA Shmuel Reis, MD, MHPE, Bar Ilan University Faculty of Medicine, Safed, Israel

Acknowledging scared decision making - the elephant in the consulting room

Presenters: Pål Gulbrandsen, University of Oslo Eirik Ofstad, University of Oslo Emily Boss, Johns Hopkins Medical Institutions Mary Catherine Beach, Johns Hopkins University Paul Han, Maine Medical Center Glyn Elwyn, Dartmouth Institute for Clinical Practice and Health Policy

Advanced Cancer Caregivers: Implications of Communication

Presenters: Lee Ellington, University of Utah Alexandra Terrill, University of Utah Ronald Epstein, University of Rochester Medical Center Richard Kravitz, University of California, Davis Michael Hoerger, Tulane Cancer Center Cleveland Shields, Purdue University Hoda Badr, Mount Sinai School of Medicine Kathrin Milbury, The University of Texas M. D. Anderson Cancer Center
An interdisciplinary, interprofessional, international approach to assessing providers’ communication behaviors in clinical simulations

Presenters:
Suzanne Campbell, The University of British Columbia
Eileen R. O'Shea, Fairfield University
Michael Pagano, PhD, PA-C, Fairfield University, Department of Communication

An Overview of Conflicting Health Information and Its Implications for Medical Decision Making

Presenters:
Delesha Carpenter, University of North Carolina at Chapel Hill
Rebekah Nagler, University of Minnesota
Katri Hämeen-Anttila, Finnish Medicines Agency
Paul Han, Maine Medical Center

Caring for patients with overweight and obesity: Weight bias and consequences for communication

Presenters:
Katie Washington Cole, Johns Hopkins University Bloomberg School of Public Health
Kimberly Gudzune, Johns Hopkins School of Medicine
Sean Phelan, Mayo Clinic

Empathy in healthcare update: How we lose empathy and how can we relearn to connect?

Presenters:
Felise Milan, Albert Einstein College of Medicine
Nancy McNaughton, University of Toronto
Kathryn Pollak, Duke University
Shmuel Reis, Bar Ilan University Faculty of Medicine in the Galilee

International advances in communication about complementary and integrative medicine in patient care

Presenters:
Christopher Koenig, San Francisco Veterans Affairs Health Care System
Evelyn Ho, University of San Francisco
Daniel Dohan, University of California, San Francisco
Adriaan Visser, Knowledge Center Innovation in Care
Mayke op ‘t Hoog, Rehabilitation Centre “de Hoogstraat” in Utrecht
Ellen de Regt, the Foundation Open Atelier in Beeld, Amsterdam, the Netherlands
Sonya Pritzker, University of Alabama, Tuscaloosa
Derjung Tarn, University of California, Los Angeles
Francesca Alby, University of Rome Sapienza

Medical visit communication with patients who have cognitive impairment: Challenges, communication patterns and effective interventions

Presenters:
Debra Roter, Johns Hopkins University
Lori Erby, National Human Genome Research Institute
Yue Guan, Johns Hopkins University
Orit Karnieli-Miller, Tel Aviv University

Non-verbal communication in clinical encounters: State of the art and future directions

Presenters:
Marij Hillen, Academic Medical Center - University of Amsterdam
Rita Gorawara-Bhat, The University of Chicago, Department of Medicine, Section of Geriatrics and Palliative Medicine
Lauren Hamel, Wayne State University-Karmanos Cancer Institute
Arnstein Finset, Department of Behavioral Sciences in Medicine, University of Oslo
Paul Han, Maine Medical Center Research Institute
Patient-Centered Communication, the Evidence Base, and Shared Decision Making in Perinatal Care

Presenters:
Elizabeth Soliday, WSU Vancouver
Yvette Miller, Queensland University of Technology
Rachel Thompson, Dartmouth College
Gabrielle Stevens, The Dartmouth Institute for Health Policy and Clinical Practice
Anna Strahm, Washington State University
Ashleigh Armanasco, Queensland University of Technology

Transforming Customers into Patients: Research on Pharmacist-Initiated Patient Engagement from Canada and USA

Presenters:
Lisa Guirguis, University of Alberta
Betty Chewning, University of Wisconsin-Madison
Carol J. Hermansen-Kobulnicky, University of Wyoming
Matthew Witry, University of Iowa

Translation and Cultural Adaptation of the Communication Assessment Tool: Experience in 4 Countries

Presenters:
Gregory Makoul, UConn Health
Vincent Kalumire Cubaka, University of Rwanda, University of Aarhus
Michael Schriver, Aarhus University
Irene Carvalho, University of Porto
Afonso Cavaco, University of Lisbon
Daniela Scala, AORN Cardarelli
Enrica Menditto, University of Naples Federico II
Andre Karger, Universität Düsseldorf
Claudia Kiessling, Medizinische Hochschule Brandenburg

Using interdisciplinary research to inform interpreter-mediated consultation training

Presenters:
Shuangyu Li, King’s College London
Angela Rowlands, Queen Mary, University of London, UK
Demi Krystallidou, Ghent University, Belgium
Peter Pype, Ghent University, Belgium
Antoon Cox, The Vrije Universiteit Brussel, Belgium and King’s College London, United Kingdom
Phillippe Humblé, The Vrije Universiteit Brussel, Belgium
Jennifer Gerwing, Akershus University Hospital, Norway

PROCEEDINGS FROM 2015 ICCH: SPECIAL INTEREST GROUPS

Communication Assessment Tool: International CAT Study

Presenter:
Gregory Makoul

Communication Skill Teaching and Assessment in Surgery and Other Procedure-Based Specialties

Presenter:
Kathleen Kieran

Communication Training for Patients

Presenters:
Melanie Hagen
Christa L. Arnold

Fear knot: Exploring the complexities of using scare tactics in clinical encounters

Presenters:
Matthew Wynia
Namratha Kandula

How do DocCom Online Resources Improve Communication Skills Learning for Students and Residents to Enhance the Patient Experience?

Presenters:
Barbara Lewis
Bill Clark

Pain Speed Networking

Presenters:
Mollie Ruben
Danielle Blanch-Hartigan
Proposing a Special Interest Group on Medically Unexplained Physical Symptoms (MUPS)

Presenters:
Anne Weiland
Sandra Van Dulmen
Marta Csabai
Dirk Vogelaers
An Mariman
Jan Van Saase
Els Tobback

Q. How did you become interested in doctor-patient communication and the Academy?

Richard Frankel: It turns out that doctors and patients first meet as strangers and their communication patterns were of interest for that reason. It also turned out that one of the graduate students was working with Barbara Korsch, a pediatrician at USC, who was videotaping and analyzing pediatrician/patient/parent encounters. Being a bit of a science nerd, I had actually read a 1968 article in Scientific American describing her work and thought it was groundbreaking. It was! Barbara was kind enough to give me access to some of her videos and I was off to the races in terms of analyzing doctor patient communication as a type of stranger-stranger service encounter. My interest in doctor-patient communication and eventually the Academy took an unanticipated turn in 1979 when my mother was hospitalized, where she had worked until retirement at age 70, with some unexplained symptoms. She had lost a brother to a late diagnosis of cancer and was concerned the same might be true for her. All of her test results were normal and at discharge her family physician told her, “There is nothing wrong with you. It’s all in your head.” Three hours after discharge from the hospital she took her own life and it was clear that her psychological suffering had gone unheeded in her care. Her death marked a major turning point in my life and career and I have spent the last 36 years doing research and teaching about doctor-patient communication with my mom’s memory continually pushing me forward. Loss of a parent to suicide is not easy, especially if it is the result of a preventable medical error. I spent the first few years after my mom’s death angry at the doctor and the profession that could let such things happen. Then, in 1986 my life took another unexpected turn when I attended the AACH national course in Portland, Oregon. I was in a small group with Wendy Levinson, Howard Beckman, Dan Duffy, Norm Jensen and Jim Florek and our group facilitator was Aaron Lazare, all physicians who helped me heal and influenced my career path. In AACH I found like-minded folks who were on their own journeys but also held fast to the value of collaboration, trust and unconditional positive regard. Who could resist finding the very values that made my life meaningful? I jumped in with both feet, was a supporter and advocate for the organization since.

Q. What are the lessons learnt from your years of research, teaching and practice?

Richard Frankel: This is a very interesting question. I could quote you chapter and verse about findings from many of the studies that I’ve been involved in, but I think there are two principles that I have learned over the years that have served me well in the various roles that I have played, genuine curiosity and deep respect. As Malcolm Gladwell points out in his book Blink, we make inferences about people and situations with astounding rapidity, literally in the blink of an eye. For example, it was relatively easy to conclude from the way in which the diagnostic news was delivered to my mom that her physician was uncaring and insensitive. A more measured approach would have been to become more curious about his knowledge of psychosocial problems and his training, if any, in how to handle them. In the absence of training, he was “flying blind” which is akin to asking a first year medical student to discern an S-3 gallop the first time they listen to heart sounds. The second principle is...
Q. How could young clinicians, investigators and other healthcare workers be more effective, productive and happy?

Richard Frankel: As we have seen in the patient and relationship-centered care movement, patients are demanding to be seen by physicians who care about them as people; not just as disease entities. I think young physicians are going into medicine with a more balanced view of what they want from life. Many more are getting married during medical school or professional training and are starting families. Why? Because they want to be able to enjoy home life and work life. Rather than give advice I would say that we need to listen to the hopes and dreams of our young professionals which is maybe a little self-centered since they will be taking care of us in a few years. Do I want a burned out, overwhelmed, distracted physician or nurse taking care of me in the office, hospital, or nursing home? Certainly not.

Q. What is the future of AACH in your vision?

Richard Frankel: AACH will always have a place in medical care. For some it is a life boat, for others a revelation in terms of skills and personal awareness. It has stood the test of time in terms of longevity and has touched many of today’s senior leaders in care planning, policy, and practice. As reimbursement policies have changed in the direction of valuing patient input and partnership AACH’s role in providing the skills necessary to advance clinical practice will continue to grow. I believe we will see large organizations (Kaiser Permanente, the VA and Cleveland Clinic) begin to adopt communication skills programs for staff that are required and are based on solid evidence of effectiveness. AACH can be a leader in bringing its teaching to scale so that its innovative message can be spread to a much larger audience.

Q. Any final message for all of us?

Richard Frankel: Live long and prosper! Thanks for the opportunity to share my personal journey and my professional formation with AACH.

Learning from Loss

Author: Suliman EL-Amin, MD, MS

Mr. J. and I talked about everything from the piano jazz style of Thelonious Monk to growing watermelon in Georgia’s red clay soil. In between those beautiful snippets of life that he relayed to me, I managed to ask a few questions regarding his health. He was aware of his weak heart, uncontrolled diabetes, and poor kidney function, but it was the debilitating fatigue and dark tarry stools that were worrisome. He was treated for a GI bleed during a previous hospitalization, but since that time, his symptoms had worsened. Now, simply getting out of the bed proved a chore. Yet, most troubling to Mr. J. was that he could not harvest his crops due to his extreme exhaustion. As a third generation farmer who owned acres of land, he prided himself on growing the best corn and spring greens in the county. This season was going to be one of the best, if only Mr. J. could tend to his crops properly.

Our medical team wanted to perform an upper endoscopy to help locate the bleed and possibly stop it via cauterization. Mr. J. adamantly refused the treatment because this was the same approach taken during his last hospital stay and it had resulted in little improvement. Nevertheless, the medical team assured him that this was the most appropriate intervention and that they would do their best to figure out the cause of his illness.

I was asked to care for Mr. J. as a third year medical student because the team thought he would be a good patient to learn from. I regret that our initial introduction felt awkward as it took place while he was getting a femoral catheter inserted through his groin. Through the pain, Mr. J. explained that he was tired and old. Yet, he had accepted his fate, having made peace with God many years ago.

I played the listener and the learner that day. For the moment, being the caretaker was secondary as I listened closely and intently to his tales of growing up in the segregated South. At some point in between his pauses, I asked again about the possibility of him getting scoped. I made no promises regarding the outcome, but I did explain that this was a necessary test for locating the source of his bleed. After hearing my request, he briefly paused and said that he would think about it.

We continued our conversation and shared a few laughs. That is when Mr. J. asked me to repeat my name. I slowly pronounced my name as “Suliman.” He paused briefly. Then, he repeated my name twice in a strong, authoritative tone, while he looked up at the ceiling as if he was trying to recall what it meant.

“Suliman, Suliman,” he repeated, as he smiled slightly.

He spoke those words, as if knowing something I did not, some secret that he wanted to share with me. I asked why he said my name in such a peculiar way.

He stated, “Because you are meant to do something special.”
As he leaned back in his bed, he continued to look at the ceiling and started to explain what he meant.

“You see Suliman,” he said. “I believe that the heavens have to agree before a person is birthed into this world. And you are meant to do something special.”

I politely thanked him and tried to quickly change the subject. I felt vulnerable and flattered at the same time. I promised him that I would read more about his condition that evening. I also promised that I would bring in some music that he could listen in the morning.

He smiled, and I left his room. That night, I read everything about his illness, from GI bleeds to heart attacks. I also wrote a thorough treatment plan to present to the team the next day.

The next morning, I came to the hospital an hour early to check on how Mr. J. fared the previous night. I met with his nurse and asked how he was doing.

She looked at me and said, “I’m sorry, he died last night around 9:30 p.m.”

My heart immediately sunk. I looked across to his room. The shades were down, the lights off. It was like an ominous sign that someone had died in the hospital. When I asked what happened, I was told that the cause of death was likely a heart attack, but an autopsy would have to be performed to confirm this. I let the news sink in for a minute, as I held his freshly produced medical plan in my hand. Then, I took a deep breath, placed the papers in my white coat, and quickly left to see other patients.

The rest of my team slowly arrived that morning, each one learning about the loss. We did not say much about the death of Mr. J., which was fine with me because at the time, I was still trying to process everything. I had so many unanswered questions. How did he die? Why did he die? Why didn’t I recognize that he was going to die? Even more importantly, did he know that he was going die?

Later in the day, a few members of my team were kind enough to ask how I was taking the news. For the most part, I was fine. However, as the day went on, I found myself thinking about Mr. J. and our last conversation more and more. I wondered about his family and friends. How were they going to take the news? I almost managed to keep my emotions in check through the end of the day; that was until I encountered one of my professors in the hallway. We had a brief discussion and he asked me how I was doing. It was at that point that I felt a rush of emotion course through me and my eyes began to water. I tried to utter the word “fine,” but I couldn’t. The tears began to flow down my cheeks. I could not hold it in anymore, and I cried like a baby. I told him that I had lost a patient today and asked him for forgiveness for appearing so unprofessional.

He smiled and said, “It is alright. It just means you are human.”

I wiped my face. As we talked a little more, I felt a bit better, more human. I cleaned myself up and carried on with my day. I went on to care for other patients in the days and weeks that followed, but Mr. J. will forever be in my memory.

Note: This narrative is compliant with HIPAA regulations. All identifying details have been changed significantly to protect patient’s privacy.

Bio: Dr. EL-Amin is a first-year resident physician in the Department of Psychiatry and Psychology at Mayo Clinic Hospital in Rochester, Minnesota.

What nurtures me, what do you mean?

Author:
Rufus L. Barfield II, Ph.D.

Context: 2nd Annual Physician Leaders Retreat for eight selected physician leaders of a faith based healthcare organization in the southeast United States. The interaction described occurs in the first of three “Self-Reflection” small group interaction sessions. The physician leaders had written individual letters of support to the facilitator consenting to participate in the retreat, been briefed on the task and purpose of the Self-Reflection sessions, and provided an annotated bibliography physician leadership reading materials and copies of selected physician leadership articles. Lastly, I had worked with the physician leaders in other training contexts prior to this meeting.

What nurtures you was the question I asked the small group of physician leaders gathered in a small picturesque meeting room located at a secluded bed and breakfast lodge for the 2nd Annual Leaders Retreat. Their response was, “What do you mean? What do you mean by what nurtures me?” I paused, took a deep breath looked around the room and repeated the question, “What Nurtures You?” This time I stated the question much slower, with slightly increased volume and was sure to enunciate the words with extra clarity. This time the response was, “What do you mean, what nurtures me?” accompanied by looks of bewilderment and suspicion upon the faces of the physician leaders.

At this juncture I began to grow a bit frustrated and somewhat irritated because in my mind the request was pretty clear. Prior to the gathering, we determined that an end goal of the retreat was personal and professional rekindling and refreshment and that we could better achieve this if we knew how we nurtured ourselves and be more in touch with what drains us of our energy. In short, the question seemed appropriate for the contextual gathering. Also, I am thinking to myself these are very smart people, very competent people who surely know the meaning of the word nurture.

I gathered myself, took a deep breath and began to wonder in my head and heart what it must be like to be in their place. As I moved into their seats (metaphorically speaking) I got in touch with the possibility that what on the surface appears to be a simple straightforward question may not be so simple and straightforward when it involves revealing self. What I did next was reframed the question stating, “What drains you of your energy?” The energy in the small picturesque room shifted quickly. It was “as if” a tremendous weight had been lifted from the group. Indivual members breathed heavy sighs of relief, taking deep breaths and in “brainstorming” fashion began rattling off numerous things that drained them of their energy. After 10 minutes of this I stopped the group and ask, “Why do you think you could readily identify things that drain you your energy but had such a difficult time understanding let alone disclosing what nurtures you? As a matter of fact we have yet to articulate what nurtures you”? My bringing us back to the original question on the one hand was a “mood killer” but on the other hand a powerful piece of our work together over a three day, two night period. More
importantly it revealed to us three important dynamics that can occur in serving and attending to our patients and or our students.

Self-Interest.
We may not give conscious daily attention to what nourishes or sustains us as we try to care for, attend to and or educate others. While it doesn’t mean that we don’t nourish ourselves, it might suggest that self gets obscured or lost to those we serve. Self-interest is not to be confused with being selfish. Maintaining a healthy self-interest implies that wellbeing of and service to others is paramount however, my most effective service to and care of others will only be as good as the interest that I take in myself. More importantly, daily reflection on and attention to nurturing self and maintaining self-interest helps us to surround ourselves with what we need to whole.

Facework-Identity.
The small group of physician leaders admitted that they have hobbies and interests outside of medicine but it’s very uncomfortable to be asked, “What nurtures you” in front of your peers. More to the point, it was in-part “fear” of not looking competent and not being able to articulate in the moment something that they should know. I shared with the physicians’ how I gave myself permission to be in their place (metaphorically speaking) earlier in the session and how it was then that I could begin to get in touch with the uncomfortableness of the moment, question and overall experience. Moreover, the group concluded the obvious and that is “everybody wants to look good or nobody sets out to look bad”. Having this revelation brought us back into the room to consider that when we reveal ourselves to others we are in fact giving up varying degrees of control and power and that is frightening. Often, physicians are perceived as possessing lots of power and knowledge and being in control of people and resources. Those perceptions may or may not be true however; we learned that amongst the leadership peer group there was a fear of looking incompetent, of not being in control and even more a fear of saying, “I don’t know what nurtures me.” Some of the physicians considered if they had put their patients or students in the same position what the response would have been. Consequently, some began to consider how this could impact patient adherence and their desire to be perceived as a competent compassionate care-giver.

Knowing what I don’t want but not knowing what I want.
Being able to readily identify “what drained them of their energy but unable/hesitant to articulate “what nurtures you” are analogous to someone in a relationship being able to say what they don’t want in the relationship but not being able to articulate what they want. Stated differently, we become what we think about and perhaps in this context readily identifying what drained them of their energy implies that they had given a substantial amount of thought and time to that subject. Perhaps the physician leaders’ personal and professional experiences informed them to draw such conclusions so readily. The task then becomes one of reframing the thoughts and creating what nurtures you in spite of the context that may not provide, have the capacity to provide or facilitate nurturing. The key for us was to consider that we can create what nurtures. The realization of this was powerful and really energized the room and physicians. Even more, the physicians realized that actively creating their own nurturing system allowed them to take control of their life and reclaim a power-base that perhaps they had given away. Furthermore, the physician leaders concluded that real leadership involves empowering others (i.e. patients and students) and spent some time exploring how they could empower/support patients and students to create nurturing systems.

Patients, Patience and Pseudomembranous Colitis

Author:
Deen L. Garba

After hearing a dramatic recollection of a hospital-induced infection by a retired physician, a young public health student aims to better understand iatrogenesis.

Stepping into the foyer of the large, Victorian neo-tudor, I looked around for symbols that would help me relate to the patient. A portrait of John Wesley hung on the wall of the staircase, suggesting a devout Methodist upbringing. Old newspaper clippings, black and white photographs, and knitting yarn were strewn across a credenza. None of these were icons I immediately identified with; still, I remained excited to learn more about the patient’s narrative.

It was my first time performing an in-home visit with a patient, and I was eager to prove my competence. As a first year undergraduate, I had been tasked with interviewing patients through a joint class I enrolled in with first year medical students. With a doctor for a father, I had long anticipated becoming a physician. This seemed like the perfect opportunity to assess my clinical aptitude.

The patient we had been assigned to, Dr. John Hathaway, was a retired internist who had a long career as a medical doctor in New York. He had a brief paroxysm with pseudomembranous colitis, and we were tasked with assessing how he perceived his treatment. Dr. Hathaway was treated at two prominent local hospitals, and he candidly recounted how events had unfolded. Most importantly, he explained how a lack of communication between patient and clinician turned what was a minor injury into a life-threatening iatrogenic illness.

Iatrogenesis, from the Greek “iatros” for healer and “genesis” for origin, means an effect on an individual resulting from the actions of a healer. In my naiveté, I found it difficult to fathom how a physician could cause a patient harm. Learning from Dr. Hathaway’s experience provided me with a newfound understanding of the realities of physician fallibility, and how medical error has become one of the greatest challenges we face today.

Mrs. Hathaway, a sweet, grandmotherly woman with faded, blue eyes beckoned us into the living room. I entered along with my two medical student teammates, Laura and Sanjay. “Thank you all for coming,” said Mrs. Hathaway. “John has been so excited about this meeting.” As we entered the room, Dr. Hathaway stood up to shake our hands. He was a stout man with sparse, white hair, and he smelled strongly of Earl Grey. That was definitely something I could identify with.

“Please, sit down”, he said. “Help yourself to some tea.” Laura, Sanjay and I sat down on the sofa across from the loveseat that Dr. and Mrs. Hathaway shared. I took out my portfolio and pen, and we began to ask Dr. Hathaway about his treatment.

After the formalities, Sanjay began with one of the questions we had compiled earlier. “So, Dr. Hathaway, can you tell us what prompted your visit to the hospital?” Dr. Hathaway took an extended sip from his mug and began explaining what had occurred. He described how,
after a minor gardening accident left his thenar eminence infected, he decided to see a physician at one of the local hospitals. “As a clinician, I recognized some of the rapid onset symptoms,” he offered. “I had a pretty good idea of what was going on, so naturally, I decided to take a trip to the hospital to get another opinion.”

“Well that turned out to be a good idea,” replied Sanjay. Laura and I nodded in agreement.

I saw an opportunity to ask a question, so I moved up to the edge of the sofa. “How was your interaction with your physician, and how did he decide to proceed?” I asked. Dr. Hathaway then related how he never seemed to really connect with his physician. “He never really understood me,” he said reflecting, “and he definitely trivialized my injury. In fact, he just left me to the PA, and she gave me some antibiotics.”

Ultimately, this led to a severe case of pseudomembranous colitis (PMC), otherwise known as C. difficile colitis. PMC is a type of intestinal inflammation that often manifests from the use of broad-spectrum antibiotics. As a medical doctor, he seemed well aware that rates of PMC have increased steadily in recent years, alongside reported trends in the dehumanization of healthcare.

PMC’s genesis is well understood, and the most ambiguous aspect of the illness lies in its diagnosis where other medications may be responsible. One example is with cancer patients, where chemotherapeutic agents may sometimes disrupt intestinal flora and trigger the development of pseudomembranous colitis. It then becomes much harder to diagnose, as was regrettablly the case with Dr. Hathaway.

Since my childhood in Nigeria, I have been aware of the vast inequity in healthcare between the developing world and the United States. Several factors always stuck out to me. Lack of skilled manpower, fiscal decentralization, and inefficient service delivery were evident in Nigeria. People rarely sought out primary care services, and, in the few instances in which they did, the high out of pocket costs were more than most families could afford.

Yet, despite the challenges inherent in developing health systems, iatrogenic illnesses disproportionately affect Western societies. Many link this phenomenon to a decreased emphasis on establishing physician-patient rapport. While physicians in the United States certainly value patient communication, increased pressure from families. They were treated in a completely different regard… I noticed some of the rapid onset symptoms, including a fever, abdominal cramps, bloody stool and diarrhea. I took a sip of Earl Grey and nodded my head. “And did you return to see your physician?” I asked. Dr. Hathaway simply shook his head. “I couldn’t see a reason to go back . . . he was an anathema to me.”

Mrs. Hathaway smiled shyly, seeming to be in total agreement. “His symptoms started three or four days after he began taking Amox… Amoxo...” she started. “Amoxicillin”, interjected Dr. Hathaway. “The symptoms didn’t bother me though. I was more concerned with the emotional strain it put on my marriage.”

“Marcy helped me with everything,” Dr. Hathaway admitted. He described how Mrs. Hathaway subsumed many care responsibilities. She brought him to and from the hospital, aided him on his frequent trips to the restroom, and scheduled his medications. This placed an extra burden on Mrs. Hathaway and ultimately led to “a lot of arguments and sleepless nights on the couch.”

“I’ve been a bad husband,” added Dr. Hathaway. “I’ve handled all of the finances. Marcy won’t even be able to pay the light bill when I’m gone.”

What happens when a partner or spouse passes, especially when one partner is responsible for specific tasks? Certainly, many couples can identify with this idea.

Dr. Hathaway also brought to life concepts my professors had introduced in class. For instance, I was taught about “the clinical gaze”, a term coined by French philosopher Michel Foucault in his celebrated Naissance de la Clinique. He defines the clinical or medical gaze to be the phenomenon in medicine whereby a patient’s body is viewed separately from their identity. This can prove incredibly harmful, as in the case of the Hathaways. Dr. Hathaway’s physician certainly could have spent additional time getting to know him, upon which he would have discovered his medical background and his physically and emotionally draining battle with prostate cancer.

During his tenure as a physician in New York, Dr. Hathaway dealt with a myriad of patients from a diverse number of racial, ethnic and socioeconomic backgrounds. One keen observation he made early was which groups were disadvantaged, as well as which groups received the best medical treatment.

“What did you notice most as a physician in New York?” asked Laura. Dr. Hathaway thought for a long time before saying, “You know... despite all the affluent folk that lived around New York City, those that received the best care were those that had physicians in their families. They were treated in a completely different regard... I mean not even the well-to-do had that privilege.”

Ostensibly, this should be the case, yet Dr. Hathaway found it beyond him that as a physician, he was being treated deplorably - at least by his own standards. “It’s harder to be a doctor-patient than a patient,” he said. The three of us laughed, admittedly in hopes of diffusing the increasingly somber ambience.

“But you know, none of the symptoms hurt nearly as much as the fact that it could have easily been prevented if the doctor just paid attention to what I was saying,” said Dr. Hathaway.

Of course, a lot of physicians are overworked and underpaid, which presents a set of other issues, but excellence in medical treatment cannot ever be compromised, as the very first rule of medicine is to “do no harm.” The fact that doctor-patients face the same issues...
with communication that other patients do highlights the gravity of this issue today.

Despite this predicament, Dr. Hathaway remained optimistic about the future of medicine. “What did you decide to do next?” I asked. Dr. Hathaway’s mood suddenly brightened. He sat up in his chair and put his cup down.

“Well, I decided I would try elsewhere.” It turns out that Dr. Hathaway asked his son-in-law for a referral, and he went to see a physician at a different local hospital. “Everything was different,” he said. “It was the best consultation I’ve ever received.” When we asked Dr. Hathaway what he felt was the biggest difference in treatment, the response was unsurprising.

“Well you know…” he listened to me. “All you have to do is just listen.” Mrs. Hathaway nodded her head in agreement, and Sanjay, Laura and I nodded and laughed politely as well.

As we wrapped up the meeting, Dr. Hathaway thanked us profusely. “It really means a lot to me and Marcy,” he said. “You’ve all listened so well.”

I honestly didn’t feel as if I did anything for Dr. Hathaway, but these last few statements echoed with me as we left, and have stuck with me on subsequent patient visits. It seems so trivial, yet listening carefully, intently, and expressing compassion can go a long way in helping patients heal. The patient’s exposé is vital in uncovering the truth behind an illness. The patient’s account can alleviate them physically, but also socially and emotionally as well.

As medical treatment becomes increasingly minimally invasive, clinicians should become more “invasive” in their probing of the entire narrative the patient brings with them. While innovative technology has been the bastion of modern medicine, it is the historical intimacy between patient and provider that distinguishes medicine from all other fields. As Dr. Hathaway stated, “health is the greatest sustenance we have, and our relationships are key to that.” At the end of the day, we all just want someone to listen.

And that’s something we all can identify with.

Incomplete Knowledge

Author: Jack Coulehan, Center for Medical Humanities, Compassionate Care, and Bioethics, Stony Brook University

Pretending it didn’t hurt, he got up from his recliner and showed me the film he had badgered his doctor to lend.

By the dim lamp, the film exhibited chalky coalescence where his right lung should have been and spots on the left.

My father-in-law asked what I thought of the situation, while commenting in a casual voice that he had decided on radiation, a plan the oncologist had convinced him would be effective.

For some reason I stared at clusters of finger smudges on the film’s surface—they irked me. His face, drained and shattered now that its padding had disappeared, seemed ethereal. His cigarette hand fluttered above the pocket of his shirt for a pack. I nodded in agreement.

Radiation, I told him, is the best choice.1

Commentary:
The pain must have been terrible. My father-in-law, a man of few words and dour countenance, had little patience for “complainers.” Yet, in early 1969 his back pain had become so bad that he was reduced to asking me, a fourth year medical student, what I would suggest that might help. Since the previous autumn, he had been seeing a local chiropractor, but spinal adjustments had evidently not helped. In fact, he now complained that the drill-like agony in his lower back had become unbearable. He had lost a lot of weight as well, but pooh-poohed its significance. Nonetheless, he had scheduled an appointment to see an internist the following week.

Two weeks later Anne and I learned over the phone that her father was suffering from small cell carcinoma of the lung with numerous bone and liver metastases. He was at home considering treatment options. We jumped in the car and drove in record time to the small Appalachian mining town where Anne’s family lived. As I entered the back room where my father-in-law sat as usual in his recliner watching television, he pointed to some x-ray films lying on top of a bookcase. “Take a look at those,” he commanded, while struggling to get to his feet. Once again, he wanted my opinion.

The films showed white-out of his entire right lung field. His heart was displaced toward the left, and there were several small spots in his left upper lung field. I don’t think I had ever seen such a devas-
tating x-ray finding. The cancer was everywhere. It made my head spin. Anne’s father was carefully watching my expression.

“Surgery or radiation?” he asked, then without waiting for an answer, remarked, “They think they can take care of it with radiation.”

What could I say? I was looking at a death sentence in my hand, a sentence that would soon be carried out regardless of what treatment was attempted. My nascent medical mind asked itself what the goal of radiation was. The answer popped up: to prevent or delay future bronchial obstruction and post-obstructive pneumonia. However, my nascent medical heart was not so glib in responding to the situation. Though the state of shock lasted no more than a few seconds, it must have been plenty of time for the man to notice my panicked expression. Or at least that’s how it felt.

I agreed that radiation would be the best approach.

Over the next few months, my father-in-law weakened, his dyspnea increased, and he developed threatening episodes of hemoptysis. He never discussed his condition with me again, except to reply, “I’m feeling a little better” or “The pain isn’t as bad as it was.” Seemingly, his only interest at the time, our only focus of conversation, was Anne’s early pregnancy: our first child, his first grandchild. He insisted that I buy a life insurance policy and start a savings account.

Less than three weeks after beginning my internship, I was once again examining x-rays, this time with my ward team in the basement of the Hospital of the University of Pennsylvania, when I received a phone call. Anne’s brother was on the line. Their father had died. Could I break the news?

I wrote “Incomplete Knowledge” some forty three years after these events. Looking at my father-in-law’s chest films may have been the first time I felt the burden of being privy to expert knowledge. Everything clicked: the man would die of cancer within months. There was so much I knew that he didn’t. I thought how stupid he was not to have seen a medical doctor earlier, and how ridiculous his hope of being cured by radiation. I also thought myself admirable for being able to maintain—after the initial shock—a medical composure. However, my nascent medical heart was not so glib in responding to the situation. Though the state of shock lasted no more than a few seconds, it must have been plenty of time for the man to notice my panicked expression. Or at least that’s how it felt.

I’m happy that after all these years the poetry of that encounter emerged in written form to remind me of that struggle.

References

Ruffled White Feathers

Author: Amir Adam Tarsha, MS, University of Miami Miller School of Medicine

Morning rounds: coffee in hand as they drag their feet from door to door to door.

Ah! The wingless white swan—and her swanlings stumbling in tow!

Q: Good morning Cynthia, what hurts today?
A: Well, what has a bottom at the top?
The chief resident, Liz, (Who Cynthia has dubbed “girl with sighs inside her smiles”) lifts the sheets and notes that the serpiginous lesions on her legs have deepened.

Cynthia has been digging again, for worms only she can see.

-collective sigh-

Q: How can we make you more comfortable?
A: What loses its head in every morning, but gets it back every night?
Liz gets her a pillow.

Any questions, Cynthia?
they ask, turning to leave, when:

Spotless cygnets! Some parting words-

The pond you swim is seldom clear, but in the murk you mustn’t fear.
Dive headfirst into the muck, finding worms takes more than luck.

The truth is a wing-beat away.
Now fly white feathers, fly!
Dive white feathers, dive!

Commentary:
Communicating with patients, medical and/or psychiatric, may be the most important skill for medical students to learn. One of the first realizations I had in my early medical education was that in conversations with patients, what the patient hopes to take away and what the practitioner hopes to gather, are often not the same.
Take for instance the physician and his team during a particularly busy morning of rounds. The physicians and students hope to gather as much relevant clinical data as possible from the patient in the least amount of time. This is a practical goal given the constraints at hand: innumerable patients and only 24-short hours in a day. The patient and her/his family however, has likely have been anxiously waiting for the return of the attending since she/he parted yesterday. While many patients are happy to oblige the teams’ inquiries about ambulation, diet, and bowel function, most also hope for a deeper level of communication. They hope to gain a better understanding of the long-term trajectory of their care, a few moments to share their doubts and fears, and perhaps most importantly the sense that the team is making an effort to get to know them, not just her/his imaging and lab results.

This poem tells the story of a patient who seems to want more from her conversation with the care team than the perfunctory medical questions. She speaks in riddles and metaphors and appears eager to challenge the young medical students in their thinking. The patient appears less concerned with her psychiatric condition and its medical consequences (the fascinating, controversial, and heartbreaking disease call Morgellons) than with encouraging the physician and students to dig deeper, to ask questions that fall outside of the morning checklist. Though the team appears frustrated with the patient’s odd style of communication and strange demands, the reader hopefully gets the feeling that the student may have something to learn from the patient - that just deep to her riddles and metaphors there is a valuable lesson lurking.

What to look for when listening

Author: Daniel Becker, University of Virginia School of Medicine

Tone is what the dog hears.
Ellen Bryant Voigt

We’re talking about what to look for when listening, and the lively discussion over intonation, whether it counts as verbal or nonverbal, leaves me scratching my head,
in a manner of speaking. Videos are scored for all that isn’t said. Leaning forward means getting closer, and that’s true in any language, especially true for bad news sinking in.

Eye contact can be too much of a good thing. Someone taught me to stare at the nose not the eyes in order to keep a safe distance. That works, but there you are, a serious conversation, studying every pore on some poor nose. Someone claims we can teach monkeys to stare, and heads nod, but I’m not so sure. Dogs yes. Their dark eyes beckon.

The point is that body language should emerge—a rheostat?—otherwise some nonverbals are too bright, too loud, too taught. It’s hard to know what to dial in, but a pause,

then a soft hand on the shoulder, a parenthetical hand, (picture the kind teacher asking that quiet kid, so quiet it’s disquieting, still with us?) is what quiet kids are here to learn.

What can we learn from all the different ways patients say I don’t know during memory tests they happen to be failing?

I don’t know, aside from the sad fact there are too many ways. The data are audio, so we can’t count shrugs or eye contact that’s running on empty or long slow looks out the window

if the patient is lucky enough to have a window that might offer if not a hint at least something else to think about. We don’t know if the scorer leaned in

or shifted the chair in a sympathetic angle.

I’ve tested patients with simple questions I’m rooting for the answers to. I know I shouldn’t give hints,

but if the third object to recall is “watch” I might look at my wrist, then look up, get some eye contact, then check the time again. That’s always a long minute. Turns out I’m not supposed to use watch as an object.

Chevrolet yes. Or cow. For instance that cow with blue light explaining its back, the same blue as the mountains

standing behind the herd in my friend’s painting of October. Not our mountains, but October is October.

In every room there’s someone who talks too much,

someone to tune out while talking to yourself and looking out the window that isn’t there and thinking hard about intonation at the lectern and tone on the page.

You don’t need to say the words to hear them and own them. Tone inflects meaning, except for the Norwegians here—an international meeting—who inflect the end of every sentence.

As do the French—n’est-ce pas?—but with a different scale. We add meaning as we listen, for instance the dog that comes, sits, and drools whenever he hears the whistle.

One note, always the same note, no misunderstanding. As for what the other senses are trying to tell us: who’s to say what experience is?

When Sappho says mere air these words, but delicious to hear might what fizzed for her taste flat to me? I can’t taste those hints of blackberry in the wine

but if that concept wants to waft up to the brain where the blackberries are waiting to remind me how they grew wild along the fence between our field

and what used to be the cow field shouldn’t I try to listen? Who can forget those cows or how their field ends at the woods crossed by a stream

that leads to a river where we cool off on a hot day? The dogs like that. In fact, their dark eyes beckon.

Commentary:

In October 2015 I attended the ICCH meeting in New Orleans. I don’t travel a lot, aside from staring out the window, but I had some findings I wanted to share, a resident I wanted to introduce to the right
people, and a physician wife with similar interests in doctor-patient communication. My wife and I also share gastronomic interests that a meeting in New Orleans allowed us to indulge. On Monday I attended a symposium on non-verbal communication and a workshop on the language of dementia. The poem blends those experiences. It is also a means of thanking the meeting.

Poetry has been defined as the best words in the best order, a concept that resonated with more than a few ICCH sessions. Writing poetry is also a means of thinking out loud while permitting your thoughts to jump all over the place. Poetry critics call that elliptical. I call that free verse with ADD. A poem discovers its intent as it wanders down the page. In “What to look for when listening” the first six stanzas are thinking about intonation and non-verbal expression, about the parallels with poetic tone, about a doctor on video repositioning his chair and himself while sharing difficult news. A dog wanders into the poem. Why are dogs allowed? I love dogs, and a teacher of mine described poetic tone as what the dog hears. Then, in an elliptical jump that should only be confusing for a moment, the poem considers what it is like to listen to a demented patient say I don’t know. That’s the workshop on dementia and memory testing asking to be remembered. I’ve asked patients to remember things that they could name a few minutes before the memory test. Things like the watch on my wrist. One of the things that the ICCH meeting taught me is that I am doing the mini-mental status test incorrectly. Oops. I ad-lib. I’m lucky to be in a profession that lets me make things up as I go along. Those difficult conversations require some improvisation to get you through the tough parts. By that point in the poem it is time to leave ICCH and ask some broader questions about discovering meaning and how the mind shapes experience. Poetry is able to make room for a blue cow or hints of blackberries. I’m no philosopher, but I know that Wittgenstein liked poetry and poetic solutions to the language problem that he wrote about. I’m no psychologist, but I know that Freud, describing his theory of mind, said the poets were here before me. I also know that every poem needs to end and my poem about my trip to New Orleans ends by taking me home, to the field that I am looking at now. Thank goodness for windows. As for the dogs in the poem, we have two, and they are next to me now, giving me that look.
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